Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

30 January 2024

09:30 GMT Europe/London

Virtual -TEAMS

Click here to join the meeting

AGENDA

2401 - A MEETING BUSINESS

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

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 30 January 2024 v3.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 30 January 2024 at 09:30
Via MS Teams

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

D3	Freedom to Speak Up Bi-annual Report & Speaking Up Strategy 2024-2028 *Zoe Lintin, Chief People Officer* *Paula Hill, Freedom to Speak Up Guardian*	*Approve*		10
BREAK 10:50 – 11:00				
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:00**
E1	Chair's Assurance Log - Finance & Performance Committee *Mark Day, Non-executive Director*	*Assurance*		**5**
E2	Finance Update *Jon Sargeant, Chief Financial Officer*	*Note*		10
E3	Postal Service Contract *Jon Sargeant, Chief Financial Officer*	*Approve*		10
E4	Directorate of Recovery, Innovation & Transformation Update *Jon Sargeant, Director of Recovery, Innovation & Transformation*	*Assurance*		10
E5	Operational Performance Update *Denise Smith, Chief Operating Officer*	*Assurance*		10
F	**STRATEGY**			**11:45**
F1	Research & Innovation Strategy Update *Zoe Lintin, Chief People Officer* *Professor Sam Debbage, Director of Education & Research* *Dr Jane Fearnside, Head of Research*	*Assurance*		10
F2	Doncaster & Bassetlaw Healthcare Services Ltd Update *Jon Sargeant, Chief Financial Officer*	*Assurance*		10
G	**GOVERNANCE AND ASSURANCE**			**12:05**
G1	True North, Breakthrough and Corporate Objectives Q3 2023/2024 *Richard Parker OBE, Chief Executive*	*Assurance*		10
G2	Board Assurance Framework (Risks 1 – 7) Trust Risk Register 15+ (as reference for the above item) *Fiona Dunn, Director Corporate Affairs / Company Secretary* *All Executive Directors*	*Assurance*		20
G3	Chair's Assurance Log - Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*		5
G4	Acute Federation - Committees in Common Agreement *Fiona Dunn, Director Corporate Affairs / Company Secretary*	*Approval*		10
H	**INFORMATION ITEMS (To be taken as read)**			**12:50**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair of the Board*	*Information*		

H2	Chief Executive's Report *Richard Parker OBE, Chief Executive*	*Information*		
H3	Integrated Quality & Performance Report *Executive Directors*	*Information/ Assurance*		
H4	Minutes of the Finance and Performance Committee – 30 October 2023 *Mark Day, Non-executive Director*	*Information*		
H5	Minutes of the People Committee – 7 November 2023 *Mark Bailey, Non-executive Director*	*Information*		
H6	Minutes of the Quality & Effectiveness Committee – 3 October 2023 *Jo Gander, Non-executive Director*	*Information*		
H7	Minutes of the Charitable Funds Committee – 29 September 2023 *Hazel Brand, Non-executive Director*	*Information*		
H8	Minutes of the Audit & Risk Committee – 19 October 2023 *Kath Smart, Non-executive Director*	*Information*		
I	**OTHER ITEMS**			**12:50**
I1	Minutes of the meeting held on 19 December 2023 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
I2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		
I3	Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
I4	**Date and time of next meeting: Date:** Tuesday 27 February 2024 **Time:** 9:30 **Venue:** MS Teams	*Information*		
15	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair of the Board*	*Note*		
J	**MEETING CLOSE**			**13:05**

*Governor Questions

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

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

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

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

Suzy Brain England OBE
Chair of the Board

2401 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

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

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

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

REFERENCES

Only PDFs are attached

A1 - Register of Interests & FPP (24.01.2024).pdf

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

Register of Interests

Suzy Brain England OBE, Chair of the Board

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

Kath Smart, Non-Executive Director

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

Mark Bailey, Non-Executive Director

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

Jo Gander, Non-Executive Director

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

Mark Day , Non-Executive Director

Health Development Director, Equity Solutions Group - (Investment and development organisation that specialises in partnerships with the public sector and the Design, Build, Finance and Operation (DBFO) of bespoke buildings)
Non-Executive Chair, Summerhill Service Limited (SSL)- SSL is a wholly owned subsidiary of Birmingham and Solihull Mental Health NHS Foundation Trust providing a range of support services to the Trust and other customers
Director of Corporate Services, Money Advice Trust, aregistered charity providing debt advice to the public, influencing public policy, and collaborating with a range of partners to improve practice

Hazel Brand , Non-Executive Director

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

(as at 24 January 2024)

Lucy Nickson , Non-Executive Director
Chief Executive for Day One Trauma Support, national charity

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

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

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

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

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

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

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

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

The following have no relevant interests to declare:

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

(as at 24 January 2024)

Fit and Proper Person Declarations

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

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

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

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

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

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

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

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

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

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

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

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

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

(as at 24 January 2024)

2401 - A2 ACTIONS FROM PREVIOUS MEETING (NO ACTIVE ACTIONS)

Standing item

Suzy Brain England OBE, Chair of the Board

No active actions

PRESENTATION

- Information Item

2401 - B1 INTELLISPACE CRITICAL CARE AND ANAESTHESIA DIGITAL SOLUTION

Information Item 09:40

Andrew Foulds, Digital Practitioner
Mark Luscombe, Anaesthetist

15 minutes

REFERENCES

Only PDFs are attached

B1 - Intellispace Critical Care & Anaesthesia Digital Solution.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Department of Critical Care
Clinical Information System Team

A CLINICAL INFORMATION SYSTEM FOR INTENSIVE CARE AT DBTH

Dr Mark Luscombe (Clinical Lead Intensive Care DBTH /Clinical Project Lead)

Andrew Foulds (Lead Digital NURSE Practitioner)

Philips Intellispace Critical Care and Anaesthesia (ICCA)

- Why did we do it?
- What does it do?
- What are the benefits?
- What is the future?

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

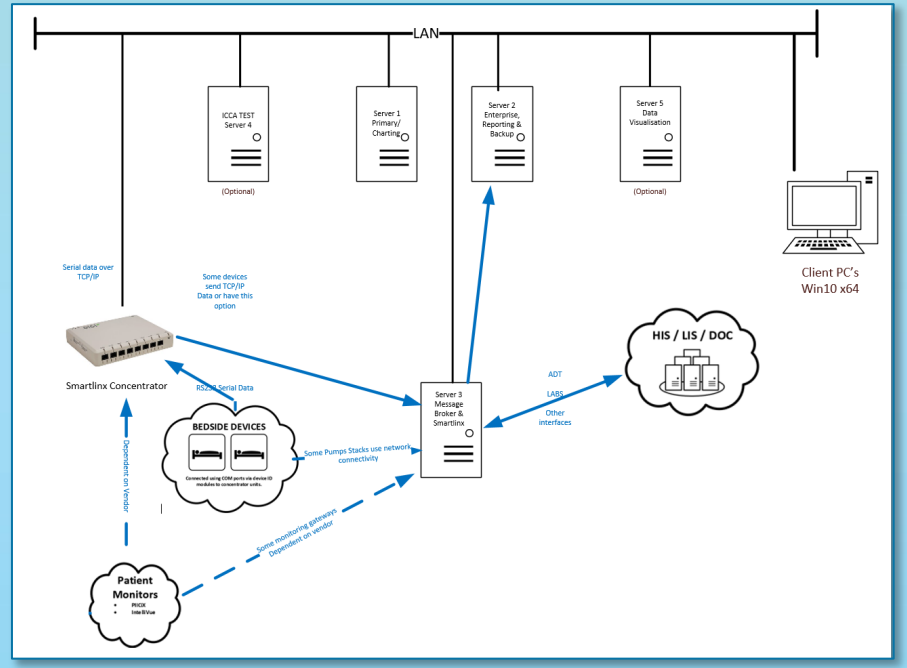
Department of Critical Care
Clinical Information System Team

WHY DID WE DO IT?

- DBTH Intensive care facing recruitment crisis
  - Provide a modern environment
  - Research opportunities
- Need to anticipate new unit/new hospital
  - Have infrastructure ready to move
- Good timing?
  - "Change accepting" staff after COVID-19
- First draft business case July 2020
- Scrutiny of existing systems: clinician selected Philips ICCA

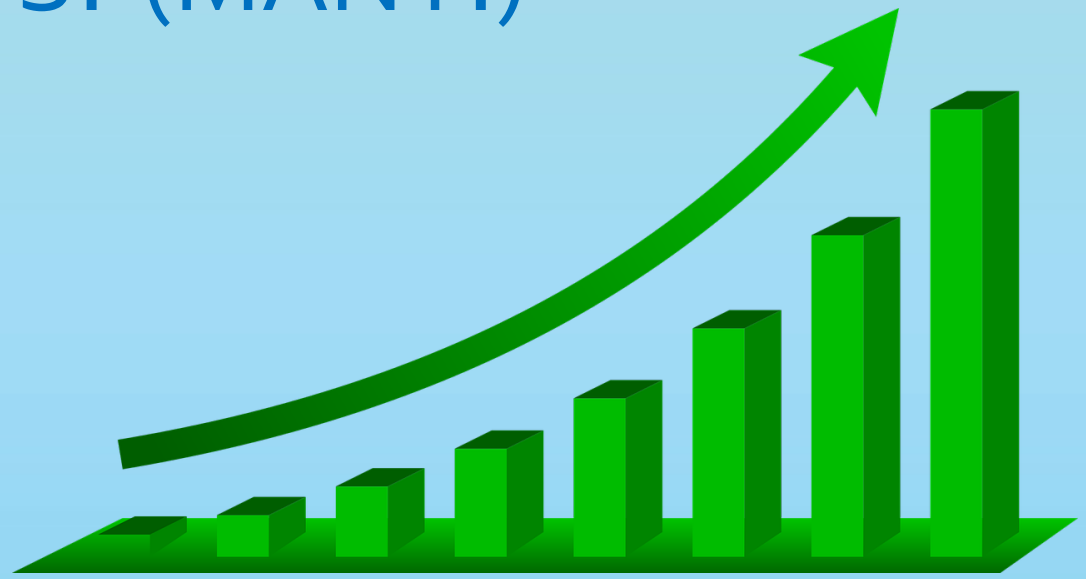
WHAT DOES IT DO?

- Provides both EPR & EPMA
- Collects & stores data – Patient Monitors, Pumps, Fluid infusion pumps, Ventilators, Dialysis machines.
- Automatically calculates fluid balances (and other automated calcs).
- Easily allows Audit of data to improve Patient Care
- "One stop shop" – all patient information is in one place.



WHAT ARE THE BENEFITS? (MANY!)

- Doctor/Nurse time
- Remote access to real time patient data
- Reduces Errors in calculations (automatic) & prescribing (standard orders)
- High quality granular data collected – easy to allow Audit/QI/Research/Mortality and Morbidity



BENEFITS? SECOND SLIDE

- Coding data collected to allow improved trust finances
- National Audit data collected to high standard
- Hopefully improve our recruitment and retention prospects for consultant staff
- High quality discharge documentation for safe transfer of patients

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Department of Critical Care
Clinical Information System Team

WHAT IS THE FUTURE?

- This is the ***start*** of a journey
- Research
- Decision support
- Imprivata one-sign
- EPMA interface with hospital
- Expansion to other areas

2401 - C TRUE NORTH SA1 QUALITY & EFFECTIVENESS

2401 - C1 EXECUTIVE MEDICAL DIRECTOR UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

C1 - Executive Medical Director Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**C1**
Report Title:	**Executive Medical Director Update**		
Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Julie Butler, Senior Manager to Exec Medical Director		
Appendices:			

Report Summary

Executive Summary

Clinical Update and Overview of MD Team Activities

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

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

Recommendation:	The Board is asked to note and take assurance from the content of the report.			
Action Require: *Highlight relevant action:*	~~Approval~~	~~Review and discussion/ give guidance~~	**Take assurance**	~~Information only~~
Link to True North Objectives: *Highlight which SAs this report provides assurance for:*	**TN SA1:** ***To provide outstanding care and improve patient experience***	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire & Bassetlaw ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes ~~/No/ NA~~		**Yes ~~/No/ NA~~**	

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

Assurance Route	
Previously considered by:	

Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

1. INTRODUCTION

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

2. MEDICAL DIRECTOR FOR WORKFORCE AND SPECIALTY DEVELOPMENT

2.1 Job Planning Performance

The table below shows job plan performance as at 2 January 2024.

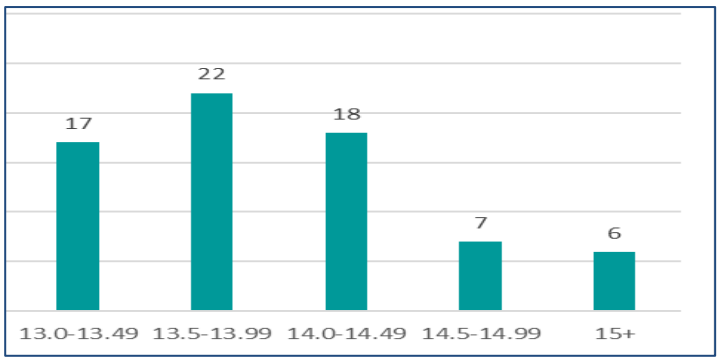
Job Plan Status	No.	%
Job Plans agreed and signed off	201	55%
Job Plans agreed and waiting Clinician or Manager sign off	63	17%
Job Plans in discussion: - agreed/re-published (within 12 months of last sign-off) = 10 (0.03%) - never had a signed off job plan = 59 (16%) down from 92 in the previous report	98	27%
Job Plans in mediation	3	1%
Job Plan Locked Down	1	0%
Total	**366***	**100%**

baseline figure fluctuates with leavers/starters and the allocation of job planning system licences

2.2 Plan for Managing High Levels of Job Planned Programmed Activities (PAs)

The European working time directive (EWTD) requires the working week to be an average of 48 hours (12 PAs) which is measured over a fixed period of time (usually 6 months). This is health and safety legislation to protect employees from working excessive hours, safeguarding health and wellbeing of staff and safe practise. Doctors have the option to opt out of the working time rules due to the nature of their work.

Work has commenced to proactively review those doctors with job plans in excess of 13 PAs (54 hours per week) starting with analysis of job plan activity held on the electronic job planning system. There are currently 70 doctors across the Trust who have job plans with 13 or more PAs. The chart below shows the distribution of these in 0.5 PA increments.



(Allocate data extract 02/01/2024)

The next phase of this work will be a series of further discussions, consultation and complex negotiation to:

- Understand the drivers for high PAs, such as vacancies within difficult to recruit specialties and increasing capacity to meet demand.
- Agree the Trust policy for acceptable upper and lower limits of the 'average' working week.

- Plan the process for managing the review of job plans and redistribution of PAs if appropriate.

2.2 Job Planning Assurance

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

- Proposal to standardise Supporting Programmed Activities (SPA)/clinical administration allocation – proportionate to number of Direct Clinical Care (DCC) activities. Principles to be circulated for comment among consultant colleagues.
- Review of sample job plans with 14+ PAs, queries documented and all actions to be followed up.
- Next meeting to focus on research activity and appropriate allocation of PAs.

2.3 Workforce Planning

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

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

2.4 Workforce Development and Engagement

The Clinical Directors leadership development sessions have now extended to all consultants in leadership roles. The workshops continue to receive positive feedback and are scheduled at 3 monthly intervals.

In addition, the New Consultant Forum continues to offer advice and support for new senior medical staff to the Trust, with sessions scheduled for 2024/25.

3. MEDICAL DIRECTOR FOR OPERATIONAL STABILITY AND OPTIMISATION

3.1 Getting It Right First Time (GIRFT)

A series of GIRFT events have been scheduled in February 2024, with divisions and regional clinical GIRFT leads for specialties to present a review of progress and delivery in 2023/24 against GIRFT recommendations, along with plans for 2024/25.

The national GIRFT team, led by Professor Tim Briggs, are rolling out a programme called 'Further Faster' to deliver rapid clinical transformation with the aim of reducing 52-week waits. The programme aims to support adoption of outpatient transformation guidance, as well as GIRFT's 'high volume, low complexity' (HVLC) surgical standardised pathways, including day case pathways and the use of elective surgical hubs.

DBTH is in the second cohort of acute Trusts to take part in the programme which commenced in November 2023, with a series of on-boarding events at specialty level.

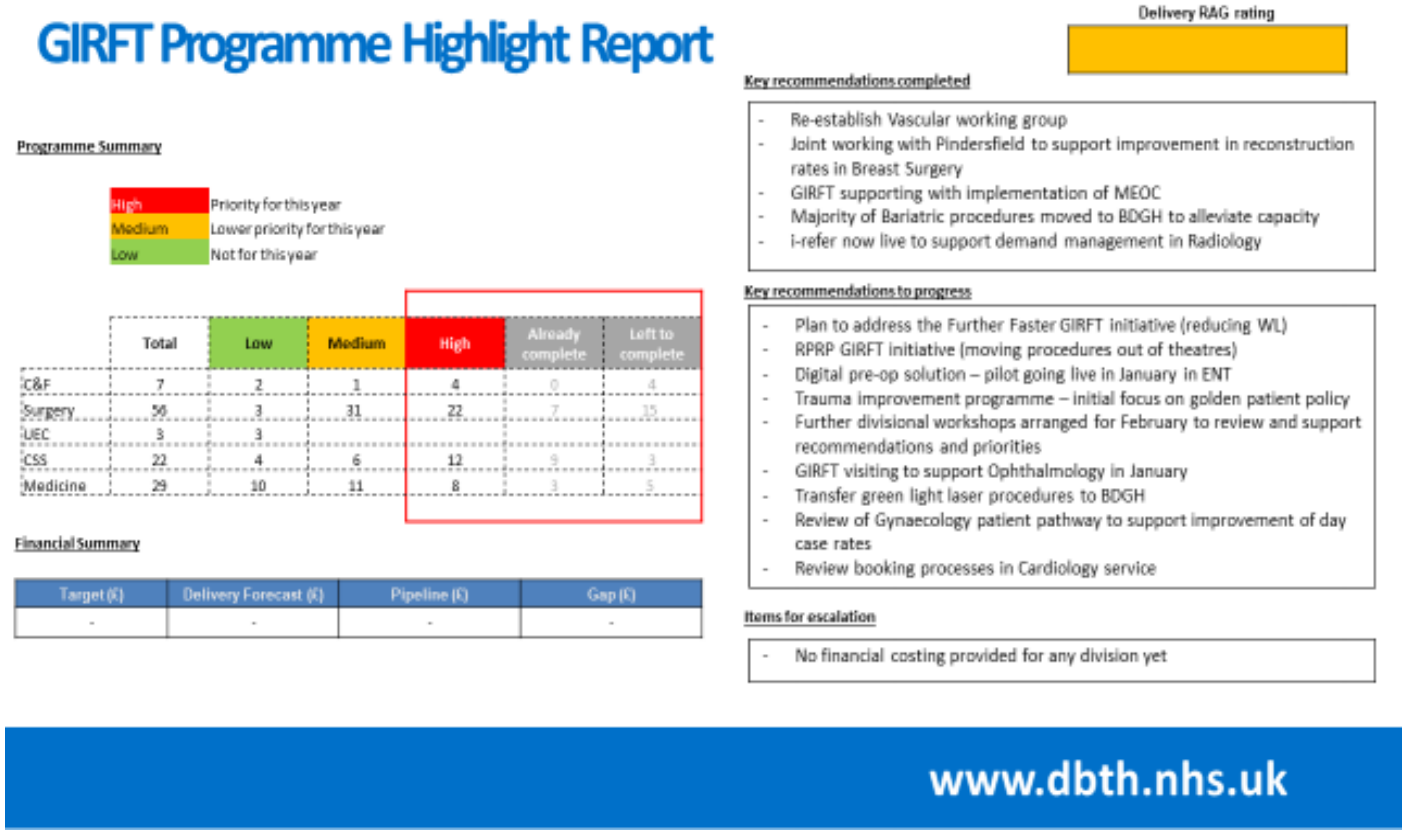
The initial ask of Trusts is to:

- Map current pathways against the GIRFT Specialty Outpatient Guidance to identify the gaps and opportunities and implement plans.

- Engage with the Specialty Clinical Groups to:
    - a) overcome barriers to adopting the best practice pathways;
    - b) work together with our national clinical leadership to build on that guidance further.

- Undertake a series of 'super clinics' or similar initiatives, adopting the approaches taken in a number of organisations to help increase the pace of recovery.

The below highlight report for January 2024, gives a high level summary of progress from recent meetings with divisions. The highlight reports are updated for Trust Executive Group, Transformation Board and presented to Finance and Performance Committee as requested.



GIRFT Programme Highlight Report

Delivery RAG rating

Programme Summary

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

	Total	Low	Medium	High	Already complete	Left to complete
C&F	7	2	1	4	0	4
Surgery	56	3	31	22	7	15
UEC	3	3				
CSS	22	4	6	12	9	3
Medicine	29	10	11	8	3	5

Financial Summary

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

Key recommendations completed

- Re-establish Vascular working group
- Joint working with Pindersfield to support improvement in reconstruction rates in Breast Surgery
- GIRFT supporting with implementation of MEOC
- Majority of Bariatric procedures moved to BDGH to alleviate capacity
- i-refer now live to support demand management in Radiology

Key recommendations to progress

- Plan to address the Further Faster GIRFT initiative (reducing WL)
- RPRP GIRFT initiative (moving procedures out of theatres)
- Digital pre-op solution – pilot going live in January in ENT
- Trauma improvement programme – initial focus on golden patient policy
- Further divisional workshops arranged for February to review and support recommendations and priorities
- GIRFT visiting to support Ophthalmology in January
- Transfer green light laser procedures to BDGH
- Review of Gynaecology patient pathway to support improvement of day case rates
- Review booking processes in Cardiology service

Items for escalation

- No financial costing provided for any division yet

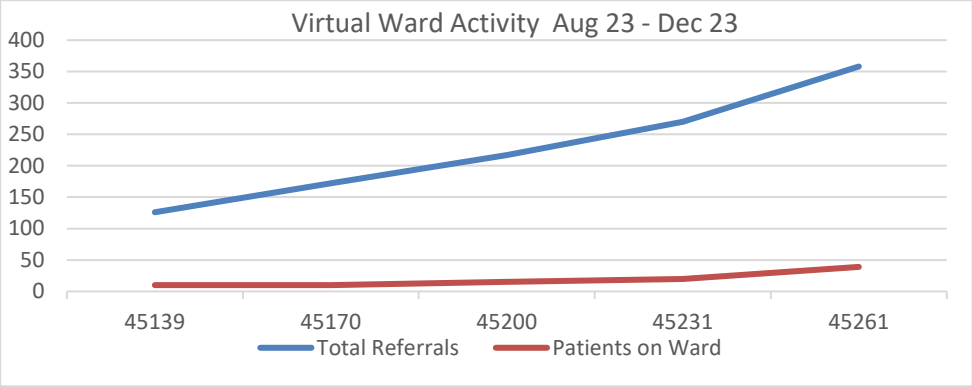
www.dbth.nhs.uk

3.2 Virtual Ward

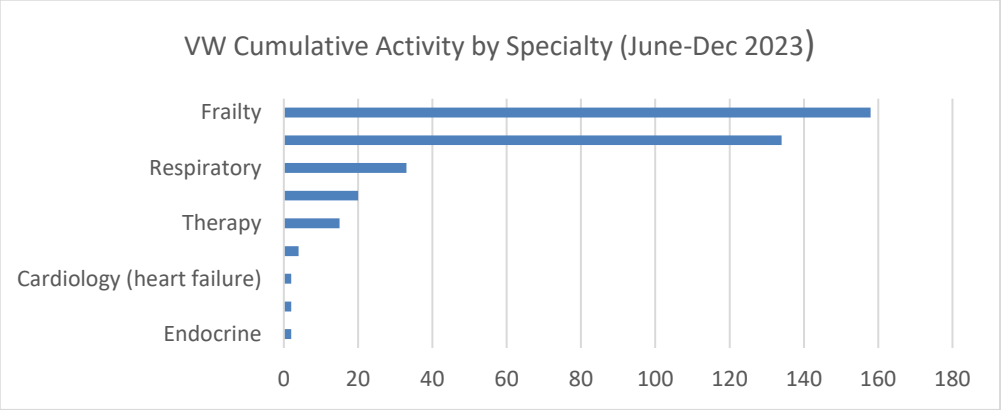
Good progress is being made on virtual ward (VW) pathways. There has been good clinical engagement enabling virtual ward pathways to be developed in other acute areas beyond the initial scope of frailty and respiratory.

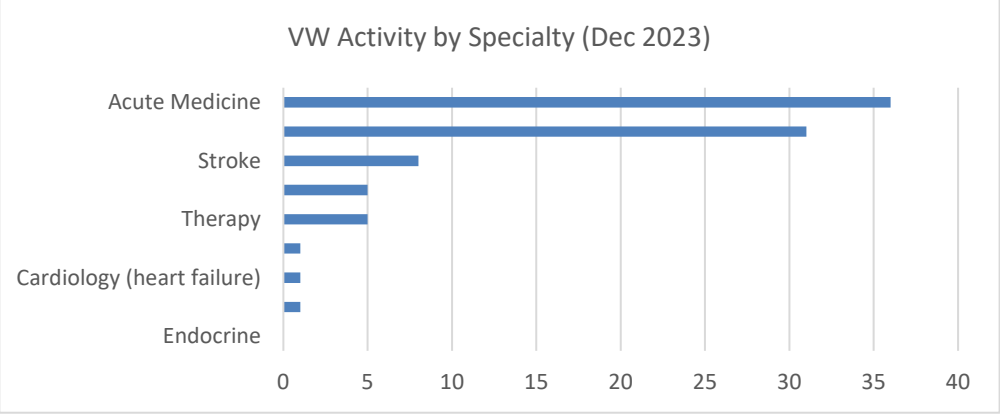
As at 31 December 2023, there were 39 patients on a VW pathway with a further referrals for review against acceptance criteria. This position fluctuates daily as people are discharged and new referrals received. The aim is to maximise virtual ward capacity to ensure as many people as possible can be cared for in their own home.

3.2.1 Cumulative Number of Patients Referred to Virtual Ward Service



3.2.2 Virtual Ward Activity by Specialty





3.2.3 Future Plans and Next Steps

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

Future Plans – The next planned pathway to go live is Orthopaedics supported by community physiotherapy at the end of January 2024.

3.3 Risk Stratification, Clinical Validation and Prioritisation

The Medical Director's office has drafted a Clinical Harm Review Policy, which will be accompanied by a Standard Operating Procedure outlining the process for patients experiencing harm as a result of deterioration in their condition due to long waits to be seen. The Clinical Harm Review process will follow the same principles and approach as the existing process for cancer pathways.

Divisional plans are being developed on the management of patients on non-admitted pathways at specialty level and the resource needed for clinical validation. Some of this is currently being piloted, with further work needed on ensuring a process is in place for documenting the validation and additional funding to support additional clinical sessions for patients that need to be seen for urgent review.

Implementation of the patient pathway management system will take place in 2024, following end user acceptance testing and pilots in the following areas:

- Pain Management Services
- Cardiology
- Paediatrics

4. ASSOCIATE MEDICAL DIRECTOR PROFESSIONAL STANDARDS AND REVALIDATION

4.1 Appraisal Performance and Revalidation

Medical Appraisal Completion Rate:

2023/24	Q1 01/04/2023	Q2 01/07/2023	Q3 01/10/2023
Total Completed Appraisals	**71** (93.42%)	**60** (74.07%)	**73** (40.33%)

Active chasing is ongoing to increase compliance. The Medical Appraisal Policy is due for review and the revised version will include an escalation flow chart for non-compliance.

Revalidation period 05/12/2023 to 03/01/2024:

Status	No.
Recommendations for revalidation approved	2
Recommendations for deferral approved	2
On hold pending GMC investigation (MHPS tribunal scheduled May 2024)	1
Non-engagement recommendation – doctor now engaged and undertaken appraisal. Action plan in place moving forward.	1
Trust referrals to GMC	0

4.2 Electronic Appraisal Platform

The contract with L2P Enterprise Ltd for the new electronic healthcare appraisal system has been signed and clinician information has been submitted to populate the system. Formal launch is scheduled for 1st April 2024, and communications with senior medical colleagues in this regard will commence this month.

Training dates scheduled:

Staff Group	L2P Training Dates		
Appraiser training	Thurs 18 Jan	Thurs 25 Jan	Mon 5 Feb
Revalidation Admin	Wed 17 Jan	Wed 24 Jan	

Training for appraisees using the new system will be minimal as the system is intuitive and easy to navigate. Video blogs are available and links to the system will be shared within wider communications during January/ February.

4.3 Maintaining High Professional Standards (MHPS) Investigation

Currently, there are 2 MHPS investigations ongoing (1 conduct and 1 conduct/capability). One is nearing completion and awaiting investigation report.

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

Doctor Concerns monthly meeting – the Professional Standards arm of the MD's office meet monthly with Chief People Officer and Head of Recruitment & Medical HR to discuss not only the MHPS informal/formal investigations but concerns/complaints/grievances involving doctors handled locally (with HR support) or by the HR team. Triangulating evidence/knowledge available, this meeting provides meaningful insight into situations which in turn enables the MD team to provide pastoral support or signposting where required.

GMC Outreach Employer Liaison Adviser (ELA) quarterly meetings – the Trust's interim GMC ELA is Paul Rafferty. Paul's role is to provide advice and support to Trusts, as and when required. Quarterly meetings provide an opportunity for organisational updates and discussions around local concerns and investigations. The GMC provide an update on open and closed cases. Historically, the Trust has made few referrals to the GMC. Open enquiries/cases are often complaints from patients and/or relatives. If an incident occurs involving the police, and more particular an arrest, Police will notify the GMC who in turn will open an enquiry which the Trust is required to respond to.

Furthermore, appraisal and revalidation are discussed with emphasis around deferrals and non-engagement. The next meeting is planned for Monday, 8th January 2024.

NHS Resolution (Practitioner Performance Advice) – William Beaumont is the Trust's designated adviser. Advice is sought directly from NHSR in relation to initiated MHPS investigation followed by regular updates. Every discussion is documented by NHSR to be shared with the doctor for transparency. Doctors can also contact Practitioner Performance Advice direct.

5. ASSOCIATE MEDICAL DIRECTOR CLINICAL GOVERNANCE/PATIENT SAFETY

5.1 Mortality

The Clinical Governance Committee met on the 15th December 2023, where the following mortality reports were presented.

The last Mortality Governance meeting was held on the 8 December when HED data was available. Medical Examiner's office continues to scrutinise 100% of adult deaths in hospital and in the community which is a significant achievement.

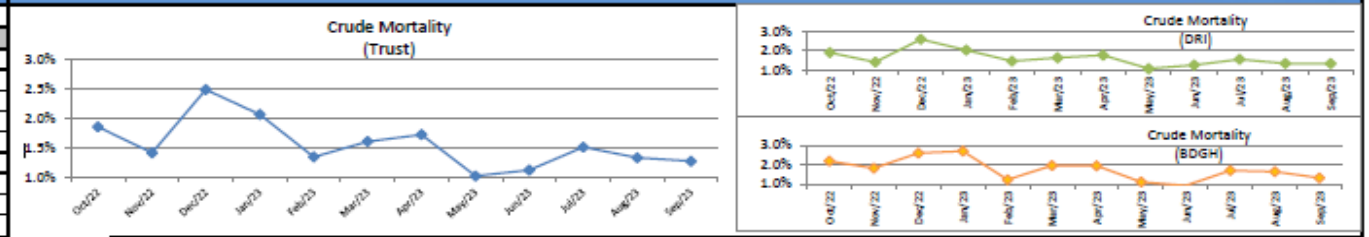
Hospital Standardised Mortality Ratio (July 2023 data)

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

HSMR Trend (monthly)

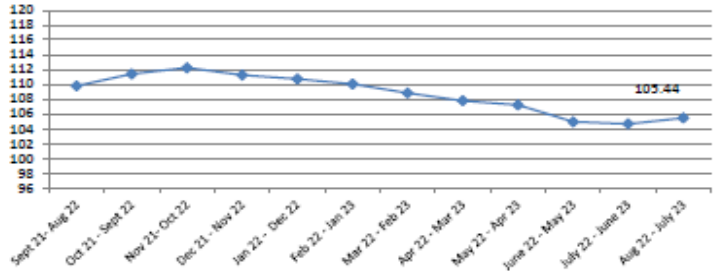
	2019	2020	2021	2022	2023
January	105.78	110.26	118.93	117.90	109.85
February	98.13	92.56	104.15	108.60	93.11
March	101.87	102.51	94.56	104.50	94.40
April	100.70	118.40	79.25	104.03	98.03
May	91.36	132.00	98.24	108.90	80.63
June	98.32	97.72	102.39	102.61	97.12
July	104.77	91.35	90.56	111.46	127.73
August	112.17	88.54	104.48	122.28	
September	83.64	87.38	101.46	122.04	
October	100.24	117.01	105.55	115.65	
November	88.64	131.37	109.36	98.03	
December	103.24	144.89	117.93	112.18	

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

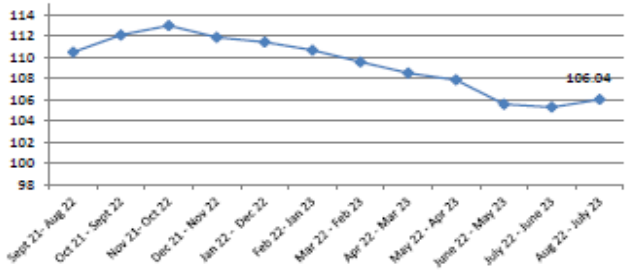


	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Trust	1.86%	1.42%	2.49%	2.07%	1.35%	1.61%	1.73%	1.03%	1.13%	1.52%	1.34%	1.28%
DRI	1.88%	1.40%	2.57%	2.02%	1.45%	1.62%	1.76%	1.06%	1.24%	1.54%	1.33%	1.33%
BDGH	2.18%	1.81%	2.59%	2.69%	1.22%	1.95%	1.94%	1.10%	0.92%	1.69%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

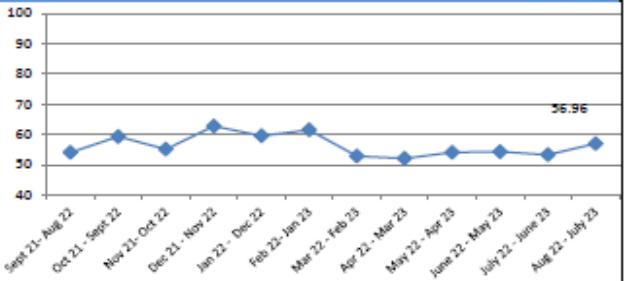
Overall HSMR (Rolling 12 months)



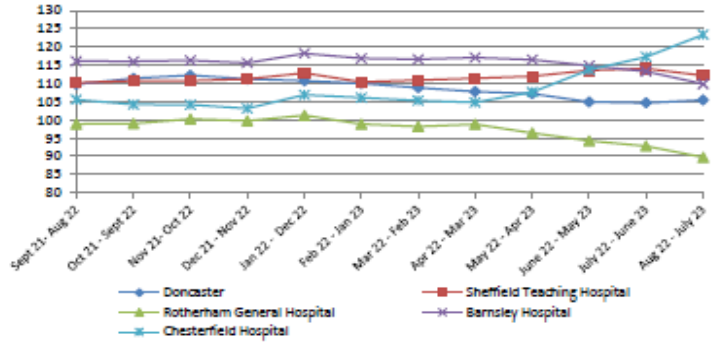
HSMR - Non-elective Admission (Rolling 12 months)



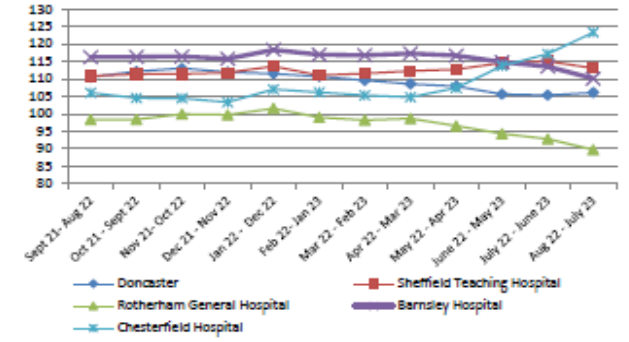
HSMR - Elective Admission (Rolling 12 months)



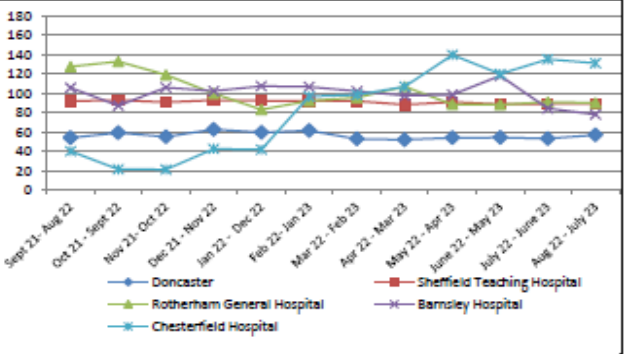
Regional Comparison Overall HSMR (Rolling 12 months)



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



Regional Comparison HSMR - Elective Admission (Rolling 12 months)



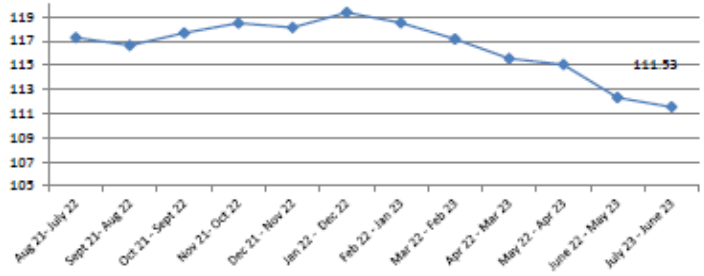
Summary Hospital Mortality Indicator (June 2023 data)

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

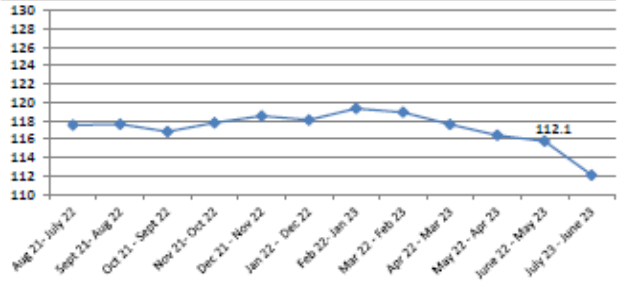
SHMI Trend (monthly)

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

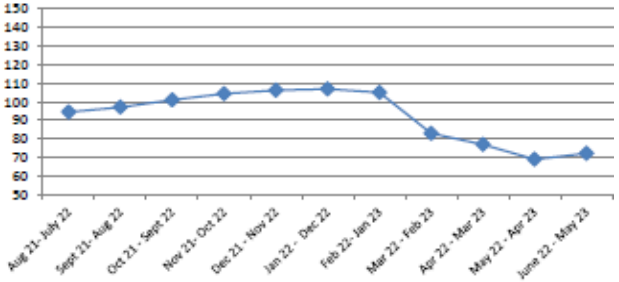
Overall SHMI (Rolling 12 months)



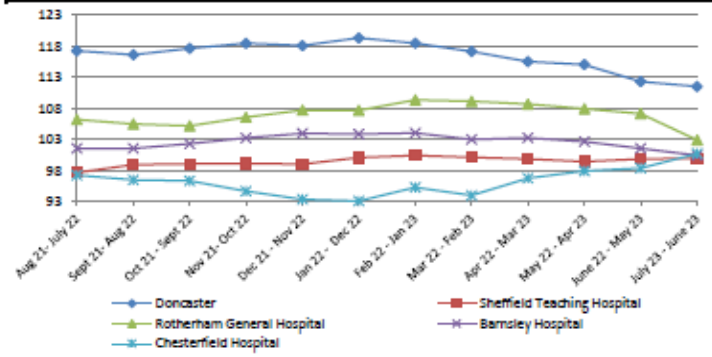
SHMI - Non-elective Admission (Rolling 12 months)



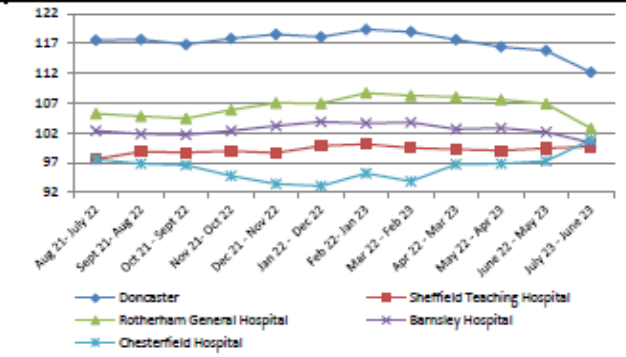
SHMI - Elective Admission (Rolling 12 months)



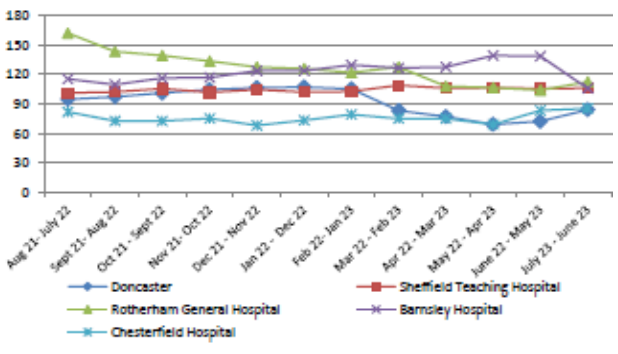
Regional Comparison Overall SHMI (Rolling 12 months)



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



Regional Comparison SHMI - Elective Admission (Rolling 12 months)



With regards to HSMR, we saw a spike in July. The reasons for this are not apparent, however this now improving and settling with HSMR below 100 for September. SHMI has been elevated previously although reducing with a lot of background work in the Coding Department in terms of co-morbidity coding. On the whole, mortality performance is looking positive.

5.2 Structured Judgement Reviews (SJRs) / Learning from Deaths

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

The following is planned to improve the Trust's position:

- A review of clinical staff already trained in the SJR process has identified 23 colleagues who have had previous training and need some re-training.
- There is an appetite from clinicians to undergo training and be involved in the SJR process
- Learn from other Trusts in the region, understand their SJR process (e.g. Barnsley FT have a trained cohort of clinicians to undertake SJRs who are paid for their time to do this)
- Appraise nationally available SJR software from NHS England that The Rotherham Hospital FT are using to understand whether this would benefit DBTH
- Previous Trust mortality lead has returned to work with us for one day a week, to deliver the following:
    a) In house SJR training
    b) Meeting governance leads across the Trust regarding SJRs/Learning from Deaths
    c) Quantify the time commitment needed to complete the backlog of SJRs, and whether more people need to be trained for us to be more proactive moving forward
    d) Reinstate mortality MDT meetings
    e) Development of an action plan for ongoing improvement

5.3 Clinical Governance

As a number of executive directors are new in post, they have taken a decision to review the Trust's framework for clinical governance to ensure it is fit for purpose and aligns to the Care Quality Commission (CQC) domains of Safe, Effective, Caring and Responsive.

Once review and redesign of the new Trust clinical governance arrangement is complete, the intention is for the changes to be signed off through the Trust's governance processes and enacted alongside Patient Safety Incident Response Framework (PSIRF) implementation. This will be completed before the end of 2023/24.

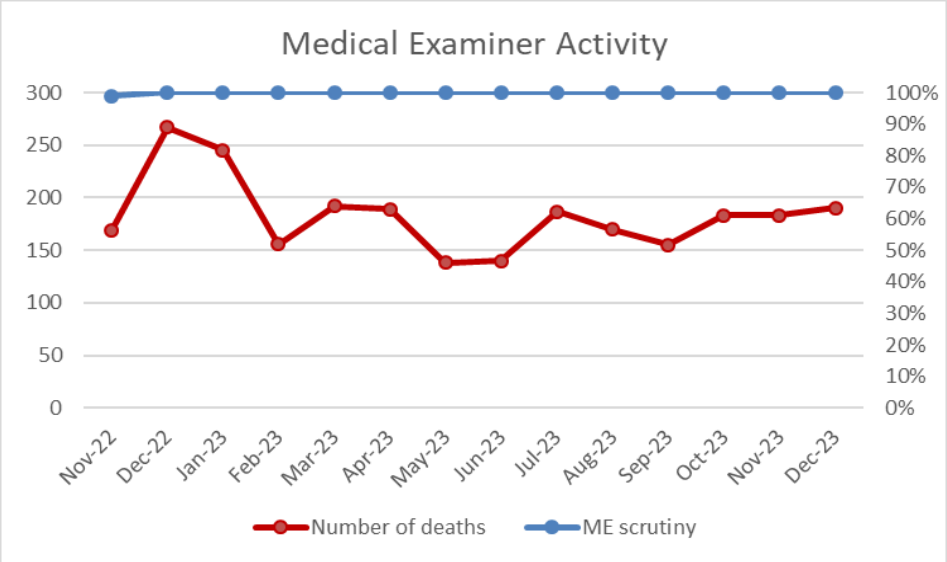
There are plans to review the Patient Safety Review Group and Audit and Effectiveness Forum, which will progress in line with implementation of the new clinical governance structure.

6. MEDICAL EXAMINER'S UPDATE

December 2023 Data:

- Total Acute Deaths*= 190 (Deaths in November 2023 = (183)
- Community Total Deaths 2023 = 183 (Deaths in 2023 = November (143)
- Total amount death scrutinised December 23 = 373

Inpatient and Emergency Department deaths over the age of 18



Completion and issuing of Medical Certificate of Cause of Death (MCCD) and referral to His Majesty's Coroner (HMC)

Dec 2023	Deaths	% Scrutinised by ME Team	MCCD issued	MCCD Issued> 3 days	HMC ref.	HMC ref not required following ME Scrutiny
DRI	143	100%	111 (78%)	29 (20%)	32 (22%)	1 (1%)
BDGH	47	100%	42 (89%)	7 (15%)	5 (11%)	0 (0%)

Interaction with bereaved families

	Number	Interaction with Bereaved	Compliment	Concern	Complaint
DRI	124	(87%)	8(6%)	5 (4%)	6(4%)
BDGH	40	(85%)	4(10%)	0	1(1%)

- Compliment = Exceptional care and specific mention of ward/staff member
- Concern = referred to ward manager or Consultant.
- 5 Bereaved families not spoken to at BDGH due to service pressure. 2 Cases not appropriate to phone.
- 14 Bereaved families not spoken to at DRI due to service pressure. 5 Cases not appropriate to phone.

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

	Cause	DRI	BDGH	Total
1	Pneumonia	34	13	47
2	Cardiac related	18	4	22
3	MOF	6	6	12
4	Old age and frailty	7	2	9
5	Metastatic cancer	4	3	7

Non-acute deaths

Dec 2023	Deaths	MCCDs released	HMC referrals	HMC referral not required after ME scrutiny	Families spoken to	Cases with no NOK	Released to prevent delay	N/A already referred to HMC
DRI	128	117	11	0	105	8	12	3
BDGH	55	39	16	1	45	2	5	3

Summary:

- Total number of acute deaths for December 2023 have increased slightly to 190 deaths from 183 deaths in November 2023.
- 100% of acute deaths across both sites have been reviewed by a member of the ME team.
- 86% of families have been spoken to by a member of the ME team.
- Cases continue to be scrutinised by the ME team prior to sending to HMC.
- Non-acute scrutiny in December 2023 = 183 deaths.
- Total deaths scrutinised by the ME team December 2023 = 373

Data correct from Mortality Database as of 11/1/24

7. EXECUTIVE MEDICAL DIRECTOR'S CLOSING SUMMARY

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

Key highlights are:

- Job Planning progressing well
- Continuing to improve the leadership development offer for the Trust's clinical leaders
- Medical appraisal going well and plan to achieve similar high levels of completed appraisals this financial year. Implementation of electronic appraisal system L2P going to plan
- Work on mortality, governance and risk continues with improving trends in HSMR and SHMI
- Plan to improve the completion rate and timeliness of SJRs, along with Learning from Deaths process
- The Medical Examiner team continue to scrutinise 100% of hospital adult deaths and have commenced scrutiny of community deaths

2401 - C2 CHIEF NURSE UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

C2 - Chief Nurse Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**C2**
Report Title:	**Chief Nurse Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Simon Brown, Deputy Chief Nurse		
Appendices:	None		

Report Summary

Executive Summary

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

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

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

The paper highlights patient experience metrics including complaints data.

Key Points

There were six serious incidents logged across October 2023.

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

The FFT response rates continue to be monitored. Across all FFT data positive scores consistently achieve above the national average in Inpatient, A&E, Outpatients and Maternity.

45 complaints were received in October 2023 which was a reduction from September.

Recommendation:	To note the report and take assurance			
Action Require:	~~Approval~~	~~Review and discussion/ give guidance~~	**Take assurance**	~~Information only~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire & Bassetlaw ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes /~~No/ NA~~		**Yes /~~No/ NA~~**	

Implications	
Board assurance framework:	BAF Risk 1
Risk register:	None
Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements
Legal:	N/A
Resources:	None

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

Chief Nurse Report - January 2024

Introduction

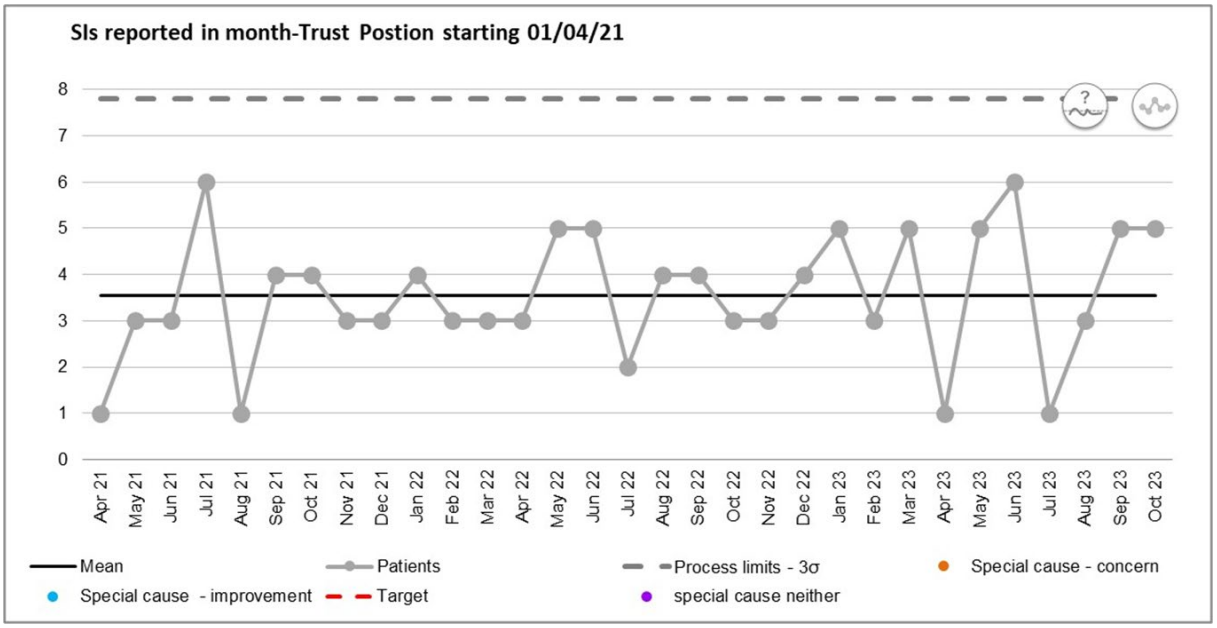
This report provides the Board of Directors with an update on the key issues, challenges and relevant information with regard to the Chief Nurse's areas of responsibility.

Patient Safety Incident Response Framework (PSIRF) Implementation

The Patient Safety Incident Response Framework (PSIRF) was published on 16 August 2022, it is a major piece of guidance on how NHS organisations respond to patient safety incidents and ensure compassionate engagement with those affected. All providers contracted under the NHS standard contract are required to transition to PSIRF during the Autumn of 2023. The PSIRF Implementation Group continue to meet monthly. The Chief Nurse is pleased to report as a Trust we transitioned to PSIRF on 1 December 2023. The PSIRF Implementation Group continue to monitor progress monthly. There will be a period of "double running" to ensure completion of previous processes.

Patient Safety Reporting

Serious Incidents



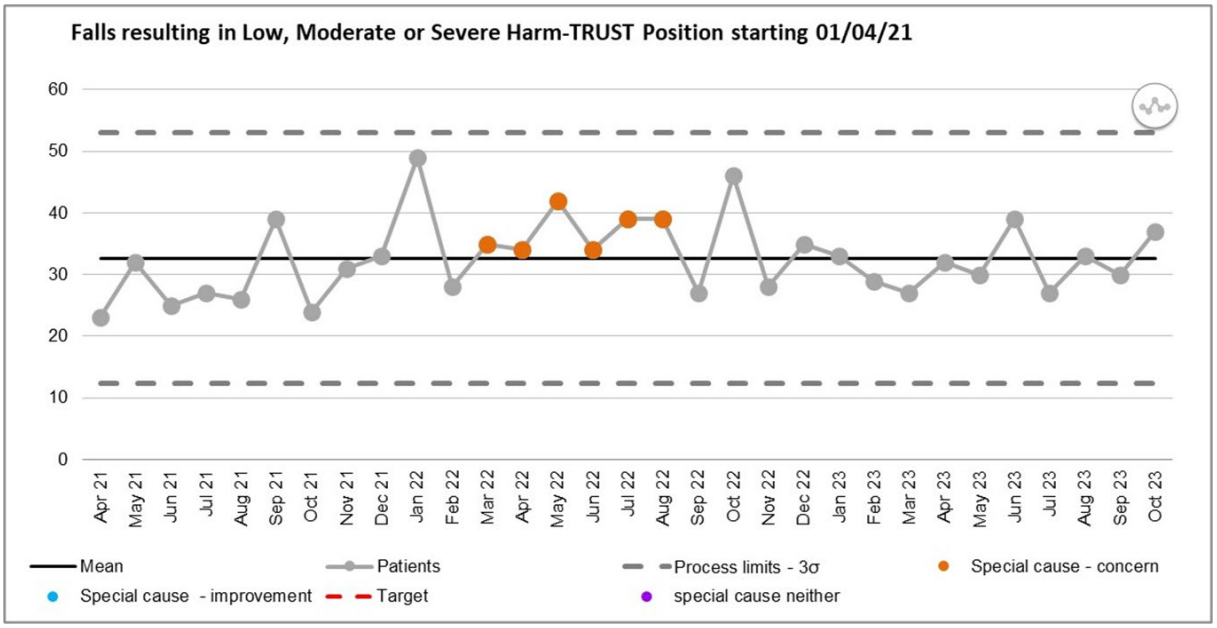
There were six serious incidents logged across October 2023.

Serious Incident Detail	Immediate Safety Actions
Patient attended ED DRI neutropenic sepsis delay in recognition and treatment. Sadly patient died and referral to the coroner.	This case was identified as part of the Sepsis improvement audit work in ED. Ongoing improvement project and increased training.
Damage following laparoscopic hysterectomy, complications after closure.	A concern regarding a theme of uterine injuries were noted by the CSS governance lead.

During the procedure vaginal wall bleeding was stopped using intra-abdominal suture. Injury occurred to Ureter as a result.	Safety measures now in place and being monitored by the Women's and Children's governance team.
Delay in acting on an ECG performed on an inpatient showing ST elevation, delay is administering ACS medications.	Feedback and increased training to ward team.
Patient initially presented to DBTH in November 2022 following a fall, CT c spine incidentally showed T4 lytic lesion likely metastatic. Patient had Cancer of unknown primary referral made. September 2023 attended DRI with severe back pain, has not been discussed in MDT or received intended follow up.	Cancer management team safety action taken to ensure all MDT referrals receive a letter and are uploaded to Medisec. Not via email only.
Child death BDGH ED. Underlying health issue	Immediate identified learning regarding the expected process/policy to follow in the event of a child death. Training commenced.

Falls

The chart below shows all falls resulting in low, moderate or severe harm as an overall Trust position.



Tendable audit results for October showed a compliance score of 98% compliance (649 inspections). This demonstrates an improved compliance in all falls question sets. The inspections

focus on a visual assessment of the "5 for falls" principles. There are now fewer falls reported to the improvement panel where "5 for falls" principles have not been implemented.

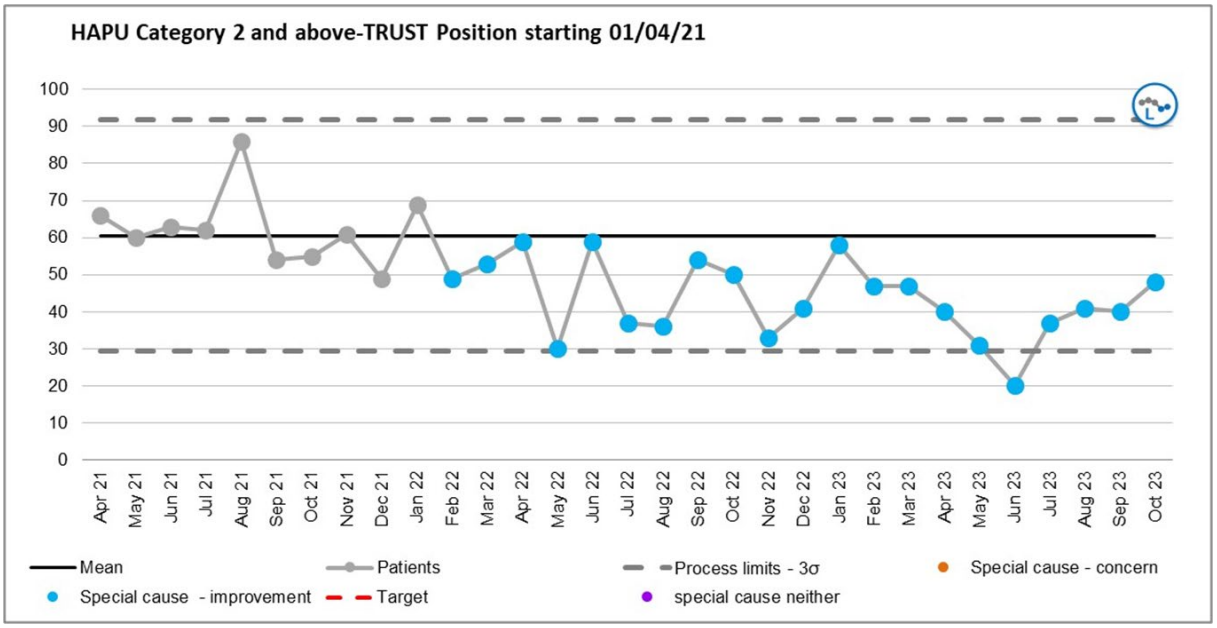
Learning identified through the falls improvement panel:

- Promote awareness and use of clinical judgement regarding change in condition, and when to repeat Lying & Standing Blood Pressure (L&S BP). A case presented this month demonstrated that, despite reports of dizziness, medication had been stopped that treats postural hypotension, the team did not repeat the L&S BP. Discussed on panel and added to local action plan.

- Delay in inpatient referral to the frailty team for support with a complex patient with Parkinson's disease. Reported on Nerve centre to refer for 7 days, no referral made. Learning to be shared widely through clinical governance speciality meeting, including referral to falls prevention and patient centred care practitioner if concerns about elderly complex patients.

- Post fall management theme identified regarding poor adherence to correct moving and handling equipment. Local action plan created for hoverjack use.

Hospital Acquired Pressure Ulcers (HAPU)
The chart indicates the numbers of HAPU 2s remain on track to meet the reduction trajectory.

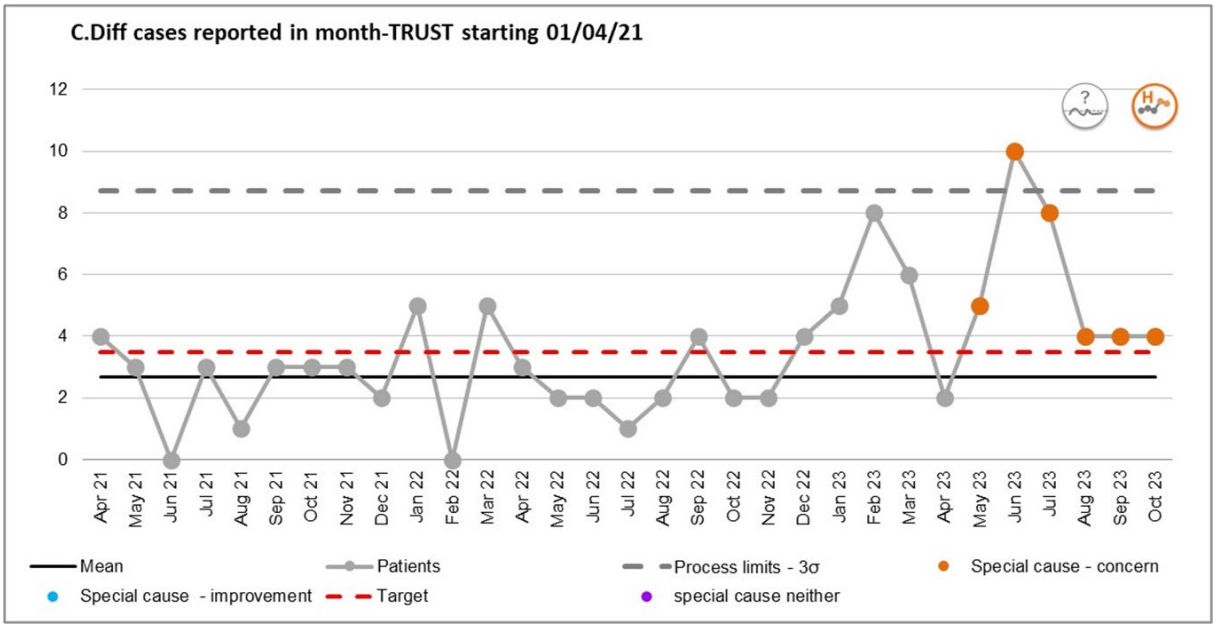


Infection Prevention and Control (IPC)

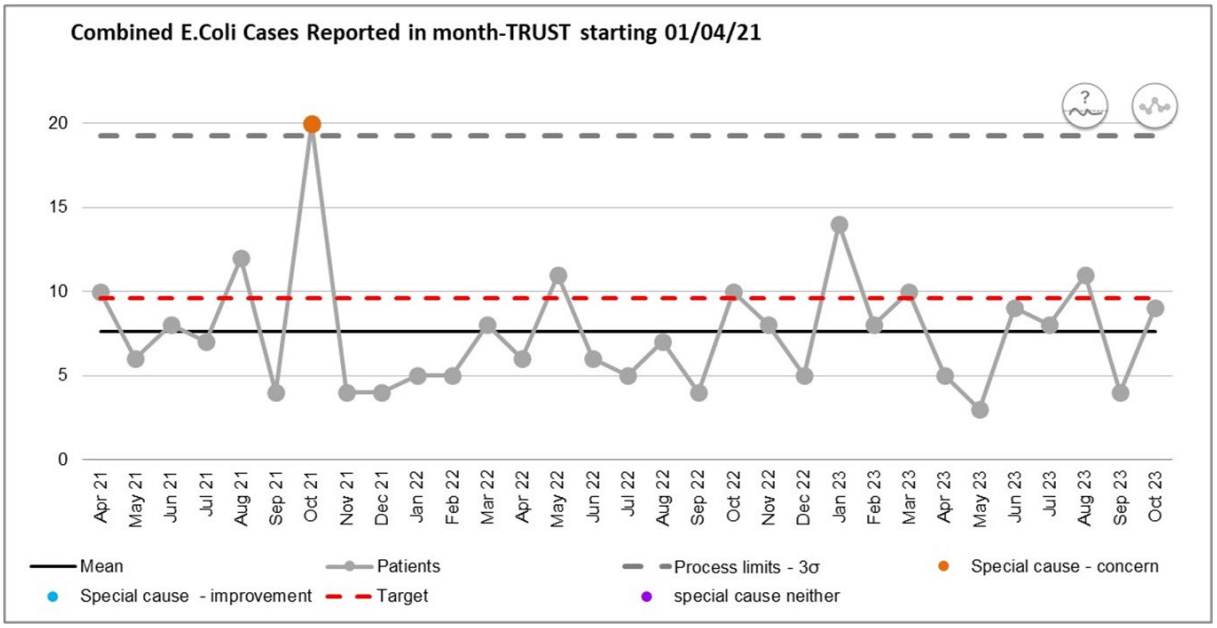
Clostridium difficile (C.diff): There were four case of Clostridium difficile in October 2023. All four were Hospital Onset, Hospital Associated (HOHA) infections. The total number of cases of Clostridium difficile for the financial year is now 37, against a trajectory of 42.

This increase is in line with national data with an overall increase in rates across the country.
The IPC team have presented at the Trust Executive Group (TEG) and have an improvement plan in place.

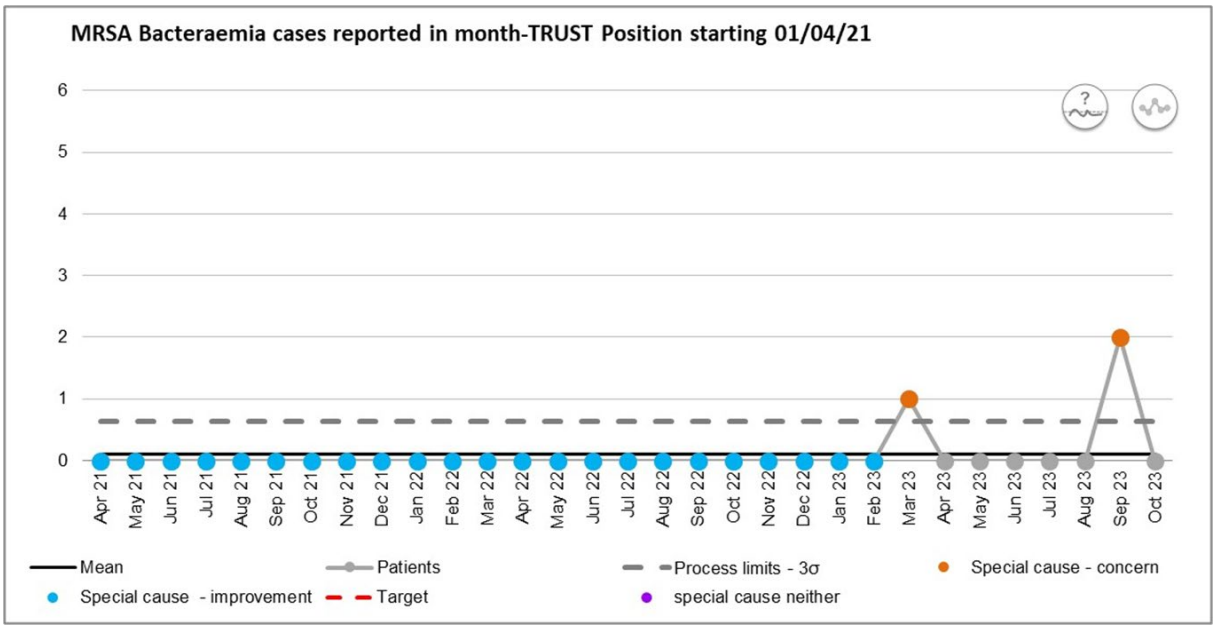
The figures remain just within normal variation, but the nationally set thresholds will be a challenge this financial year. Each division has a specific action plan in place and is monitored by the Infection Control Committee.



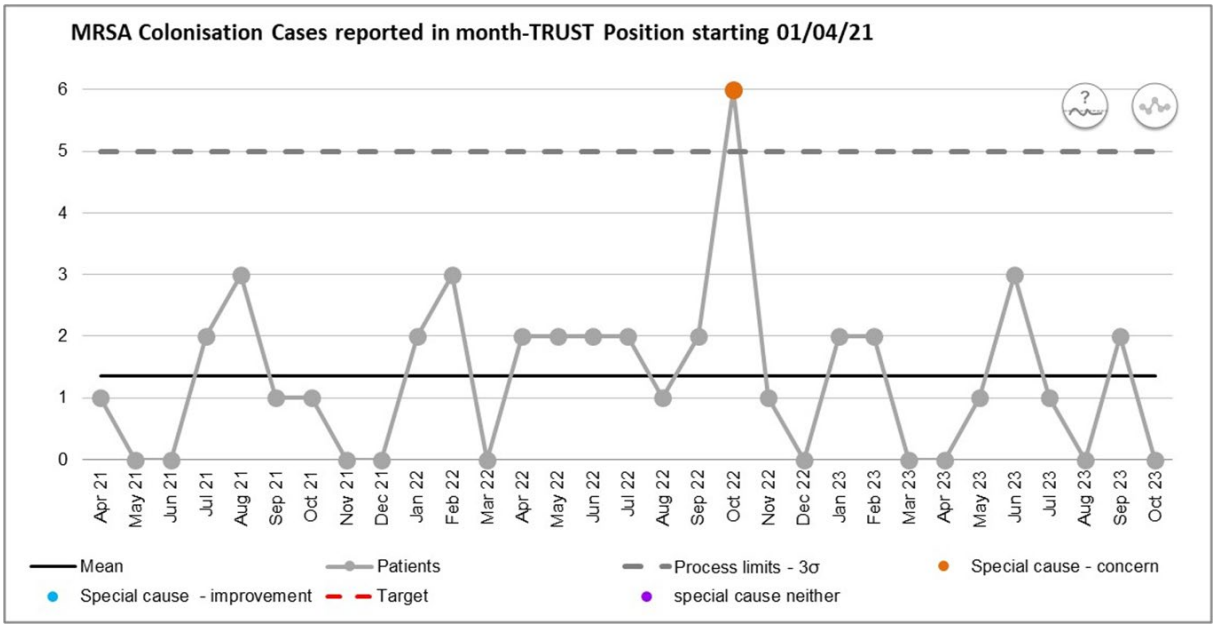
E-Coli Bacteraemia: There were nine cases of E.coli bacteraemia in October 2023. Four were HOHA, and five were COHA. The total to the end of October is 48 with a trajectory of 80 for the year.



MRSA bacteraemia: There were zero MRSA bacteraemia reported in October 2023.



MRSA Colonisation: There were no reported MRSA colonisations in October



Improvement

Shared Learning

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

At October's PSRG, learning was shared from an intrauterine fetal death at 34 weeks and learning which had taken place following an incidental finding around lack of plotting on scan growth charts in the MDT diabetic clinic prior to seeing the consultant. This has now been actioned and the specialist midwives for diabetes will check the scan has been plotted correctly in the admissions room in antenatal clinic prior to the patients seeing the consultant. An auditing process is place to ensure compliance.

Patient Experience

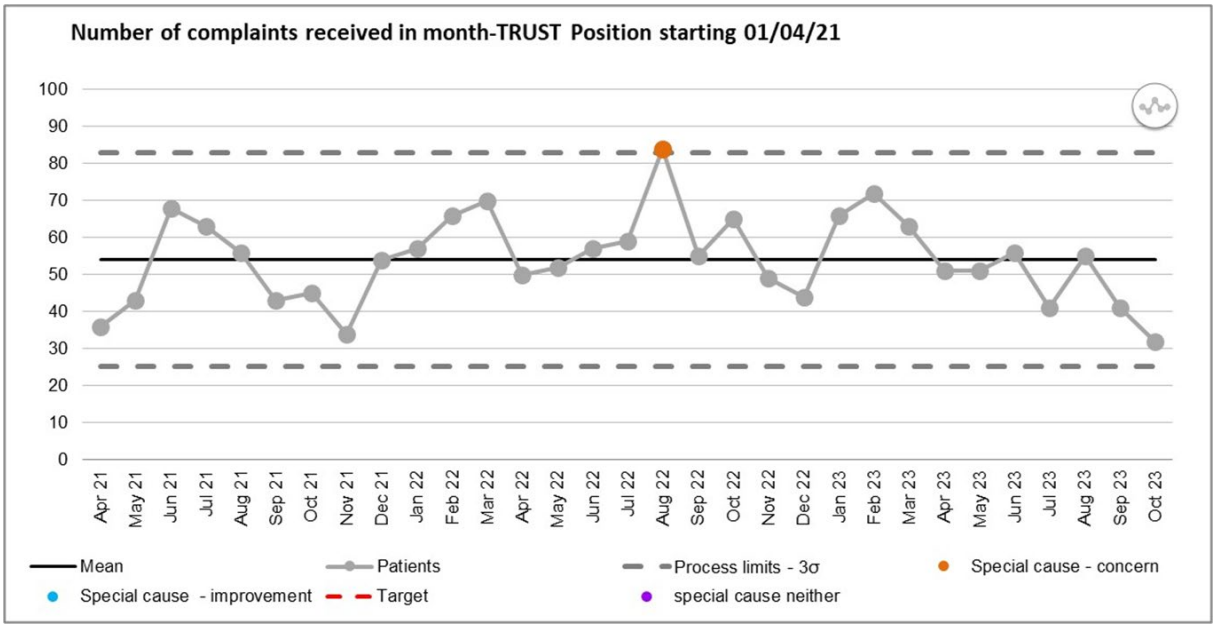
Friends and Family Test (FFT)

The FFT response rates continue to be monitored. Across all FFT data positive scores consistently achieve above the national average in Inpatient, A&E, Outpatients and Maternity.

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

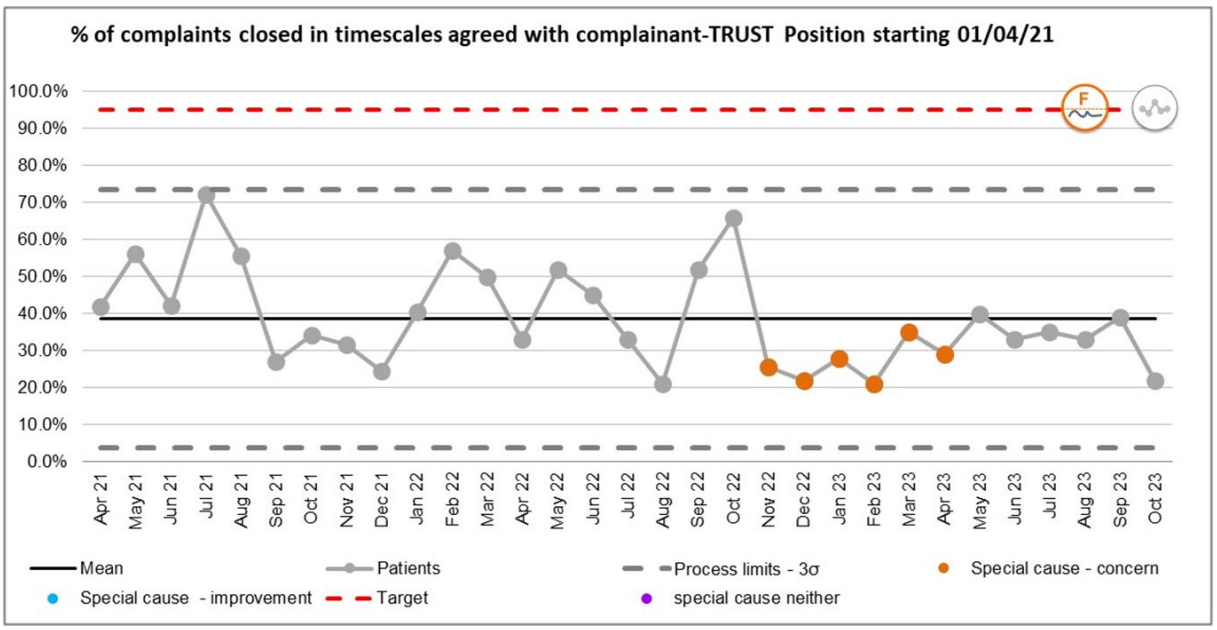
Complaints

45 complaints were received in October 2023 which was a reduction from September when 51 complaints were received. This brought the year-to-date total 2023/2024 for complaints to 372.



Complaints closed in agreed timescale

59 complaints were closed in October 2023, which was an increase from September when 49 complaints were closed. 22% of complaints met the timeframe for closure. This was because the focus of the divisions was closing outstanding complaints which had been overdue by a significant amount of time. At the end of October, there were two complaints that were older than 90 days, these are due to the complexities of the complaints and multi- provider response. Work to review capacity in both the complaints team and divisions is planned.



Conclusion

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

2401 - C3 MATERNITY & NEONATAL UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

- C3 - Maternity & Neonatal Update.pdf
- C3 - Appendix 1 - Training Action Plan Safety Action 8.pdf
- C3 - Appendix 2 Saving Babies Lives Toolkit.pdf
- C3 - Appendix 2 Saving Babies Lives Toolkit.xlsx
- C3 - Appendix 3 - Board Surveillance DBTH December Q3 2023.pdf
- C3 - Glossary of Terms - Maternity.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**C3**
Report Title:	**Maternity & Neonatal Update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse, Paediatrics		
Appendices:	Appendix 1 - Action plan to achieve 90% training Appendix 2 - Saving Babies lives Toolkit Appendix 3 – Board Surveillance		

Report Summary

Executive Summary

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

Work against the current year 5 clinical negligence scheme for trusts (CNST) is ongoing, and the service remains on track to submit full compliance on 1 February 2024. The progress has been monitored by the LMNS at assurance meetings, and the current position has been shared at the LMNS Collaborative on 9 January 2024.

The service is non-compliant with British Association of Perinatal Medicine (BAPM) nursing requirements but has an action plan in place to meet these requirements. Work is ongoing to improve transitional care for eligible babies, and their families.

Midwifery staffing is stable, and the service is continuing to recruit to midwifery posts.

Medical staffing remains stable, and consultants have attended in person when required.

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

Recommendation:	For the Trust Board of Directors to note and take assurance from the detail provided within this Maternity and Neonatal report.			
Action Require:	~~Approval~~	~~Review and discussion/ give guidance~~	**Take assurance**	~~Information only~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

We believe this paper is aligned to the strategic direction of:	South Yorkshire & Bassetlaw ICS	NHS Nottingham & Nottinghamshire ICS
	Yes	**Yes**

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

Assurance Route	
Previously considered by:	Governance Meeting in Children's & Families Division Children & Families Board
Date:	6 October 2023
Any outcomes/next steps	Support to continue improvements in maternity & neonatal service, and achieve year 5 CNST standards
Previously circulated reports to supplement this paper:	

Monthly Board Report

January 2024

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

1. Findings of review of all perinatal deaths

1.1 Stillbirths and late fetal loss > 22 weeks

There was 1 stillbirth.

1.2 Neonatal Deaths

There were no neonatal deaths in December 2023.

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

Two cases were closed and moved to the report writing stage.

Date	Type of Death	Gestation	Antenatal / Intrapartum / Neonatal	Information
Oct	Stillbirth	25+6	Antepartum	No learning identified
Oct	Stillbirth	41+2	Intrapartum	Awaiting information from another provider
Nov	Stillbirth	24+6	Antepartum	No learning identified
Nov	Stillbirth	24+5	Antenatal	No immediate learning identified For review in January Perinatal Mortality Meeting
Nov	Stillbirth	30+3	Antenatal	No immediate learning identified For review in January Perinatal Mortality Meeting
Nov	Stillbirth	29+1	Antenatal	Multiple appointments missed which were followed up appropriately
December	Stillbirth	31+4	Antenatal	No immediate learning identified For review in February Perinatal Mortality Meeting

2. Neonatal Services

Neonatal staffing is 89% recruited with 87% of establishment at work, with 5% maternity leave. The Qualified in Speciality ratio is below the 70% standards at 64% on the Neonatal Unit (NNU). During December we had 89% of shifts resourced within British Association of Perinatal Medicine (BAPM) standards compared to a quarter 2 average of 75% at DRI and 59% at Bassetlaw. All the shifts below BAPM standards were due to there being a missing supernumerary co-ordinator. A workforce review and 3 year plan to meet BAPM and CNST standards was discussed in the Trust Executive Group in September 2023, the gaps were acknowledged and it was agreed to support the development of a phased business plan to be submitted to Trust Capital Investment Group and included in the divisions business planning requirements for 2024/25. This was reported to Trust Board in October with plan to submit the business case in March.

The Local Maternity and Neonatal Service (LMNS) and Operational Delivery Network (ODN) have been updated on the gaps and action plan.

No new serious incidents or Maternity and Newborn Safety Investigation Programme (MNSI) eligible cases.

The Getting It Right First Time (GIRFT) action plan for Neonatal service remains open while we establish transitional care, a joint Quality Improvement (QI) programme commenced in June to develop a transitional care plan for neonates on both sites. Work to review neonatal consultant cover including planned absences is ongoing in relation to a historic Serious Incident (SI) with a paper going to the Capital Investment Group in January 2024.

2.1 Avoiding Term Admissions into Neonatal Units (ATAIN)

The process for reviewing term babies that have been admitted to the neonatal unit has been strengthened. This is a multidisciplinary review, and the team will ensure that all babies are reviewed in the month following their admission.

Month	Live Births All Gestations	Term babies Inborn (>37/40)	Inborn admissions: (all gestations)	Inborn TERM admissions (>37/40) excl transfers	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions
Apr-23	331	309	32	9	2.7%	5.0%	6.0%	2	6.3%
May-23	391	362	30	11	2.8%	5.0%	6.0%	3	10.0%
Jun-23	381	333	38	15	3.9%	5.0%	6.0%	5	13.2%
Jul-23	404	366	46	15	3.7%	5.0%	6.0%	0	0.0%
Aug-23	397	370	34	13	3.3%	5.0%	6.0%	2	5.9%
Sep-23	384	351	27	13	3.4%	5.0%	6.0%	4	14.8%
Oct-23	390	361	25	9	2.3%	5.0%	6.0%	1	4.0%
Nov-23	387	355	26	10	2.6%	5.0%	6.0%	0	0.0%

In November there were no avoidable term admissions.

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

Executive summary

Table 1 MNSI cases

	Cases to date
Total referrals	27
Referrals / cases rejected	8
Total investigations to date	19
Total investigations completed	19
Current active cases	0
Exception reporting	0

3.1 Reports Received since last report

The outstanding report has been received by the service, following a stillbirth.

There was one safety recommendation:

- The Trust to ensure that when a fetal heart rate cannot be confirmed, it is treated as an obstetric emergency to ensure urgent escalation to the multidisciplinary team to allow birth as soon as possible, if indicated.

The recommendation will be shared in the governance newsletter and discussed at the relevant meetings in the service. An action plan has been written, and this will be monitored through governance meetings and overseen by the integrated care board.

3.2 Current investigations

No cases.

3.3 Maternity and Newborns Safety Investigations (MNSI) / NHS resolutions (NHSR) / Care quality Commission (CQC) or other investigation with a concern or request for action made directly to the Trust

None.

4. Serious Incident Investigations (Internal)

There is on case ongoing and the report is being written.

5. Training Compliance

There has not been any further training over the festive period, current training figures on 31 December 2023 are as below:

K2 E learning package and Cardiotocograph (CTG) Study Day

Table 2 - K2 & CTG figures

Staff Group	K2 CTG Compliance	Study Day Compliance
90% of Obstetric Consultants	**93.3 %**	**80% →**
90% of All other Obstetric Doctors including trainees	**90 %**	**80% →**
90% of Midwives including Bank & NHSP	**90.9%**	**86.3% →**

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

Table 3 - PROMPT figures

Staff Group	Prompt Compliance
90% of Obstetric Consultants	**100% →**
90% of All other Obstetric Doctors including trainees	**89.5% →**
90% of Midwives including NHSP & agency	**85.3 % →**
90% of Maternity Support Workers	**80.6 % ↓**
90% of Obstetric Anaesthetic Consultants	**100 % ↑**

Newborn Life Support (NLS) Training

Table 4 - NLS figures

Staff Group	NLS Compliance
90% of neonatal consultants or paediatric consultants covering neonatal units	**100% →**
90% of neonatal junior doctors	**92% →**
90% of neonatal nurses (Band 5 7 above)	**100% →**
90% of advances neonatal practioners (ANNP's)	**100% →**
90% of Midwives	**92.5 % ↓**

6. Service User Feedback

The service continues to work closely with the maternity and neonatal voices partnership. There has been new guidance published on 28 November 2023 providing advice on fulfilling the statutory obligations around involving people and communities in the planning proposals and decisions regarding NHS maternity and neonatal services. Responding to the action and responsibilities laid out in the three year delivery plan for maternity and neonatal services. To set out areas to consider when commissioning and supporting effective maternity and neonatal partnerships (MNVPs).

The MNVP chairs, the service and local maternity and neonatal system (LMNS) are working together to implement the guidance at DBTH and in the LMNS. This will lead to changes in how MNVPs are commissioned, set and run.

Work against the current work plan is ongoing, and the senior team meet with the chairs on a regular basis.

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

None.

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

Work is continuing to achieve the Year 5 CNST standards, with operational oversight from the CNST and Ockenden Oversight Committee. The service continues to collect evidence to support compliance with the safety actions and the service is on track to submit full compliance with all ten safety actions. This has been shared at the LMNS Collaborative Board, and assurance meetings have taken place with the LMNS.

The Trust claims scorecard, complaints and incidents have been reviewed at the Children's & Families Board. These have been used to inform the patient safety incident response plan (PSIRP) for the Trust. These themes include:

- Access, admission, assessment and transfer of care
- Communication and documentation
- Assessing and responding to and escalating the deteriorating patient
- Medication
- Recognising and responding to behaviours of concern
- Infection Prevention and Control

The maternity service has implemented the patient safety implementation framework on 1 December 2023 in line with the rest of the Trust.

8.1 Board Level Safety Champion

The board level safety champion continues to be actively involved in the work plans in maternity. Karen Jessop (safety champion) has attended a number of meetings.

8.2 Culture, Leadership & SCORE survey

There is a workshop planned with the services facilitator on 11 January 2024 to triangulate the information collected from the SCORE survey, and subsequent staff feedback sessions. The quadrumvirates will work with the facilitator to identify areas for improvement and be supported to work with the staff working in the service to make changes to improve the culture.
Once published the service will utilise the staff survey results to cross reference the finding from the SCORE survey and inform any further work that is required.

9. Perinatal Surveillance dashboard

The perinatal surveillance dashboard has been included with all the data from Q3.

There has been improvement with:

- Babies born in the right place (no births < 27 weeks at DBTH)
- Smoking rates at time of birth

Ongoing higher levels of:

- Post-partum haemorrhage - discussions are ongoing about identifying women at risk of being identified proactively, and prophylactic management undertaken

Progress with CNST safety actions, saving babies lives version 3 and ockenden (1st report) is progressing well.

10. Midwifery staffing

Midwifery staffing continues to be stable, and a further four internationally educated midwives have recently joined the team. The use of NHSP shifts has decreased, and the newly qualified midwives are settling into their roles with support from the pastoral team, and more experienced midwives. The skill mix remains a risk that the service recognises and the pastoral team work closely with the newly qualified midwives to provide support.

The service is planning to hold open days for the midwives who qualify in October 2024, and have been invited to the University of Hull to share the career pathways available at DBTH. The service will aim to be fully recruited in October 2024 offering all vacant posts to the newly qualified midwives.

The service continues to offer different routes into midwifery including a postgraduate course, conversion from nursing to midwifery course and a midwifery apprenticeship.

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

Doncaster - 99.5 %
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 December 2023:

Table 5 Doncaster BR+ © data

Red Flag	Number of times
Delayed or cancelled critical time activity	4
Coordinator unable to maintain supernumerary status providing 1:1 care	1

Management Actions taken	
Redeploy staff internally	12
Unit on divert	6
Escalate to Manager on call	5

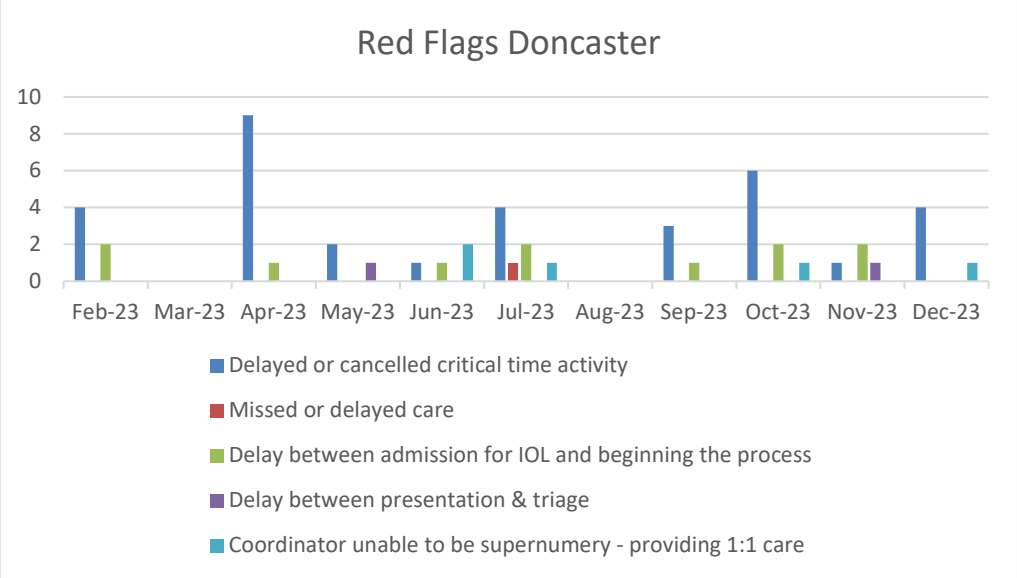
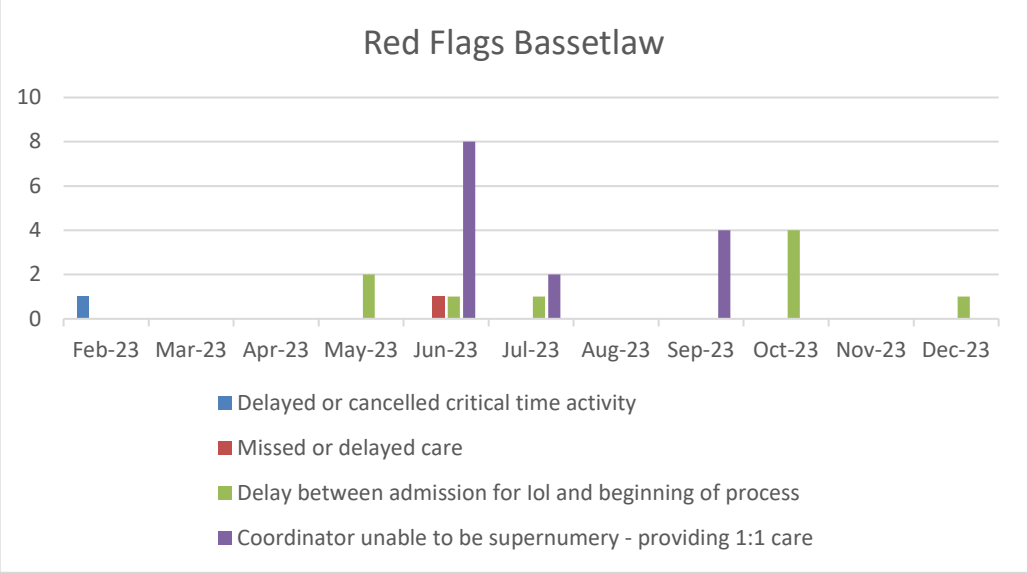


Table 10 Bassetlaw BR+ © data

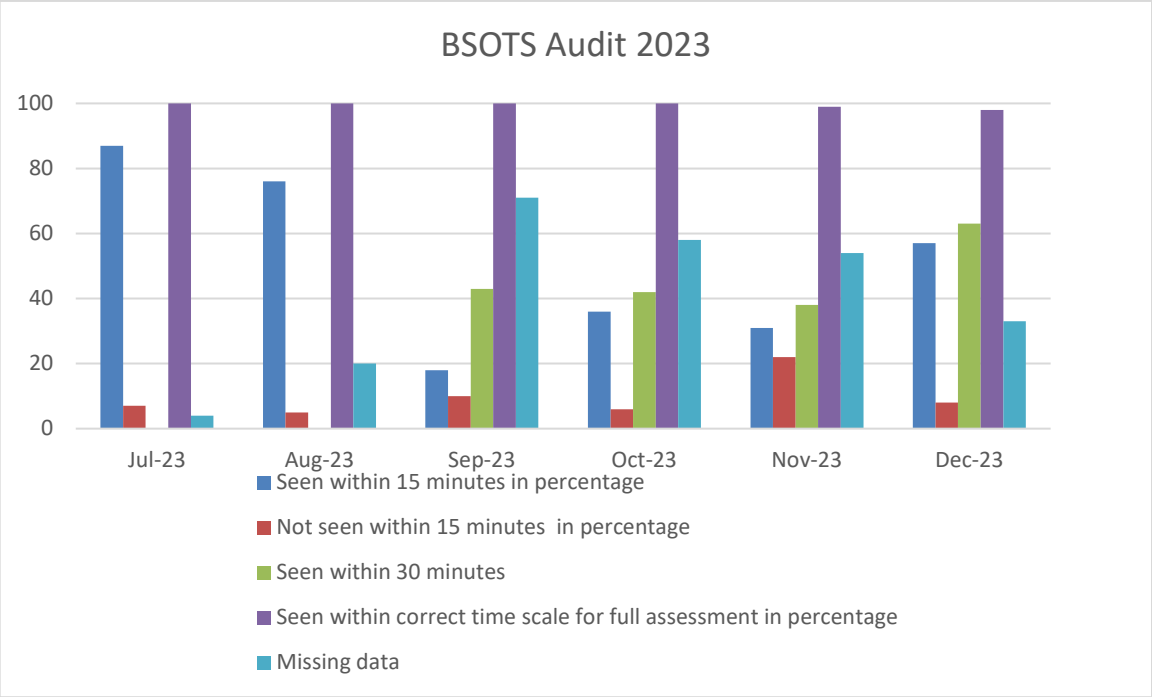
Red Flag	Number of times
Delay between admission for induction and beginning of process	1
Management Actions taken	
Redeploy staff internally	1
Utilise on call midwife	1
Unit of divert	2
Escalate to Manager on call	3



The Triage Service

The triage service continues to monitor their performance against the 15 and 30 minutes standards to be seen.

Below is the performance:



The service has set a target to be achieved by 31 March 2024 as:

- Less than 30% of missing data (month on month improvement)
- Achieve > 60% of women seen within 15 minutes of arrival
- Maintain > 60% seen within 30 minutes of arrival

The service is improving performance each month, and team are working hard to continue that improvement.

11. Medical Workforce

Medical staffing in obstetrics and neonates remains stable. However there has been an increase in sickness levels, these have been managed using locum medical staff to cover the rota.

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

12. 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 CNST standards is detailed, the Trust Board of Directors are asked to consider the assurance provided in this report together with the perinatal surveillance dashboard.

Appendix 1

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Training Action Plan

Action plan to achieve 90% compliance for all staff groups if not achieved by 01/12/23 by 23/02/24

Action	Lead	Support Required	Timescale
Ensure that all remaining members of staff who are not booked are booked on	SR/ES/LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	ASAP
Continue to monitor compliance weekly/monthly and escalate as appropriate.	SR/ES/LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	Ongoing
90% achieved for Fetal Monitoring study day – Consultants	SR/ES	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	06/02/24
90% achieved for Fetal Monitoring study day – Doctors	SR/ES	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	05/12/23
90% achieved for Fetal Monitoring study day – Midwives (Inc B&A)	SR/ES	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	06/02/24
90% achieved for Prompt study day – Doctors	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	12/01/24
90% achieved for Prompt study day – Midwives (inc B&A)	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	26/01/24
90% achieved for Prompt study day – Maternity Support Workers	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	26/01/24
90% achieved for Prompt study day – Anaesthetic Consultants	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	14/12/24
All leads to send an email 1 month prior to expiration date of the individual's competency. This will serve as an early reminder before the member of staff becomes non-compliant to keep the 90% up	SR/ES /LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	Ongoing monthly

Updates will be provided to Trust Board as the 90% is achieved.

01/12/2023
Author - Angela Lister, Project Manager - Maternity
Contributor - Danielle Bhanvra, HOM

Saving Babies Lives Care Bundle (Version 3)

Implementing Version 3 of the Care Bundle

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

Organisational roles and responsibilities

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. Successful implementation of SBLCBv3 requires providers, commissioners, and networks to collaborate successfully:

→ **Providers** are responsible for implementing SBLCBv3, including baselining current compliance, developing an improvement trajectory, and reporting on implementation with their ICB as agreed locally. They are also responsible for submitting data nationally relating to key process and outcome measures for each element.

→ **ICB's** are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting and challenging local delivery. Where there is unresolved clinical debate about a pathway, providers may wish to agree a variation to an element of the care bundle with their integrated care board. An integral part of ICSs, **LMNSs** are accountable to ICBs and have the system's maternity and neonatal expertise to support planning and provide leadership for improvement, facilitating peer support, and ensuring that learning from implementation and ongoing provision of SBLCBv3 is shared across the System footprint.

→ **Clinical Networks and Regional Maternity teams** are responsible for providing support to providers, ICBs and LMNSs to enable delivery and achieve expected outcomes. It is important that specific variations from the pathways described within SBLCBv3 are agreed as acceptable clinical practice by their Clinical Network.

Implementation tool user guide

The Futures NHS Collaboration Platform includes a user guide for use alongside this implementation tool. This user guide is intended for all LMNS and Trust colleagues who are responsible for implementing SBLCB v3. The user guide includes a variety of resources, videos, testimonials, presentations and freqently asked questions to support the use of the implementation tool. To view the resources or request access to the user guide use the link below:

Implementation Tool - Saving Babies' Lives Implementation Tool - FutureNHS Collaboration Platform

Contents

Element 3 – Raising awareness of reduced fetal movement

Element 4 – Effective fetal monitoring during labour (N.B. information not capturable in MSDS v2.0)

Element 5 – Reducing preterm birth

Element 6 – Management of Diabetes in Pregnancy

Contact Us

Queries or questions in relation to the functionality or use of the implementation tool: england.maternitytransformation@nhs.net

Queries or questions in relation to the NHS Resolutions CNST guidance: nhsr.mis@nhs.net

Queries or questions in relation to the Saving Babies Lives Care Bundle Version 3 guidance: england.maternitytransformation@nhs.net

Further Support/Information

Saving babies' lives version three: a care bundle for reducing perinatal mortality - published 31 May 2023

NHS Resolutions Maternity Incentive Scheme – year five - published May 2023

Core competency framework version two - published 31 May 2023

Saving babies' lives implementation tool user guide (NHS Fututes) - published July 2023

Standard Operating Procedure

Developed by: Jo Hadley - Midlands Regional Digital Midwife
Jenny Brown - Midlands Senior Quality Improvement Manager
Tony Kelly - National Clinical Advisor for National Maternity and Neonatal Safety Improvement programme and Leadership and Culture Programme
Karen Thirsk - Senior Project Manager
Charlie Podschies - Senior Programme Manager
Rachel Vollans - Project Coordinator

Quality assured by: NHS England

Saving Babies Lives Care Bundle (Version 3)

Document version history

Version	Date Issued	Brief Summary of Change
V0.1	26/05/2023	Draft version of newly designed SBLCB v3.0 Implementation Tool
V0.2	09/06/2023	Beta version for testing
V1.0	03/07/2023	Final version for publishing
V1.1	13/07/2023	Updated for technical issue on Element 5 with assessment drop-down fields
V1.2	18/07/2023	Logo and acknowledgement updated
V1.3	15/11/2023	Various changes - see 'Implementation Tool Version 1.3 Change Log' for further details.

Saving Babies Lives Care Bundle (Version 3)

How to Print the Implementation Tool

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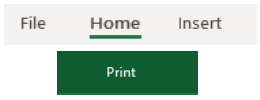

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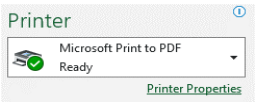
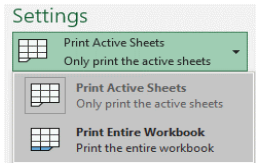
Select Print from the Menu List or Alt and P (simultaneously) on the keyboard to open the Print Option



Select the Printer option. You can either print to a PDF document which can be saved and then emailed or shared. Or you can select an available printer from the drop down list and print to paper.



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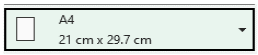
Print only the selected worksheet you are currently viewing; OR

Print all worksheets within the implementation tool.

The page orientation, margins and scaling have been set within the tool and do not need to be changed in the printer settings.



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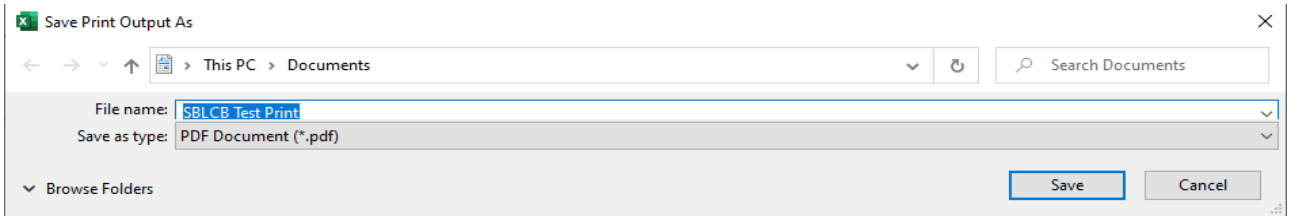
Select the required number of copies and select Print.

If you choose to print to a PDF document, you will be prompted to select the save location and file name for your PDF:



Saving Babies Lives Care Bundle (Version 3)

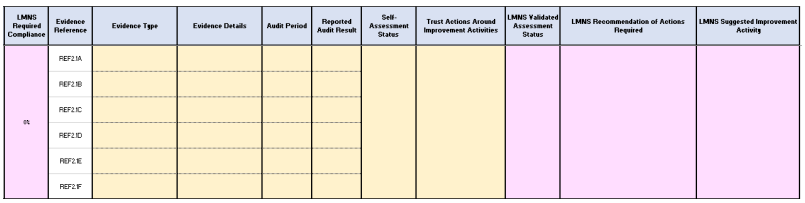
How to Use the Implementation Tool

This implementation tool is designed to gather information on progress towards full implementation of the Saving Babies' Lives Care Bundle Version 3, published 31 May 2023. This tool will support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory. The results of this survey will enable NHS maternity providers to self-assess their compliance against the interventions and their alignment to Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle. Links to both guidance documents are included below under 'Further Support/Information'.

Provider Guidance

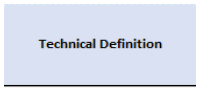
NHS maternity providers are required to complete the yellow boxes only on each of the following worksheets (the pink boxes are for completion only by the LMNS as part of their assurance process):

Implementation tool E1
Implementation tool E2
Implementation tool E3
Implementation tool E4
Implementation tool E5
Implementation tool E6



LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
0%	REF2.1A									
	REF2.1B									
	REF2.1C									
	REF2.1D									
	REF2.1E									
	REF2.1F									

The relevant data items for the process and outcome indicators related to SBLCBv3 should be recorded where possible on the provider's Maternity Information System and included in the MSDS submissions to NHS England in an MSDSv2 (Information Standard Notice compatible format, including SNOMED-CT coding). Each of the above worksheets include, where available, technical guidance related to measuring and collecting evidence within the Maternity Services Data Set (MSDS) or another data collection tool. Where available, you can click on the relevant process or outcome indicator link to take you to the technical reporting guidance:



For ease at the top of each of the technical definition worksheets, there is a button that when clicked will take you directly back to the implementation tool worksheet that you were working on:

Process indicator 2i

Each intervention within each element enables up to six pieces of evidence to be submitted for review and verification by the LMNS. Each piece of evidence submitted should be named using the reference number listed on the implementation tool in line with the intervention it relates to. You should also ensure your Trust name is specified in the evidence description/title. E.g. when saving evidence for Element 1, Intervention 1 use 'REF1.1A TRUST NAME Evidence description' as the document/evidence name.

If a piece of evidence relates to multiple interventions you only need to save and submit the evidence once. In this case include all reference numbers listed in the implementation tool in line with the interventions the evidence relates to. E.g. 'REF1.1A REF2.2B REF3.2C TRUST NAME Evidence description'.

The Futures NHS Collaboration Platform has restricted folders for every maternity provider which has been set up by NHS England to store evidence to demonstrate implementation and hold a live copy of the implementation tool for each provider. Please follow the link below to access the tool for your system and provider.

Implementation Tool - Saving Babies' Lives Implementation Tool - FutureNHS Collaboration Platform

Permissions have been granted based on the contacts authorised by LMNSs, alongside relevant NHS England regional and national programme leads. If you require access for other colleagues please email:

england.maternitytransformation@nhs.net

Please see LMNS SBLCB SOP for further information.

Completed tools will be analysed for the purpose of understanding national and regional implementation challenges and areas where further support may be required to help support full implementation. NHS England will aim to collate overall implementation progress of SBLCB v3 to allow organisations to gain insights and provide useful benchmarking. This will not form part of the assurance process but will aid understanding of the degree of implementation at a national level. By using this tool, you are granting NHS England access to your submitted data. If you do not wish for your data to be collated, please email england.maternitytransformation@nhs.net.

england.maternitytransformation@nhs.net

Saving Babies Lives Care Bundle (Version 3)

How to Assure with the Implementation Tool

LMNS Guidance

Following a system first approach, Local Maternity and Neonatal Systems (LMNS) should be assuring themselves that maternity providers within their systems are fully implementing the care bundle and meeting the CNST maternity incentive scheme in relation to the Saving Babies Lives Care Bundle Version 3. LMNS's should review the evidence through their system level governance frameworks at least quarterly and validate compliance against each of the standards. This will enable the ICSs and providers of services to identify common problems and barriers to implementation and develop and share effective solutions.

To reduce assurance burdens, national implementation surveys are being stepped down. Instead, trusts will be asked to use the implementation tool in 2 ways to ensure local oversight:

1. Track and demonstrate compliance to the Trust Board and ICBs. 'Full implementation' of the care bundle means completing all interventions for all 6 elements. Compliance will therefore be expressed as a percentage of completed interventions for each element, and across all elements.

2. Holding quarterly quality improvement discussions with the ICB.

Developing the standards for local compliance:

There is variation in clinical care across England and as a result setting an arbitrary single national ambition or aim is unrealistic. However, there needs to be robust local provider-commissioner discussions regarding the level of local ambition in relation to previous improvements and related benchmarking. Within each intervention, where available, we have included a stretch ambition and a minimum level of expected achievement (see Column G). The level of ambition is to be set following discussions between the LMNS and the Trust and should appropriately challenge realistic improvements within organisations.

For each intervention, Column I on the following worksheets, should be completed by the LMNS with the agreed required compliance level prior to the provider completing the worksheets to demonstrate their evidence to meet the defined local ambition target.

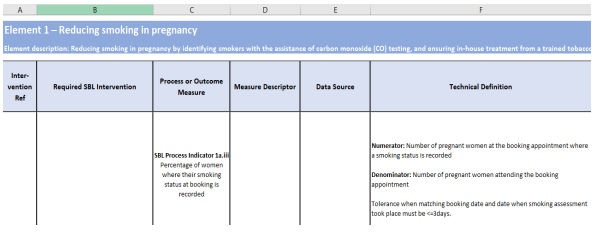
Implementation tool E1
Implementation tool E2
Implementation tool E3
Implementation tool E4
Implementation tool E5
Implementation tool E6

When assessing if the agreed compliance threshold is met for each intervention, compliance should be measured over an appropriate timeframe that demonstrates sustained and embedded improvements. LMNSs should consider provider's progress, and systems and procedures in place to monitor compliance, when setting appropriate monitoring timeframes. For example, a provider that has regular audit mechanisms in place and can consistently demonstrate achieving the ambitions set may be suitable to submit six monthly audits to monitor continued achievement of the ambitions set. Whereas a provider that demonstrates audits that inconsistently meet the ambitions set, would require closer monitoring and more frequent audit timeframes. The LMNS should be assured quarterly that providers are meeting or are on track to meet the required interventions and elements.

Measuring improvements and data sources:

Official Statistics about NHS-funded maternity services in England, from the Maternity Services Data Set (MSDS), including activity at booking and pregnancy outcomes, can be found at https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics. NHS England has moved to a provisional and final processing submission model for the Maternity Services Data Set (MSDS). MSDS data will be published on NHS Digital's website earlier than before as 'provisional' data. A finalised version of the data will also be published later as normal. This will enable data to be available more quickly for operational decision making and planning purposes.

Where there are no defined MSDS measure descriptors in column D of the implementation tool elements, providers may use local data to drive real-time quality improvement. Where it is not possible to source this data through their maternity information system (MIS), this may be measured through snapshot audits of consecutive records as agreed with their local maternity and neonatal system (LMNS). Guidance has been provided within the technical definition (column F) for these interventions on the data to be collected and analysed to measure improvements.



A	B	C	D	E	F
Element 1 – Reducing smoking in pregnancy					
Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco					
Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition
		SBL Process Indicator 1a.iii Percentage of women where their smoking status at booking is recorded			Numerator: Number of pregnant women at the booking appointment where a smoking status is recorded Denominator: Number of pregnant women attending the booking appointment Tolerance when matching booking date and date when smoking assessment took place must be <=3days.

System peer assessment and validation:

Through an appropriately agreed governance framework (for example the LMNS SBLCB SOP), the ICB/LMNS should review the evidence submitted and complete the pink boxes (columns O, P and Q) on each of the 'Implementation Tool Element' worksheets to validate compliance and identify improvement actions.

LMNS SBLCB Quarterly Assurance meeting:

Providers and their LMNS partners need to meet at the end of each quarter to discuss progress against this version of the Saving Babies Lives Care Bundle. The dates of these meetings should be logged within the tool on the:

Progress and LMNS review record

When validating the implementation status of each intervention within each element the following criteria should be used:

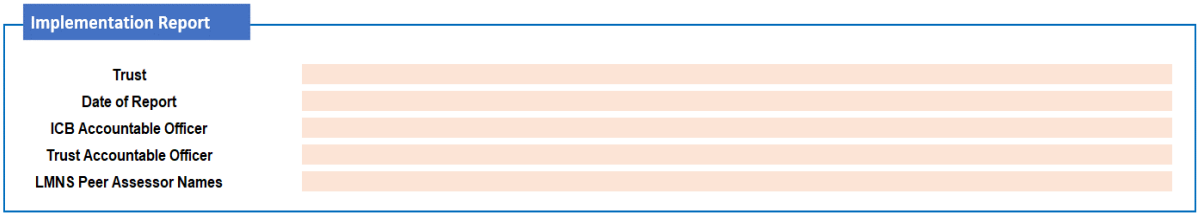
Element Progress	Progress Measure

Fully implemented	All minimum evidence requirements (column G) and where applicable the LMNS required compliance (column H) are met
Partially implemented	1 or more, but less than all, minimum evidence requirements (column G) and where applicable the LMNS required compliance (column H) are met
Not implemented	None of the minimum evidence requirements (column G) and where applicable the LMNS required compliance (column H) are met

There should be a minimum of two Quarterly Assurance meetings prior to the final Clinical Negligence Scheme for Trusts (CNST) submission date. Following each meeting the Trust should submit a summary report to their organisation and system board demonstrating progress to date. The Board report template developed within the tool can be used:

Board report and action plan

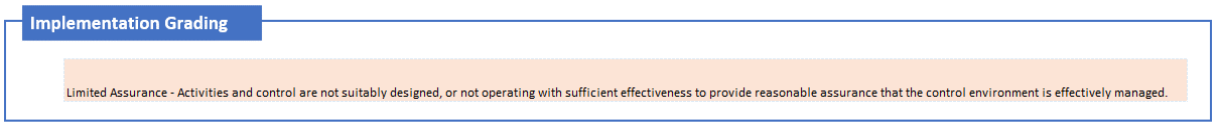
Complete the Trust details, date of assessment and assessors names in the pink boxes on the 'Board report and action plan' worksheet:



The Board Report and Action Plan show an aggregate of the intervention implementation across each of the six elements and also across all elements combined. This also maps to the current year's NHS Resolution Maternity Incentive Scheme compliance requirements for Safety Action 6 (correct at time of publishing the tool). When aggregating the interventions the Board Report table uses the LMNS validated assessment scores only and applies the following criteria:

Element Progress	**Progress Measure**
Fully implemented	All interventions in an element are fully implemented
Partially implemented	More than 1, but less than all interventions in an element are fully implemented
Not implemented	All interventions in an element are partially implemented, not implemented, or a mixtures of both

Following validation of the implementation of the care bundle evidence, apply an appropriate assurance grading on the confidence of full implementation.



Recommended content of LMNS SBLCB quarterly meetings should include the following areas:

1. Review of areas within the implementation tool that are not implemented or partially implemented for each element and specific improvement work being undertaken.
2. Review of SBLCB Process and Outcome Indicators for each element by trust, and review trust SBLCB improvement plans and progress made between quarterly review meetings.
3. Review SBLCB audit plans developed by trusts to ensure they are appropriate to meet the interventions.
4. Review trends and themes identified by trusts following their examination of outcomes in relation to the interventions.
5. Review all population groups and identify any health inequalities across all six elements.
6. Review evidence of continuous learning by individual trusts and sharing of learning within their local ICB and neighbouring trusts.
7.Review of engagement work with bereaved families through the Maternity and Neonatal Voice Partnerships (MNVP) to ensure all voices are heard and ensure lessons are learnt from every baby's death so continual improvement can be made.

While there will be no routine, deadline-based submissions of data to the national NHS England team for the purposes of assurance, the maternity team will review data stored on trust implementation tools on an ad-hoc basis to assess national progress in implementation.

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Implementation Report

Trust	**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
Date of Report	**13-Dec-23**
ICB Accountable Officer	**Cathy Winfield, Executive Chief Nurse**
Trust Accountable Officer	
LMNS Peer Assessor Names	**LMNS PMO Team - Programme Director, Obstetric Clinical Lead, Neonatal Clinical Lead,**

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

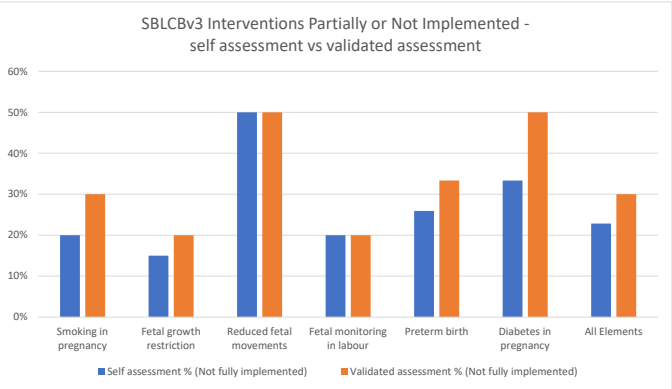
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

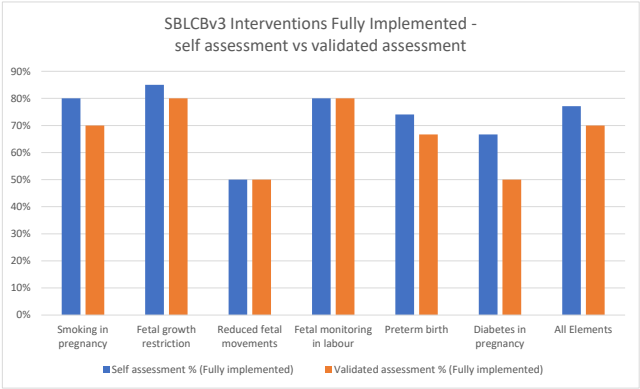
Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	74%	Partially implemented	67%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	77%	Partially implemented	70%	CNST Met





Action Plan

	Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
	INTERVENTIONS				
Element 1	1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small smaple audit of CO2 at every contact (to discuss - why small
	1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that guideline flow chart includes smoking status at all appointments - not clear in flow chart or main body of guideline that
	1.4	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included and 83.9% referred. Require minimum of 90% referrals for SBL (with plan to 100% to deliver the national tobacco model)
	1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that the smoking in pregnancy guideline also refers to the RDASH policy - ie guideline says women could be referred to the GP for NRT (in community) whereas the RDASH guideline (and
	1.6	Fully implemented	Fully implemented	0	Reported audit results (in tool) indicate compliance based on RDASH data - however, the evidence uploaded (RDASH smoke free pregnancy activity) does not match these figures (for 1c and 1d).
	1.7	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Discussed at meeting. Minor update to guideline to reflect regualr audit.
	1.8	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence included (in the tool) shows <90% training compliance - not clear where these %s have been derrived from. Continued roll out of training plan.
	1.9	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training provided as part of mandatory training. Evidence of compliance required.
	1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email included from RDASH confirming staff are trained to NCSCT standards. There is no data or evidence accompanying this. Information accepted in good faith.
	INTERVENTIONS				
Element 2	2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
	2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
	2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.5	Fully implemented	Fully implemented	0	Discussed at the meeting. Fully implemented - approach and evidence explained.
	2.6	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Plan included as evidence. Timeline indicates review of guideline aligned to SBLv3 deadline (March 2023)
	2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit evidence added post meeting demonstrating compliance.
	2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.11	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	TNA included as evidence. Training compliance is evidenced (30%) ongoing training plan included, although timescales for this are not clear.
	2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	2.14	Partially implemented	Partially implemented	0	Ensure reference to assessment of fetal and maternal condition in guidance, or reference to PlGF. To implement digital BP monitors.
	2.15	Fully implemented	Fully implemented	0	0
	2.16	Fully implemented	Fully implemented	0	0
	2.17	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Clarify core specialist MDT team and ensure there is a specific clinic available - to be uploaded. Audit evidence included with actions to be completed by January 24 and so remains partially implemented
	2.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline indicates delivery should occur at 37 weeks. Should include that this should be no later than 37+6 weeks.
	2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Ensure ongoing audit.
	2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	INTERVENTIONS				
ent 3	3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Elem	3.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Audit evidence included, however, unclear if 72 hours is always next working day. Additional audit / analysis required to demonstrate current position.
Element 4	**INTERVENTIONS**				
	4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	4.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Final version guideline reviewed at meeting. Audit evidence required.
	4.3	Fully implemented	Fully implemented	0	Final version guideline reviewed at meeting - to be uploaded to evidence portal.
	4.4	Fully implemented	Fully implemented	0	0
	4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
Element 5	**INTERVENTIONS**				
	5.1	Partially implemented	Partially implemented	0	JD for Obstetric and neonatal leads required. Confirmation required on the maternal medicine JD that is included as evidence - this does not appear to be an explicit pre-term role.
	5.2	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Patially implemented due to national ambition - work is underway and rate is improving due to QI work. With continued improvement and QI work, local trajectory to be agreed with a stretch to the
	5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.6	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included with actions to be completed by January 24 and so remains partially implemented until actions are implemented and re-audit demonstrates improvement in practice.
	5.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit discussed and clarified.
	5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Discussed. Additional guideline reviewed which articulates referral pathway from DBTH. Possibly clarity required regionally to ensure consistency but clear from DBTH perspective. Section 7 of guideline
	5.14	Fully implemented	Fully implemented	0	CoC plan included which includes realistic timelines based on MCoC guidance - to establish teams when building blocks allow. To note this does not indicate compliance with MCoC - but that there is a
	5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Additonal guideline reviewewd at the meeting which states information to be shared and information leaflet reviewed. Comms published version to be added as evidence.
	5.16	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included, currently below required compliance. To complete actions relating to review of local practice.
	5.17	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Additional evidence included. Still requires ODN data to be compiled. To ensure all elements are included within the guideline including thermal care at birth, early EBM.
	5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small number of off-pathway births occuring per quarter. To include evidence to demonstrate review (avoidable or non-avoidable) and any learning.
	5.20	Fully implemented	fully implemented	0	Audit data discussed. Variation due to manual data cleanse which is not reflected in the ODN data until the following quarter.
	5.21	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included demonstrating <90%. Action plan included identifying actions. Include data for outcome 5j(brain injury)
	5.22	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included, however there is variation between local and ODN published. To discuss. Both data sets indicate <90%. Action plan included but this is not specific to antibiotics.
	5.23	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Progress made. Ensure action plan focusses on DCC.
	5.24	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data indicates <target. Action plan included.
	5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	To review updates to Q2 data when ODN Q3 data is published to ensure improved DQ.
	5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 6

INTERVENTIONS				
6.1	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Trust confirm that model is in place as set out in evidence (JDC RR) however, post meeting it appears that the pilot of 2 separate clinics has ceased - to be reinstated. Confirmation there is a dietician
6.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice.
6.3	Fully implemented	Fully implemented	0	0
6.4	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice.
6.5	Fully implemented	Fully implemented	0	To include criteria for referral to MMN as evidence - not in the guideline
6.6	Fully implemented	Fully implemented	0	0

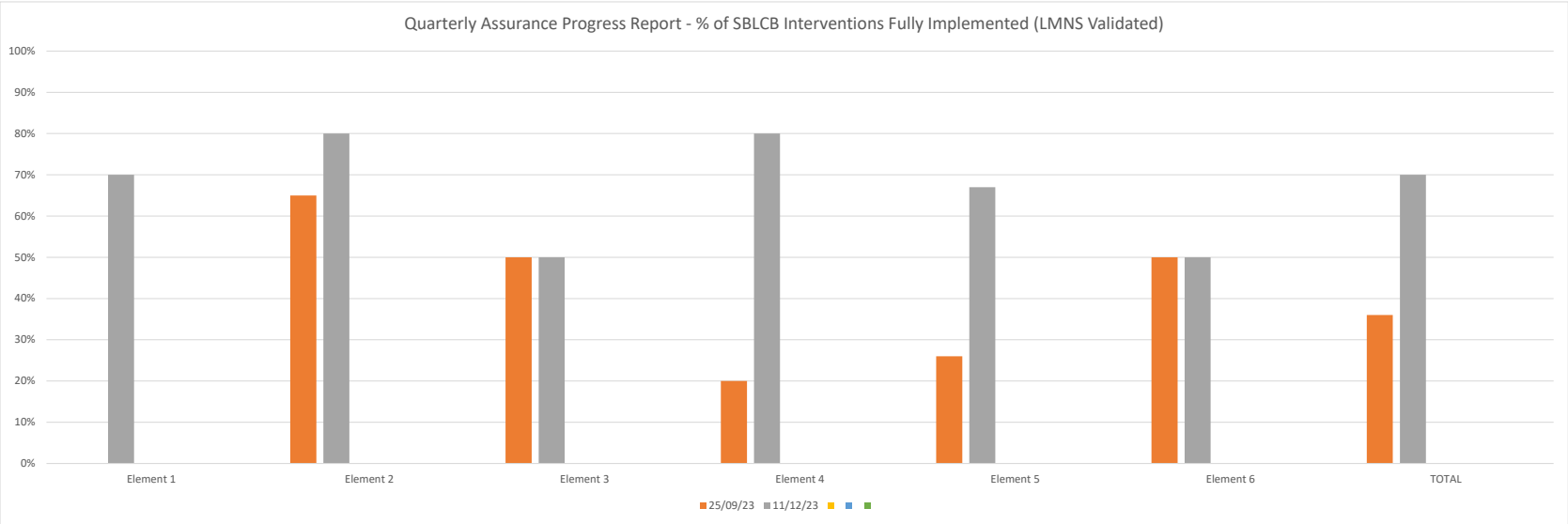
LMNS Quarterly Assurance Meeting Record on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Trust: **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**

ICB: **North East and Yorkshire**

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10	Assessment 11
Review Quarter	**Q3 23/24**	**Q4 23/24**										
Assurance Review Date	**25/09/23**	**11/12/23**										
Element 1	0%	70%										
Element 2	65%	80%										
Element 3	50%	50%										
Element 4	20%	80%										
Element 5	26%	67%										
Element 6	50%	50%										
TOTAL	36%	70%										

% of Interventions Fully Implemented (LMNS Validated)



Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco dependence adviser[1] is offered to all pregnant women who smoke, using an opt-out referral process.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
1.1	CO testing offered to **all** pregnant women at the **antenatal booking** and **36 week** antenatal appointment.	**SBL Process Indicator 1a.i** Percentage of women where there is a recorded CO measurement at booking appointment	SBL_Element1_ProcessIndicator1 SBL_Element1_ProcessIndicator2	Recording of CO measurement for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & Tobacco Dependence Treatment data collection.	Pass DQ checks on MSDS Dashboard Clinical Quality Improvement Metrics **Numerator:** Number of pregnant women attending booking appointment where a CO value (ppm) is recorded **Denominator:** Number of pregnant women attending booking appointment Tolerance when matching booking date and date when CO testing took place must be <=3days.	Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric for the most recent published data. If the data quality is not met there should be a plan in place and agreed by the LMNS to improve data quality. Guideline evidencing surveillance pathway of routine CO testing at booking and 36 weeks. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. An ambition of 95% for high performing organisations with minimum ambition of 90%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to consider interventions to maintain adequate compliance.	90%	REF1.1A	Dashboard	DBTH Maternity Dashboard	Sep-23		Fully implemented	Compliant	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small smaple audit of CO2 at every contact (to discuss - why small sample when K2 available?) In order to deliver against the national tobacco model: Recommend that there is continued review of smoking status & CO2 at all contacts - action plan included.
								REF1.1B									
								REF1.1C									
								REF1.1D									
								REF1.1E	Guideline/policy	Smoking in pregnancy guideline							
								REF 1.1F	Audit	CO @ booking - data quality checked and ratified	Q2 23/24	93%		Public Health Midwife (PHM) in post. Audit complaince - lack of availble equipment meaning no CO @ booking recorded for 4.03%. Work ongoing to ensure equipment availble. PHM actioning			
								REF1.1G	Guideline/policy	Antenatal Risk Assessment and ongoing care (ANRA)	previously uploaded						
								REF1.1H	Other	CO levels and smoking status numerator and denominator not data quality checked for CO reading	Q2 23/24						
								REF1.1I	Other	Action plan							
		SBL Process Indicator 1a.ii Percentage of women where there is a recorded CO measurement at 36-week appointment	SBL_Element1_ProcessIndicator3	Recording of CO measurement for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & Tobacco Dependence Treatment data collection.	**Numerator:** Number of pregnant women at the 36 week appointment where a CO value (ppm) is recorded **Denominator:** Number of pregnant women attending the 36 week appointment Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks).	Guideline evidencing surveillance pathway of routine CO testing at booking and 36 weeks. Details of the stop smoking strategy and any plans for improvement. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. An ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to consider interventions to maintain adequate compliance.	80%	REF1.1J	Guideline/policy	ANRA	previously uploaded					
								REF1.1K	Guideline/policy	Smoking in pregnancy guideline and trust QUIT smoking information along with trust strategy							
								REF1.1L	Audit	36/40 CO Testing data quality checked and ratified	Q2 23/24	91.10%		Compliant			
								REF1.1M	Other	Action Plan							
								REF1.1N	Audit	declines							
1.2	CO testing offered at all other antenatal appointments to groups identified within: NICE Guidance NG209	Percentage of smokers* where CO measurement is recorded at all antenatal appointments	N/A	Recording of CO measurement for each pregnant woman in line with NG209 on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** The number of pregnant smokers* who have a recorded CO measurement at each antenatal appointment during pregnancy **Denominator:** Number of pregnant smokers* who have come to the end of their pregnancy*** Tolerance when matching antenatal contact date and date when CO testing took place must be <=3days. * In line with NICE guidance a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). ***End of pregnancy is the trigger point which includes a) transfer of care to another provider, b) miscarriage, c) ectopic pregnancy d) termination of pregnancy e) following birth (live or stillborn).	Guideline evidencing surveillance pathway of routine CO testing at all antenatal appointments for pregnant smokers* as per NICE Guidance NG209. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'. Regular audit of testing rate and declines is recommended to consider interventions to maintain adequate compliance. There is an expectation that data is reported to the MSDS and audited using the Measure Descriptor processes. However, as there is no defined MSDS measure descriptor, providers may use local data to drive real-time quality improvement. Where it is not possible to source this data through MIS, this may be through Snapshot Audit of consecutive records as agreed with the local system.	50%	REF1.2A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented	compliant	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF1.2B	Audit	K2 Audit report consultations vs co reading	Q2 23/24	74.9%					
								REF1.2C	Dashboard	DBTH Maternity Dashboard - numerator and denominator for smokers who have delivered in Q2	Sep-23						
								REF1.2D	Other	CO levels and smoking status numerator and denominator not data quality checked for CO reading	Q2 23/24	64.0%					
								REF1.2E			7						
								REF1.2F									
1.3	Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.	**SBL Process Indicator 1a.iii** Percentage of women where their smoking status at booking is recorded	N/A	Recording of smoking status for each pregnant woman in line with NG209 on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of pregnant women at the booking appointment where a smoking status is recorded **Denominator:** Number of pregnant women attending the booking appointment Tolerance when matching booking date and date when smoking assessment took place must be <=3days.	Guideline evidencing surveillance pathway of routine CO testing and smoking assessment as per NICE Guidance NG209, followed by delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g. referral, feedback, data collection). Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to maintain adequate reliability with meeting the intervention.	80%	REF1.3A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented	Compliant	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that guideline flow chart includes smoking status at all appointments - not clear in flow chart or main body of guideline that smoking status must be obtained alongside CO reading (although evidence is included that this is happening)
								REF1.3B	Audit	VBA evidence	Q2 23/24	99.2%					
								REF1.3C	Audit	Smoking status recorded @ booking	Q2 23/24	100.0%					
								REF1.3D	Other	CO levels and smoking status numerator and denominator not data quality checked for CO reading	Q2 23/24						
								REF1.3E									
								REF1.3F									
		SBL Process Indicator 1a.iv Percentage of women where their smoking status at 36 weeks is recorded			**Numerator:** Number of pregnant women at the 36 week appointment where a smoking status is recorded **Denominator:** Number of pregnant women attending the 36 week appointment Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks).	Guideline evidencing surveillance pathway of enquiry about smoking status at 36 weeks as per NICE Guidance NG209. Details of the stop smoking strategy and any plans for improvement. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. An ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to maintain adequate reliability with meeting the intervention.	80%	REF1.3G	Guideline/policy	Smoking in pregnancy guideline							
								REF1.3H	Standard operating procedure	cessation SOP							
								REF1.3I	Audit	K2 data quality checked and ratified	Q2 23/24	100.0%					
								REF1.3J									
								REF1.3K									
								REF1.3L									
		Percentage of smokers* where smoking status is recorded at all antenatal appointments			**Numerator:** The number of pregnant smokers* who have a recorded smoking status at each antenatal appointment during pregnancy **Denominator:** Number of pregnant smokers* who have come to the end of their pregnancy*** Tolerance when matching antenatal contact date and date when smoking assessment took place must be <=3days. * In line with NICE guidance a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). ***End of pregnancy is the trigger point which includes a) transfer of care to another provider, b) miscarriage, c) ectopic pregnancy d) termination of pregnancy e) following birth (live or stillborn).	Guideline evidencing surveillance pathway of enquiry about smoking status at all antenatal appointments for pregnant smokers* as per NICE Guidance NG209. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'. There is an expectation that data is reported to the MSDS and audited using the Measure Descriptor processes. However, as there is no defined MSDS measure descriptor, providers may use local data to drive real-time quality improvement. Where it is not possible to source this data through MIS, this may be through Snapshot Audit of consecutive records as agreed with the LMNS.	50% (ensuring booking and 36 week targets met)	REF1.3M	Guideline/policy	Smoking in pregnancy guideline				Compliant			
								REF1.3N	Audit	K2 data	Q2 23/24	74.9%					
								REF1.3O									
								REF 1.3P									
								REF1.3Q									
								REF1.3R									
	Instigate an opt-out referral for all women			Recording of opt out referral for each pregnant	**Numerator**: Number of pregnant smokers who have an opt out referral to an in-house/in-reach tobacco dependence treatment service recorded **Denominator:** Number of pregnant smokers*	Guideline evidencing referral pathway in place as per NICE Guidance NG209. Service specification from Tobacco Dependence Treatment service.		REF1.4A	Guideline/policy	Smoking in pregnancy guideline							
								REF1.4B	Audit	RDaSH Data	Q4 & Q1						

Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco dependence adviser[1] is offered to all pregnant women who smoke, using an opt-out referral process.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
1.4	who have an elevated CO level (4ppm or above), who identify themselves as smokers, or have quit in the last 2 weeks, for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.	**SBL Process Indicator 1b** Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service	N/A	woman who is a smoker* on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	* A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). In-house service is where clinical leadership, delivery and oversight of the service and its outcomes remains with maternity. Services are considered as in-house when the woman's care for treating their tobacco dependence remains within the maternity service i.e. is not referred out to another provider like a local authority stop smoking service. In-reach services, where a third party, such as the local authority stop smoking service, provide services as part of the maternity team with the patient staying under the care and management of the maternity service would count as in-house.	Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 90%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). An additional quality improvement check would be for providers to look at referrals that are made after 15 weeks gestation/trimester 1 to understand why late referrals are being made and what if any improvements can be made.	90% for SBL - plan to 100% (based on tobacco model)	REF1.4C	Audit	opt out referal complaince	Q2 23/24	83.9%	Fully implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included and 83.9% referred. Require minimum of 90% referrals for SBL (with plan to 100% to deliver the national tobacco model)
								REF1.4D	Standard operating procedure	cessation SOP							
								REF1.4E	Other	action plan and QI plan							
								REF1.4F	Service specification	Service Spec RDASH							
1.5	Nicotine replacement therapy (NRT) should be offered to all smokers and provision ensured as soon as possible.	N/A	N/A	N/A	N/A	Guideline evidencing NRT treatment offered to all smokers in place as per NICE Guidance NG209. Service specification from Tobacco Dependence Treatment service.	N/A	REF1.5A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that the smoking in pregnancy guideline also refers to the RDASH policy - ie guideline says women could be referred to the GP for NRT (in community) whereas the RDASH guideline (and practice) indicates direct supply / e-voucher for NRT.
								REF1.5B	Guideline/policy	trust NRT guidance the word Midwife is being added							
								REF1.5C	Service specification	Service Spec RDASH							
								REF1.5D									
								REF1.5E									
								REF1.5F									
1.6	The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree. Successful implementation of this standard could be measured by audit of recorded treatments at specific appointments, however, implementation should result in improved overall outcomes in relation to reducing smoking in pregnancy, which is the focus of the subsequent process/outcome measures.	**SBL Process Indicator 1c** Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date	N/A	Recording of quit dates and CO verified smoking status in Maternity Information System (MIS) and submitted to Tobacco Dependence Treatment data collection.	**Numerator:** Number of pregnant smokers* with an opt out referral recorded who have set a quit date **Denominator:** Number of pregnant smokers* with an opt out referral recorded * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days).	Guideline evidencing NRT treatment pathway for all smokers in place as per NICE Guidance NG209. Service specification from Tobacco Dependence Treatment service. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition based on current system performance and improvement trajectory to reach stretch ambition of 60%. Clear action plan to be in place to meet to achieve 60% reliability (within locally agreed timeframes). See 'How to assure with the tool'.	30% (to increase to 50, then 60 with incentives)	REF1.6A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented		Fully implemented	Reported audit results (in tool) indicate compliance based on RDASH data - however, the evidence uploaded (RDASH smoke free pregnancy activity) does not match these figures (for 1c and 1d). Discussed at meeting - no data provided by ABL (at the time - now available) - so Trust have reviewed data across all providers and arrived at the percentages. Fully implemented - but requires additional evidence upload to show % across both providers.
								REF1.6B	Guideline/policy	NRT							
								REF1.6C	Other	RDaSH Data	Q4 & Q1	94.0%					
								REF1.6D	Service specification	Service Spec RDASH							
								REF1.6E									
		SBL Outcome Indicator 1e Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks			**Numerator:** Number of pregnant women in the denominator who are recorded as a CO verified non-smokers at 4 weeks (28 day) **Denominator:** All pregnant women who have a 4 week (28 day) smoking status outcome recorded in a given month The tolerance for recording the 4 week (28 day) quit is in line with the NCSCT recommendations at -5 to +14 days. If no outcome is recorded within 45 days of the quit date a default outcome of "smoker" should be used. * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days).	Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 60% of smokers who set a quit date are CO verified non-smokers at 4 weeks for high performing organisations with minimum ambition of 50%, with a clear action plan to achieve 60% reliability (within locally agreed timeframes). Of these, 85% have should have CO verification. An additional quality improvement check would be a sample audit of women who opt-out or fail to engage to understand why and what can be done to address this.	30% (to increase to 50, then 60 with incentives)	REF1.6F	Other	RDaSH Data	Q4 & Q1	60.0%					
								REF1.6G	Other	ACTION PLAN STRETCH TARGETS AND QI							
								REF1.6H	Service specification	ABL							
								REF1.6I									
								REF1.6J									
		SBL Outcome Indicator 1d Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks			**Numerator:** Number of denominator with a CO reading at =<4ppm and self-identified as a non-smoker at the 36 week appointment (within the tolerance) **Denominator:** Number of women who were identified as a smokers* at booking who birthed at or after 37+0 weeks The tolerance of gestational age contact date for the 36 week appointment is within 245 days (35+0 weeks) and 258 days (36+6 weeks). * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days).	Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'. Additional quality improvement checks would be for providers to look at: a) women who had a CO level =>4ppm / identified as a smoker at booking but had an end of pregnancy before 36 weeks to identify smoking status at the most recent appointment and any associated learning points / trends. b) women who do not have 36 week CO test or smoking status reported within the relevant tolerance, but do have one reported after 37 weeks for learning points/ trends.	10% (with stretch to 20%)	REF1.6K	Other	RDaSH Data	Q4 & Q1	66.7%					
								REF1.6L	Other	QI PLAN							
								REF1.6M									
								REF1.6N									
								REF1.6O									
1.7	Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional.	Percentage of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not book or attend appointments with the in-house tobacco dependence treatment service.	N/A	N/A	**Numerator:** Number of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not book or attend appointments with the in-house/in-reach tobacco dependence treatment service **Denominator:** Number of woman who do not book or attend appointments with the in-house/in-reach tobacco dependence treatment service In-house service is where clinical leadership, delivery and oversight of the service and its outcomes remains with maternity. Services are considered as in-house when the woman's care for treating their tobacco dependence remains within the maternity service i.e. is not referred out to another provider like a local authority stop smoking service. In-reach services, where a third party, such as the local authority stop smoking service, provide services as part of the maternity team with the patient staying under the care and management of the maternity service would count as in-house.	Guideline evidencing follow up and feedback processes to the pregnant woman's named maternity healthcare professional in place. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	Embed feedback loop within practice - with action plan to improve. Must be included within guidance and audited to demonstrate continua improvement	REF1.7A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented	SIP Guideline updated. Feredback currently providedwd via email however new template just launched. This will ensure that moving forward the feedback is more robust	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Discussed at meeting. Minor update to guideline to reflect regualr audit.
								REF1.7B	Other	Feedback proforma							
								REF1.7C	Audit	Audit of feedback	Sept-Nov 23	13.4%					
								REF1.7D									
								REF1.7E									
								REF1.7F									
1.8	Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result. See Core Competency Framework Version 2	Percentage of staff with in date training compliance on the use of a CO testing and discussion of results	N/A	Local training records.	**Numerator:** Number of denominator with in-date annual training compliance on the use of a CO monitor and interpretation/discussion of results **Denominator:** Number of staff delivering front line care who use CO monitors in accordance with local pathways Training requirements are outlined in the Core Competency Framework Version 2. For quality improvement purposes training should be analysed by all grades/bands and disciplines who are required to use a CO monitor e.g. medical staff; midwives; support workers; nurses.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A minimum ambition of 80% attendance with a annual update (provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period) and a stretch ambition of >95% attendance, with a clear action plan to achieve >95% for those organisations on an improvement journey as outlined in the Core Competency Framework.	90%	REF1.8A	Training plan/TNA	Uploaded			Partially implemented	percentage is a combination of tea trolly and rest complaince	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence included (in the tool) shows <90% training compliance - not clear where these %s have been derrived from. Continued roll out of training plan.
								REF1.8B									
								REF1.8C	Training compliance	Tea Trolley evidence uploaded - 80 staff members	Q2 23/24	%					
								REF1.8D	Training compliance	REST study day for CO and VBA 45 staff members	Q2 23/24	46.8%					
								REF1.8E	Other	Action plan							
								REF1.8F									
1.9	All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g. referral, feedback, data collection).	Percentage of staff providing maternity care with annual in date training compliance on the delivery	N/A	Local training records	**Numerator:** Number of staff providing frontline maternity care with in date annual training compliance on the delivery of VBA, making an opt-out referral and maternity pathway processes **Denominator:** Number of staff providing frontline maternity care	A training plan should be in place to cover all six core modules of the Core Competency Framework. Very Brief Advice on smoking in pregnancy can be accessed via NCSCT e-learning or HEE eLearning for Health Hub. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'.	90%	REF1.9A	Training plan/TNA	Uploaded			Partially implemented	VBA training is a mandatroy request for all staff on e-learning. Provided via e-lfh.	Partially implemented	Focus required on improvement of audit levels to meet	
								REF1.9B	Audit								
								REF1.9C	Other	Action plan							

Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco dependence adviser[1] is offered to all pregnant women who smoke, using an opt-out referral process.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
	See Core Competency Framework Version 2	compliance on the delivery of VBA, making an opt-out referral and maternity pathway processes	N/A	Local training records.	Training requirements are outlined in the Core Competency Framework Version 2. For quality improvement purposes training should be analysed by all grades/bands and disciplines who are required to use a CO monitor.	A stretch ambition of 95% for high performing organisations with minimum ambition of 80% (provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period), and a clear action plan to maintain 90% reliability, for those organisations on an improvement journey as outlined in the Core Competency Framework.		REF1.9D REF1.9E REF1.9F					Partially implemented	Difficulty in pulling complaince data from e-lfh. Education lead to investigate.	Partially implemented	implementation ambitions and LMNS trajectories.	Evidence of compliance required.
1.10	Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards.	Percentage of individuals delivering tobacco dependence treatment interventions who are fully trained to NCSCT standards	N/A	Local training records.	**Numerator:** Number of staff delivering tobacco dependence treatment interventions with in date annual refresher training compliance to NCSCT standards **Denominator:** Number of staff delivering tobacco dependence treatment interventions	A training plan should be in place to cover all six core modules of the Core Competency Framework. NCSCT derived competency frameworks are also available on NHS Futures. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Minimum 90% reliability of staff delivering tobacco dependence treatment are trained to NCSCT standards.	90%	REF1.10A REF1.10B REF1.10C REF1.10D REF1.10E REF1.10F	Training plan/TNA email	Uploaded RDASH complaince with training confirmation		100.0%	Fully implemented	Received confirmation via email and individual certificates from all staff being complaint as per the standard	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email included from RDASH confirming staff are trained to NCSCT standards. There is no data or evidence accompanying this. Information accepted in good faith.

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
2.1	Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm (for example Appendix C) agreed with the local ICS and regional maternity team.	Percentage of women booked who had a risk assessment for Aspirin at booking	N/A	N/A	**Numerator:** Number of women booked who have had a completed risk assessment undertaken for Aspirin at booking **Denominator:** Number of women booked The pathways in Appendix C have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing assessment at booking to determine if prescription of Aspirin is needed using an appropriate algorithm. Agreement of use of an appropriate algorithm for assessment by the local ICS and regional maternity team. If using Appendix C of the SBLCBv3 then no agreement is necessary. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	100% (of women had risk assessment)	REF2.1A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
								REF2.1B	Audit	Audit of aspirin prescription	Q4 22/23	97.7%					
								REF2.1C	Audit	Documentation audit - Risk assessment	Q2 23/24	100.0%					
								REF2.1D									
								REF2.1E									
								REF2.1F									
2.2	Recommend vitamin D supplementation to all pregnant women.	Percentage of women booked who are recommended Vitamin D at booking	N/A	N/A	**Numerator**: Number of women booked who are recommended vitamin D supplementation at booking **Denominator**: Number of women booked	Guideline evidencing recommendation of Vitamin D supplementation to all pregnant women. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	100%	REF2.2A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
								REF2.2B	Audit	Documentation audit - Risk assessment	Q2 23/24	100%					
								REF2.2C	Audit	K2 Audit	Q2 22/23	98.1					
								REF2.2D									
								REF2.2E									
								REF2.2F									
2.3	Assess smoking status and manage findings as per Element 1.	N/A	N/A	N/A	N/A	Guideline evidencing smoking status is assessed and managed as outlined in Element 1 for women identified as at risk of fetal growth restriction. .	N/A	REF2.3A	Guideline/policy	Smoking in pregnancy	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.3B									
								REF2.3C									
								REF2.3D									
								REF2.3E									
								REF2.3F									
2.4	Perform a risk assessment for FGR by 14 weeks gestation using an agreed pathway (for example, Appendix D). In multiparous women risk assessment should include the calculation of previous birthweight centiles. The pathway and centile calculator used must be agreed by both the local ICS and the regional maternity team.	**SBL Process Indicator 2a** Percentage of pregnancies where a risk status for FGR is identified and recorded at booking	N/A	Recording of FGR risk status for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of pregnancies where a risk assessment for FGR is completed by 14 weeks **Denominator:** Total number of pregnancies submitted to MSDS The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed with local ICSs following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care. Trusts submitting data to the MSDS will be able to view the percentage of <3rd centile births in each gestational week of the third trimester in their unit annually.	Guideline evidencing risk assessment to be performed for FGR prior to 14 weeks gestation using an agreed pathway. Agreement of use of an appropriate algorithm for assessment by the local ICS and the regional maternity team. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	80%	REF2.4A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.4B	Audit	FGR risk assessment @ booking	Q2 23/24	97%					
								REF2.4C									
								REF2.4D									
								REF2.4E									
								REF2.4F									
2.5	During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff. No single provider is recommended, but technology platforms should not prevent compliance with Element 2 guidance and should follow national recommendations on the use of fundal height and fetal growth charts.	N/A	N/A	N/A	Electronic ultrasound database and MIS suppliers should provide EFW centile charts and birthweight centile charts with reference curves for the 3rd and 10th centiles. Providers using paper EFW centile charts and birthweight centile charts should ensure that the charts have reference curves for the 3rd and 10th centiles. Actual birthweight of the baby should be assessed using the same methodology used antenatally i.e., based on EFW reference, not a birthweight reference scale to ensure consistency.	Evidence from system supplier that latest software in use by the organisation complies fully with all requirements of element 2 of SBLCBv3. Evidence that EFW centile charts and birthweight centile charts in use (whether paper or electronic) include reference curves for the 3rd and 10th centiles. Evidence that actual birthweight of the baby should be assessed using the same methodology used antenatally i.e., based on EFW reference, not a birthweight reference scale to ensure consistency.	N/A	REF2.5A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented	Implementing GROW2.0. Not yet gone 'live'	Fully implemented		Discussed at the meeting. Fully implemented - approach and evidence explained.
								REF2.5B	Audit	birth centile AN and PN evidence							
								REF2.5C									
								REF2.5D									
								REF2.5E									
								REF2.5F									
2.6	As part of the risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy for all pregnant women: Recommendations for digital blood pressure monitoring in maternity services	N/A	N/A	N/A	Agree a plan for the replacement of blood pressure monitors in use with pregnant women as necessary, so that all are compliant with Guidance from the Chief Scientific Officer. Plans and timescales must be in view of local resources, with priority given to the replacement of analogue/aneroid blood pressure monitors. In the meantime, the use of non-compliant devices should be raised in the service risk register.	Evidence of a plan to roll out the use of digital monitors. Guideline evidencing that as part of the risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated. Trust equipment procurement plans if using non-compliant devices.	N/A	REF2.6A	Other	Action plan to roll out digital monitors and equipment procurment plan			Partially implemented	On risk register. Awaiting to see whoich are validiated for use in clincal area and not home use	Partially implemented	Evidence not in place - improvement required.	Plan included as evidence. Timeline indicates review of guideline aligned to SBLv3 deadline (March 2023)
								REF2.6B									
								REF2.6C									
								REF2.6D									
								REF2.6E									
								REF2.6F									
								REF2.7A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded						

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
2.7	Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation.	Percentage of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation	N/A	N/A	**Numerator**: Number of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation **Denominator**: Number of women booked that are identified as high risk for FGR The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed with local ICSs following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing women identified high risk for FGR, using an appropriate algorithm, undergo uterine artery doppler assessment between 18+0 and 23+6 weeks gestation. Agreement of use of an appropriate algorithm for assessment by the local ICS and regional maternity team. If using Appendix D of the SBLCBv3 then no agreement is necessary. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF2.7B	Audit	Growth assessment audit	previously uploaded	64	Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit evidence added post meeting demonstrating compliance.
								REF2.7C									
								REF2.7D									
								REF2.7E									
								REF2.7F									
2.8	The risk of FGR should be reviewed throughout pregnancy and maternity providers should ensure that processes are in place to enable the movement of women between risk pathways dependent on current risk.	**SBL Process Indicator 2c** Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).	N/A	Perinatal Mortality Review Tool (PMRT).	Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality report and report to their ICS on actions taken to address any deficiencies identified.	Guideline evidencing risk of FGR should be reviewed throughout pregnancy and that processes are in place to enable the movement of women between risk pathways dependent on current risk. Report demonstrating % of stillbirths which had issues associated with FGR management identified using PMRT and the actions taken and learning shared to make improvements.	N/A	REF2.8A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented	Audit needed	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.8B	Audit	Audit - low percentage is good	Q2 23-24	0%					
								REF2.8C									
								REF2.8D									
								REF2.8E									
								REF2.8F									
2.9	When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care.	N/A	N/A	N/A	N/A	Guideline evidencing robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care following an ultrasound-based assessment of fetal growth.	N/A	REF2.9A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.9B									
								REF2.9C									
								REF2.9D									
								REF2.9E									
								REF2.9F									
2.10	Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation. Measurements should be plotted or recorded on charts by clinicians trained in their use. NICE Guidance NG201	N/A	N/A	N/A	Offer symphysis fundal height measurement at each antenatal appointment after 24+0 weeks (but no more frequently than every 2 weeks) for women with a singleton pregnancy unless the woman is having regular growth scans [NICE guideline (NG201), August 2021]	Guideline evidencing women identified low risk for FGR, using an appropriate algorithm, undergo FH measurement before 28+6 weeks gestation. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF2.10A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.10B	Audit	Audit SFH done before 28+2	Q2 23-24	87%					
								REF2.10C									
								REF2.10D									
								REF2.10E									
								REF2.10F									
2.11	Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement. See Core Competency Framework Version 2	Percentage of staff with in date training on FH measurement	All staff providing antenatal care should have competence in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.	Local training records.	**Numerator:** Number of staff* with in date annual training compliance on the measurement of FH and recording and interpretation of results **Denominator:** Number of staff* to be trained *A list of staff in and out of scope for inclusion in training numbers is outlined in the technical guidance for Safety Action 8 of CNST MIS. Training requirements are outlined in the Core Competency Framework Version 2. For quality improvement purposes training should be analysed by all grades/bands and disciplines who are required to undertake FH measurements e.g. medical staff; midwives.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80% (provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period), and a clear action plan to achieve 95% reliability, for those organisations on an improvement journey, as outlined in the Core Competency Framework.	95%	REF2.11A	Training plan/TNA	Uploaded			Partially implemented		Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	TNA included as evidence. Training compliance is evidenced (30%) ongoing training plan included, although timescales for this are not clear.
								REF2.11B	Other	GAP training raw data available - password protected document	previously uploaded						
								REF2.11C	Audit	GAP training annual rolling data	GAP complaince training	30.6					
								REF2.11D	Other	Action plan	UPLOADED						
								REF2.11E									
								REF2.11F									
2.12	Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. FH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk (e.g., recurrent reduced fetal movements).	N/A	N/A	N/A	N/A	Guideline evidencing FH measurement is not undertaken for those women who are on a serial scan surveillance pathway and are receiving regular scans to monitor fetal growth.	N/A	REF2.12A	Guideline/policy	ANRA		previoulsy uploaded	Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.12B									
								REF2.12C									
								REF2.12D									
								REF2.12E									
								REF2.12F									
								REF2.13A	Guideline/policy	Fetal Growth Assessment guideline		previoulsy uploaded					

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
2.13	Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery (see RCOG guidance and Appendix D).	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing women identified at increased risk for FGR, using an appropriate algorithm, have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery. Agreement of use of an appropriate algorithm for assessment by the local ICS and regional maternity team. If using Appendix D of the SBLCBv3 then no agreement is necessary.	N/A	REF2.13B					Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.13C									
								REF2.13D									
								REF2.13E									
								REF2.13F									
2.14	When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements (see Element 3) and if required computerised CTG (cCTG). A maternal assessment should be performed at each contact this should include blood pressure measurement using a digital monitor that has been validated for use in pregnancy (hyperlink as above to follow) and a urine dipstick assessment for proteinuria. In the presence of hypertension NICE guidance on the use of PlGF/sflt1 testing should be followed.	N/A	N/A	N/A	N/A	Guideline evidencing assessment of fetal and maternal wellbeing as outlined at each contact.	N/A	REF2.14A	Guideline/policy	ANRA		previoulsy uploaded	Partially implemented	Not using digital BP monitors	Partially implemented		Ensure reference to assessment of fetal and maternal condition in guidance, or reference to PlGF. To implement digital BP monitors.
								REF2.14B									
								REF2.14C									
								REF2.14D									
								REF2.14E									
								REF2.14F									
2.15	Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks. Maternity care providers caring for women with early FGR identified prior to 34+0 weeks should have an agreed pathway for management which includes fetal medicine network input (for example, through referral or case discussion by phone). Further information is provided in Appendix D.	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing that umbilical artery doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks (as per Appendix D), along with pathway for referral.	N/A	REF2.15A	Guideline/policy	Fetal Growth Assessment guideline		previoulsy uploaded	Fully implemented		Fully implemented		
								REF2.15B									
								REF2.15C									
								REF2.15D									
								REF2.15E									
								REF2.15F									
2.16	When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed by the local ICS following advice from the provider's Clinical Network and/or regional team.	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing that the frequency of review of EFW follows Appendix D, or an alternative, when FGR suspected.	N/A	REF2.16A	Guideline/policy	Fetal Growth Assessment guideline		previoulsy uploaded	Fully implemented		Fully implemented		
								REF2.16B									
								REF2.16C									
								REF2.16D									
								REF2.16E									
								REF2.16F									
2.17	Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that must be agreed by both the local ICS and the regional maternity team.	N/A	N/A	N/A	N/A	Guideline evidencing alignment to NICE guidance on risk assessment and management of growth disorders in multiple pregnancy. Audit reviewing implementation of guideline and standards.	N/A	REF2.17A	Guideline/policy	Multiple Pregnancy Guideline		previoulsy uploaded	Fully implemented	NICE Baseline Audit to be completed	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Clarify core specialist MDT team and ensure there is a specific clinic available - to be uploaded. Audit evidence included with actions to be completed by January 24 and so remains partially implemented until actions are implemented and re-audit demonstrates improvement in practice.
								REF2.17B	Audit	MULTIPLE PREGNANCY AUDIT UPLOADED							
								REF2.17C									
								REF2.17D									
								REF2.17E									
								REF2.17F									
2.18	All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.	**SBL Outcome Indicator 2d** Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR).	N/A	Recording of FGR risk status for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of babies <3rd birthweight centile born >37+6 weeks **Denominator:** Total number of babies <3rd centile	Guideline evidencing initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation when there are no other risk factors for babies <3rd centile. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	0% Review current data / poisition	REF2.18A	Guideline/policy			previoulsy uploaded	Fully implemented	Q2 not available as IOL MW off sick. Data being compiled - will be uplaided after 15th November	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline indicates delivery should occur at 37 weeks. Should include that this should be no later than 37+6 weeks.
								REF2.18B	Audit	IOL audit	previously uploaded						
								REF2.18C									
								REF2.18D									
								REF2.18E									
								REF2.18F									
								REF2.19A	Audit	K2 data	Q2 23/24	86.4					

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
2.19	In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks (see 2.20) .	**SBL Process Indicator 2b** Percentage of pregnancies where an SGA fetus (between 3rd & <10th centiles) is antenatally detected	SBL_Element2_ProcessIndicator2	Recording of SGA risk status for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of pregnancies where an SGA fetus is detected during the antenatal period **Denominator:** Total number of pregnancies submitted to MSDS	Trusts submitting data to the MSDS will be able to view the percentage of <10th centile births in each gestational week of the third trimester in their unit annually. If MSDS data quality low a snapshot audit of 10% of denominator or 25 records, whichever is lowest. Data required via audit for compliance with intervention, however there is no recommended ambition to be achieved.	0%	REF2.19B	Audit	Undetecetd SGA Audit presentation	previously uploaded	46	Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Ensure ongoing audit.
								REF2.19C									
								REF2.19D									
								REF2.19E									
								REF2.19F									
		SBL Outcome Indicator 2e Percentage of babies >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected	N/A		**Numerator:** Number of babies >3rd birthweight centile born <39+0 weeks, where growth restriction was suspected **Denominator:** Total number of babies >3rd centile The aim of this indicator is to pick up babies who are suspected of being small, but who are not small and have been induced earlier than is necessary. This can be assessed through a representative audit but will rely on effective recording of indications for induction. Babies can be identified by birthweight and gestation initially, and then by indication for induction or delivery of suspected growth restriction .	Guideline evidencing appropriate timing of delivery in fetuses with an EFW between >3rd and <10th centile. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	0%	REF2.19G	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded						
								REF2.19H									
								REF2.19I									
								REF2.19J									
								REF2.19K									
								REF2.19L									
2.20	Opinion on timing of birth for fetuses with declining growth velocity and EFW >10th centile, where risk factors are present, should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability. In infants where declining growth velocity meets criteria (see Appendix D), with no other risk factors present, delivery should be planned from 37+0 weeks.	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing consultation with specialist fetal growth services or fetal medicine services in infants where declining growth velocity meets criteria (see Appendix D), with no other risk factors present, and that delivery should be planned from 37+0 weeks.	N/A	REF2.20A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.20B									
								REF2.20C									
								REF2.20D									
								REF2.20E									
								REF2.20F									

Element 3 – Raising awareness of reduced fetal movement

Element description: Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
3.1	Information from practitioners, accompanied by an advice leaflet on RFM, should be based on current evidence, best practice and clinical guidelines, and be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact. For example: RCOG; or Tommy's leaflet available in multiple languages)	N/A	N/A	N/A	N/A	Guideline evidencing that women are provided with information from practitioners, accompanied by an advice leaflet on RFM by 28+) weeks of pregnancy and that RMF are discussed at every subsequent contact. Advice leaflet on RFM based on current evidence, best practice and clinical guidelines, this needs to be in different languages for local populations.	N/A	REF3.1A	Guideline/policy	Reduced Fetal movements guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF3.1B	Other	Tommys leafelt, available in muiltiple languages and audio	previously uploaded						
								REF3.1C	Audit		Q2 23/24	95%					
								REF3.1D									
								REF3.1E									
								REF3.1F									
3.2	Use provided checklist (on page 40 of SBLCBv3) to manage care of pregnant women who report RFM, in line with national evidence-based guidance: RCOG Green-Top Guideline 57	**SBL Process Indicator 3a** Percentage of women who attend with RFM who have a computerised CTG	SBL_Element3_ProcessIndicator2	Recording of episodes of RFM for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women with reduced fetal movement identified at a care contact who have a computerised cardiotocogram (CTG) **Denominator:** Number of women with reduced fetal movement identified at a care contact	Guideline evidencing use of the provided RFM checklist within SBLCBv3 demonstrating that women who report RFM are offered computerised CTGs. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	100% (of women within inclusion criteria) Scan performed if no CTG	REF3.2A	Guideline/policy	Reduced Fetal movements guideline	previously uploaded		Partially implemented	need to audit if USS undertaken next working day.	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Audit evidence included, however, unclear if 72 hours is always next working day. Additional audit / analysis required to demonstrate current position.
								REF3.2B	Audit	Admssision for RFM audit	Q4 23/24	98%					
								REF3.2C									
								REF3.2D									
								REF3.2E									
								REF3.2F									
		SBL Process Indicator 3b Proportion of women who attend with recurrent* RFM who had an ultrasound scan by the next working day to assess fetal growth.	N/A	Recording of episodes of RFM and USS for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women with reduced fetal movement identified at a care contact who have an ultrasound scan by the next working day to assess fetal growth **Denominator:** Number of women with reduced fetal movement identified at a care contact *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation. Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation. Scans are not required if there has been a growth scan in the previous two weeks.	Guideline evidencing that women who report recurrent RFM are offered an ultrasound scan by the next working day to assess fetal growth and risk stratification to determine ongoing care for women presenting with RFM . Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	80%	REF3.2G	Guideline/policy	Reduced Fetal movements guideline	previously uploaded						
								REF3.2H	Audit	Audit of scans date and reson delayed	Q2 23-24	86%					
								REF3.2I									
								REF3.2J									
								REF3.2K									
								REF3.2L									
		SBL Outcome Indicator 3c Percentage of stillbirths which had issues associated with RFM management identified using PMRT.	N/A	Perinatal Mortality Review Tool (PMRT).	N/A	Report demonstrating % of stillbirths which had issues associated with RFM management identified using PMRT and the actions taken and learning shared to make improvements.	N/A	REF3.2M	Report	PMRT uploaded							
								REF3.2N									
								REF3.2O									
								REF3.2P									
								REF3.2Q									
								REF3.2R									
		SBL Outcome Indicator 3d Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation.	N/A	Recording of IOL on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of inductions before 39+0 weeks where reason for induction of labour identified as RFM **Denominator:** Number of inductions before 39+0 weeks	Guideline evidencing appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks). Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	*to discuss with fetal monitoring group and understand baseline information? Ensure following recommendation re RFM IOL <39wks%	REF3.2S	Guideline/policy	Reduced Fetal movements guideline	previously uploaded			Compliant			
								REF3.2T	Audit	IOL audits	previously uploaded						
								REF3.2U	Guideline/policy	IOL guideline	previously uploaded						
								REF3.2V									
								REF3.2W									
								REF3.2X									

Element 4 – Effective fetal monitoring during labour

Element descritpion: Effective fetal monitoring during labour

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
4.1	All staff who care for women in labour are required to undertake annual training and competency assessment on knowledge and skills required for effective fetal monitoring via Intermittent auscultation (IA) [Midwives] and electronic fetal monitoring [Midwives and Obstetricians]. See Core Competency Framework Version 2	**SBL Process indicator 4a** Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness **SBL Process Indicator 4b** Percentage of staff who have successfully completed mandatory annual competency assessment	N/A	Local training records.	**Numerator**: Number of staff* with in date annual training compliance on fetal monitoring **Denominator:** Number of staff* to be trained Principles for training packages are included in Appendix E. It is recommended that all trusts mandate annual human factor training for all staff working in a maternity setting; this should include principles of psychological safety, upholding civility in the workplace, and escalating clinical concerns. The content of training must be agreed within the LMNS, Ockenden, 2022. All staff should pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the Clinical Network. Trusts should agree a procedure with their ICB for how to manage staff who fail this assessment. *A list of staff in and out of scope for inclusion in training numbers is outlined in the technical guidance for Safety Action 8 of CNST MIS. Training requirements are outlined in the Core Competency Framework Version 2.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A minimum of 80% reliability of staff caring for women in labour trained annually on effective fetal monitoring and that have completed competency assessment, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. No member of staff should care for women in a birth setting without evidence of training and assessment within the last year. Evidence to monitor and ensure that all medical and midwifery staff working in a birth setting are compliant with training requirements (pass mark 85%).	90% 85%	REF4.1A REF4.1B REF4.1C REF4.1D REF4.1E REF4.1F	Training plan/TNA Training compliance Training compliance	Uploded K2 assessment compliance One day study day	 YTD Sept 2023 YTD sept 2023	 90% 86.31%	Fully implemented	Training requirement now down to 80% as per CNST chnages. Awaitign Action Plan from FM Midwives,	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
4.2	At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review.	Percentage of women that had a risk assessment at onset of labour to determine most appropriate fetal monitoring method	N/A	N/A	**Numerator:** Number of audited records that had risk assessment completed at the onset of labour **Denominator:** Number of women who have given birth in the period of review that were included within the audit Risk assessment should include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. This assessment should be agreed with local commissioners (ICBs) based on the advice of the Clinical Network and reflect fetal monitoring guidelines.	Guideline evidencing completion of a structured risk assessment at the onset of labour outlining the most appropriate fetal monitoring method and the freqency of review of the risk assessment throughout labour. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.	95%	REF4.2A REF4.2B REF4.2C REF4.2D REF4.2E REF4.2F	Guideline/policy	Fetal Surveillance in labour guideline	new version uploaded		Partially implemented	Risk assessments being added to guideine. Paper assessemnts ot be completed whilst awating K2. NO audit as yet. K2 does have a risk assessment function but doesn't meet all requirement paper copy now live will be able to audit	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Final version guideline reviewed at meeting. Audit evidence required.
4.3	Regular (at least hourly) systematic review of maternal and fetal wellbeing should be agreed and implemented. This should be accompanied by a clear guideline for escalation if concerns are raised using this structured process. All staff to be trained in the review system and escalation protocol.	**SBL Outcome Indicator 4d** The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. Percentage of women birthed that had an hourly systematic review of maternal and fetal wellbeing	N/A Fetal wellbeing to be assessed regularly (at least hourly) during labour and documented using a structured proforma.	Perinatal Mortality Review Tool (PMRT). N/A	N/A **Numerator**: Number of audited records that had hourly documented review of maternal and fetal wellbeing and evidence of concerns being appropriately escalated in line with clinical guidance **Denominator:** Number of women who have given birth in the period of review that were included within the audit This review should be more than recording the fetal heart rate via IA or categorisation of the CTG.	Report demonstrating % of stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monioring identified as a contributory factor using PMRT and the actions taken and learning shared to make improvements. Guideline evidencing regular (at least hourly) review of maternal and fetal wellbeing and escalation of concerns using a structured process. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.	N/A 95%	REF4.3A REF4.3B REF4.3C REF4.3D REF4.3E REF4.3F REF4.3G REF4.3H	Report Report Report Guideline/policy Audit	PMRT extract of issues and actions Audit of CTG issues with HIE incidents report of all babies where CTG mx was an issue Fetal Surveillance in labour guideline Fresh Eyes	Q2 23/24 Q2 23/24 Q2 23/24 previsouly uploaded Q2 23/24	0% 0% 0% 96.20%	Fully implemented	0% low percentage is good outcome indicator	Fully implemented		Final version guideline reviewed at meeting - to be uploaded to evidence portal.
4.4	A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.	Percentage of women birthed that had an hourly fresh eyes on all intrapartum CTGs or 4 hourly fresh eye review when IA is utilised	Introduce a Buddy system to pair up more and less experienced midwives during shifts to provide accessible senior advice with protocol for escalation of any concerns.	N/A	**Numerator:** Number of audited records that had a documented fresh eye review within required timeframe of fetal heart rate or categorisation of CTG and risk factors and any required escalation in line with clinical guidance **Denominator:** Number of women who have given birth in the period of review that were included within the audit A discussion between the midwife caring for the woman and another midwife or doctor should include the FHR (IA or CTG), review of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction, previous caesarean birth; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated (Appendix E).	Guideline evidencing 'fresh eye' review and required frequency. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.	95%	REF4.4A REF4.4B REF4.4C REF4.4D REF4.4E REF4.4F	Guideline/policy Audit	Fetal Surveillance in labour guideline Fresh Eyes	previsouly uploaded July-Sep 23	 95.60%	Fully implemented	Fresh cares recently added to guidline for IA.	Fully implemented		
4.5	Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.	**SBL Process Indicator 4c** Fetal monitoring lead roles appointed	N/A	N/A	Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Leads have dedicated time within their remit to support staff working in intrapartum care to provide high quality intrapartum risk assessments and accurate fetal heart rate interpretation using either IA or CTG. The role should contribute to building and sustaining a safety culture in intrapartum care with all staff committed to continuous improvement.	The Trust board should specifically confirm to the system that within their organisation a dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed and is in post. Job desciption of role and responsibilities.	N/A	REF4.5A REF4.5B REF4.5C REF4.5D REF4.5E REF4.5F	Job description/job plan Job description/job plan	Midwife JD/PS Obs Lead JD/PA	previsouly uploaded previsouly uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
5.1	Each provider trust should have: a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service. b) An identified local preterm birth/perinatal optimisation Midwife Lead c) A Neonatal Consultant lead for preterm perinatal optimisation d) An identified Neonatal Nursing lead for preterm perinatal optimisation	N/A	N/A	N/A	The Preterm Birth Lead Team should provide leadership and oversight of the implementation of Element 5 of SBLCBv3.	The Trust board should specifically confirm to the system that within their organisation they have appointed and have in post the leads specified. Job desciption of role and responsibilities.	N/A	REF5.1A	Job description/job plan	Maternal Medicine Midwife JD			Partially implemented	Awating JDs from Obs & NN	Partially implemented		JD for Obstetric and neonatal leads required. Confirmation required on the maternal medicine JD that is included as evidence - this does not appear to be an explicit pre-term role.
								REF5.1B	Other	email re the MM MW JD							
								REF5.1C	Job description/job plan								
								REF5.1D									
								REF5.1E									
								REF5.1F									
5.2	Each Preterm Birth Lead team should have clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation, and should engage in shared learning and QI with local preterm birth clinical networks, LMNSs and neonatal ODNs.	**SBL Outcome Indicator 5I** The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (from 16+0 to 23+6 weeks). b) preterm (from 24+0 to 36+6 weeks).	N/A	Recording of birth outcome for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who give birth to a singleton (liveborn or stillborn) between 16+0 and 23+6 weeks **Denominator:** Total number of singleton births (liveborn or stillborn) **Numerator:** Number of women who give birth preterm to a singleton (liveborn or stillborn) between 24+0 and 36+6 weeks **Denominator:** Total number of singleton births (liveborn or stillborn)	Guideline evidencing preterm pathway for prevention, prediction and perinatal optimisation. Report demonstrating % of late second trimester singleton births and preterm births (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared to make improvements. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	To be disucssed 6% *as per the national ambition	REF5.2A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented	QI project to be registered	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Patially implemented due to national ambition - work is underway and rate is improving due to QI work. With continued improvement and QI work, local trajectory to be agreed with a stretch to the national ambition.
								REF5.2B	Report	report highlighting no issues with optimisation for the babies where SB or NND have occurred in Q2	Q2 23-24	0%					
								REF5.2C									
								REF5.2D									
								REF5.2E	Dashboard	Dashboard for Q2 highlighting preterm data	Q2 23-24	7.52%					
								REF5.2F									
								REF5.2G									
								REF5.2H									
		SBL Outcome Indicator 5k Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	N/A	Perinatal Mortality Review Tool (PMRT).	N/A	Report demonstrating % of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared to make improvements.	N/A	REF5.2I	Report	report highlighting no issues with optimisation for the babies where SB or NND have occurred in Q2	Q2 23-24	0%					
								REF5.2J									
								REF5.2K									
								REF5.2L									
								REF5.2M									
								REF5.2N									
		SBL Outcome Indicator 5i Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)	N/A	Local data as submitted to National Neonatal Audit Programme	**Denominator:** Number of babies admitted to a neonatal unit whose birth gestation was 24+0 to 31+6 weeks inclusive (22+0 and 23+6 weeks for additional reporting) **Numerator:** Deaths of babies 24+0 to 31+6 weeks gestation inclusive (22+0 and 23+6 weeks for additional reporting), before discharge from hospital to home, or discharge for palliative care with agreed non-intervention plan in place followed by death prior to 44 weeks post-menstrual age Note: Babies discharged to a hospice for pallative care (such as for compassionate extubation) and who die prior to 44 weeks postmenstral age are counted in the numerator. In hospital, deaths in units not submitting data to the NNAP will be included. Change to the audit measure for 2023 data year: The NNAP will additionally report mortality at 22 and 23 weeks gestational age, however this group will not be included in reporting against the improvement goal.	Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	to be set locally based on current performance (to review NNAP data) %	REF5.2O								
								REF5.2P									
								REF5.2Q									
								REF5.2R									
								REF5.2S									
								REF5.2T									
5.3	Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways using the criteria in Appendix F.	Percentage of women at booking who had a completed risk assessment for preterm birth as outlined in Appendix F.	N/A	Recording of preterm birth risk assessment for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator**: Number of women with a completed risk assessment for preterm birth as outlined in Appendix F at booking **Denominator:** Number of women booked This assessment should take place at the booking appointment with referral by 12 weeks. Appendix F includes a suggested risk assessment and management algorithm that providers may wish to adopt. It is recognised that there are imperfections in the predictability of preterm birth on the basis of history; the use of digital algorithms & tools (for example the Tommy's app) may also be useful to support assessment.	Guideline evidencing the risk assessment at booking as outlined in Appendix F. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	90%	REF5.3A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.3B	Audit	Documentation Audit	Q2 23-24	100%					
								REF5.3C									
								REF5.3D									
								REF5.3E									
								REF5.3F									
5.4	In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUIPP) to improve predictive accuracy of triage and enable collaborative decision making.	N/A	N/A	N/A	N/A	Guideline evidencing use of evaluated prediction tools for women presenting in suspected preterm labour.	N/A	REF5.4A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented	Audit is not a requirement.	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.4B									
								REF5.4C									
								REF5.4D									
								REF5.4E									
								REF5.4F									
5.5	Networked Trusts should agree on the use of these tools within their ICS/LMNS.	N/A	N/A	N/A	There should be evidence that the trust has developed and agreed at LMNS level local transfer pathways for women predicted in preterm labour using the evaluated digital tools.	Evidence of the tool that has been agreed for use and approved through the ICS/LMNS Board.	N/A	REF5.5A					Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.5B									
								REF5.5C									
								REF5.5D									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
								REF5.5E									
								REF5.5F									
5.6	Risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local network or ICS following advice from the provider's clinical network.	N/A	N/A	N/A	N/A	Guideline evidencing alignment to NICE guidance on risk assessment and the management of growth disorders in multiple pregnancy. Audit reviewing implementation of guideline and standards. The risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network.	N/A	REF5.6A	Guideline/policy	Multiple pregnancy guidleline	previously uploaded		Fully implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included with actions to be completed by January 24 and so remains partially implemented until actions are implemented and re-audit demonstrates improvement in practice.
								REF5.6B	Audit	NICE Baseline audit uploaded							
								REF5.6C									
								REF5.6D									
								REF5.6E									
								REF5.6F									
5.7	Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks.	N/A	N/A	N/A	N/A	Guideline evidencing smoking status is assessed and managed as outlined in Element 1 (intervention 1.1) for women identified as at risk of pre-term birth.	N/A	REF5.7A	Guideline/policy	Smoking in pregnancy	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.7B									
								REF5.7C									
								REF5.7D									
								REF5.7E									
								REF5.7F									
5.8	Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network.	N/A	N/A	N/A	N/A	Guideline evidencing assessment at booking as outlined in Element 2 (intervention 2.1) to determine if prescription of Aspirin is needed using an appropriate algorithm.	N/A	REF5.8A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.8B									
								REF5.8C									
								REF5.8D									
								REF5.8E									
								REF5.8F									
5.9	Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements (and use of decision-assist tools such as the QUIPP and QUIDS apps). The use of TVCS may also be used with or without qfFN.	Percentage of symptomatic women for preterm birth that are assessed using quantitative fetal fibronectin (qfFN) measurement	N/A	Local case notes or electronic patient records.	**Numerator:** Number of symptomatic women for preterm birth assessed using quantitative fetal fibronectin (qfFN) measurement (or other prediction test if qfFN not available) **Denominator:** Number of symptomatic women for preterm birth Further advice may be sought from UK Preterm Clinical Network, BAPM, or NICE guidance55).	Guideline evidencing the assessment of quantitative fetal fibronectin (qfFN) measurements (or other prediction test if qfFN not available) and use of decision-assist tools such as the QUIPP and QUIDS apps for symptomatic women. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	% To be discussed	REF5.9A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.9B	Standard operating procedure	Actim Partus SOP	previously uploaded						
								REF5.9C	Audit	QUIPP	1/12/20-28/2/21	previously uploaded					
								REF5.9D									
								REF5.9E									
								REF5.9F									
5.10	Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her.	N/A	N/A	N/A	N/A	Guideline evidencing that each woman with a history of preterm birth is reviewed to determine whether this was associated with placental disease and prescribing aspirin discussion takes place.	N/A	REF5.10A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.10B	Guideline/policy	ANRA	previously uploaded						
								REF5.10C									
								REF5.10D									
								REF5.10E									
								REF5.10F									
5.11	Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.	Percentage of women assessed as intermediate or high risk at booking who have a completed MSU for culture and senstivity.	N/A	Recording of MSU for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women booked and assessed as intermediate or high risk who had a MSU completed at booking **Denominator:** Number of women booked assessed as intermediate or high risk	Guideline evidencing MSU is required at booking for women assesed as intermediate or high risk and repeat MSU required following positive culture and treatement. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	% To be discussed (to confirm - intermittent and high-risk for PTB, not for ALL antenatal women)	REF5.11A	Guideline/policy	Bacteruria in pregnancy	previously uploaded		Fully implemented	10% notes audited as currently not built into K2 audits therefore requiring manual pull. 10% = 136 sets notes for Q2.	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit discussed and clarified.
								REF5.11B	Audit	MSU @ booking	Q2 23-24	100%					
								REF5.11C	Audit	repeat MSU	Q2 23-24	96.3					
								REF5.11D									
								REF5.11E									
								REF5.11F									
5.12	Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation (Appendix F).	N/A	N/A	N/A	All high risk pregnant women to be offered transvaginal cervix scanning every 2-4 weeks between 16 and 24 weeks as a secondary test to more accurately quantify the risk of preterm birth. For pregnant women defined as intermediate risk single transvaginal cervix scan between 18-22 weeks as a minimum is required.	Guideline evidencing asymptomatic women have access to transvaginal cervix scanning (TVCS) as outlined in Appendix F.	N/A	REF5.12A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.12B									
								REF5.12C									
								REF5.12D									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
								REF5.12E									
								REF5.12F									
5.13	Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories. This should include access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage. These procedures are performed relatively infrequently and therefore are best provided on a supra-regional basis in order to maintain expertise.	N/A	N/A	N/A	Where preterm birth prevention clinics are not available providers should ensure that women are able to access care that guarantees that they are given evidence-based information, access to risk assessment tests and interventions as appropriate and can actively participate in decisions regarding their management. Providers should have access to supra-regional prevention services within their care pathways and networks, which include access to high vaginal and transabdominal cerclage.	Guideline referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories.	N/A	REF5.13A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Discussed. Additional guideline reviewed which articulates referral pathway from DBTH. Possibly clarity required regionally to ensure consistency but clear from DBTH perspective. Section 7 of guideline needs to be reviewed to ensure that IUT matches regional IUT guideline and please upload additional guideline as evidence. To consider amalgamating to one guideline to ensure consistency.
								REF5.13B									
								REF5.13C									
								REF5.13D									
								REF5.13E									
								REF5.13F									
5.14	Local implementation plans for midwifery CoC models should ensure prioritisation of women from the most deprived groups in line with Core20+5.	N/A	N/A	N/A	Midwifery Continuity of Carer (CoC) models, with a focus on individualised risk assessment and care pathways, may prevent preterm birth and save babies' lives: Delivering midwifery continuity of carer at full scale - published October Midwifery CoC must be supported by safe staffing levels to preserve the safety of all pregnant women and families: Final Report of the Ockenden Review - published March 2022	Evidence of local implemenation plan for midwiferyy CoC and priortisation of women from most deprived groups in line with Core 20+5.	N/A	REF5.14A	Other	CoC Plan			Fully implemented		Fully implemented		CoC plan included which includes realistic timelines based on MCoC guidance - to establish teams when building blocks allow. To note this does not indicate compliance with MCoC - but that there is a realistic plan (as per the SBL timelines) to implement.
								REF5.14B									
								REF5.14C									
								REF5.14D									
								REF5.14E									
								REF5.14F									
5.15	Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur.	N/A	N/A	N/A	N/A	Guideline evidencing that those women at risk of preterm birth are made aware of signs/symptons and actions to take. Patient information leaflet outlining the signs and symptoms of preterm birth and what to do.	N/A	REF5.15A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Additonal guideline reviewewd at the meeting which states Information to be shared and information leaflet reviewed. Comms published version to be added as evidence.
								REF5.15B	Other	PIL	previously uploaded						
								REF5.15C									
								REF5.15D									
								REF5.15E									
								REF5.15F									
5.16	Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.	Percentage of women who deliver preterm where the neonatal team have a discussion with the parents regarding care options.	N/A	N/A	**Numerator:** Number of women who deliver preterm that have a discussion with the neonatal team regarding care options **Denominator:** Number of women who deliver preterm In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in: 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation: "Conversations with parents should be clearly documented and care taken to ensure that the agreed management plan is communicated between perinatal professionals and staff shifts. Decisions and management should be regularly reviewed before and after birth in conjunction with the parents; plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change."	Guideline evidencing the neonatal team are involved when a preterm birth is anticipated. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.16A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented	Audit of only 10% for Q2 = 91 pre term deliveries. Incluided 22+0-36+6. Actions to review local practice and guideline and documentation of staff at delivery	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included, currently below required compliance. To complete actions relating to review of local practice.
								REF5.16B	Audit	Neonatal Attendance at preterm delivery audit	Q2 23-24	77.02					
								REF5.16C									
								REF5.16D									
								REF5.16E									
								REF5.16F									
5.17	Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss	**SBL Process Indicator 5h** Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5.19 to 5.25) achieved.	N/A	Recording of perinatal optimisation for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of the relevant optimisation interventions 5.19 to 5.25 achieved **Denominator:** Total number of optimisation interventions [calculated from total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation)] Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	70%	REF5.17A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented	ODN data to be compiled	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Additional evidence included. Still requires ODN data to be compiled. To ensure all elements are included within the guideline including thermal care at birth, early EBM.
								REF5.17B	Guideline/policy	Y&H IUT Guideline							
								REF5.17C	Dashboard	Preterm audit	ongoing continuous data						
								REF5.17D									
								REF5.17E									
								REF5.17F									
5.18	Acute tocolysis may be used when short term delay is desirable i.e. in utero transfer, and probably to ensure adequate antenatal exposure to corticosteroid/magnesium sulphate (i.e. no longer than 48 hours).	N/A	N/A	N/A	N/A	Guideline evidencing that tocolytics are used for short term delay of preterm birth in specific circumstances.	N/A	REF5.18A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented	ODN data to be compiled. There is clear refercnt ot use of tocolysis in ourt PT guidelinen	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.18B									
								REF5.18C									
								REF5.18D									
								REF5.18E									
								REF5.18F									
5.19	Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth: a) less than 27 weeks gestational age (in a singleton pregnancy) b) less than 28 weeks gestational age (in a multiple pregnancy) c) any gestation with an estimated fetal weight of less than 800g	**SBL Process Indicator 5a** Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the	N/A	Recording of birth location for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting	**Numerator:** 1st episode of baby born <27 weeks (singleton), <28 weeks (multiples) and <800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU) **Denominator:** Total number 1st episode of baby born <27 weeks (singleton), <28 weeks (multiples) and <800g Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 85% (in line with the Neonatal Critical Care Review) for high	85%	REF5.19A	Guideline/policy	Y&H IUT Guideline			Fully implemented	ODN data to be compiled	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small r per qu demor avoida
								REF5.19B	Audit	To be uploaded							
								REF5.19C		precept data							
								REF5.19D									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
	should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU).	same site as a neonatal intensive care unit (NICU)		system for PRECEPT National Patient Safety Programme.	Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	A stretch ambition of 85% (in line with the Neonatal Critical Care Review) for high performing organisations with minimum ambition of 70%, with a clear action plan to achieve 85% reliability, for those organisations on an improvement journey.		REF5.19E								
								REF5.19F									
5.20	Antenatal corticosteroids should be offered to women between 22+0 (where active management is agreed) and 33+6 weeks of pregnancy, optimally at 48 hours prior to birth. A steroid-to-birth interval of greater than seven days should be avoided if possible, and repeat courses of steroids should be avoided where possible.	**SBL Process Indicator 5b** Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth	N/A	Recording of AN corticosteriod administration for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of live births born before 34+0 weeks gestation who received a full course of antenatal corticosteroids within seven days of birth **Denominator:** Total number of live births born before 34+0 weeks gestation Note, live births should include singletons and multiples. Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 55% for high performing organisations with minimum ambition of 40%, with a clear action plan to achieve 55% reliability, for those organisations on an improvement journey.	55%	REF5.20A	Report	ODN data	Q2 23-24	23.5	Fully implemented	discrepnecy between local and ODN data	Fully implemented		Audit data discussed. Variation due to manual data cleanse which is not reflected in the ODN data until the following quarter.
								REF5.20B	Audit	Precept lcoal data	Q2 23-24	61%					
								REF5.20C	Guideline/policy	Preterm pregnancy, labour & birth guideline							
								REF5.20D									
								REF5.20E									
		Percentage of babies born (less than 34+0 weeks) where birth is more than seven days after completion of their first course of antenatal corticosteroids	N/A		**Numerator:** Number of live births born before 34+0 weeks gestation and more than 7 days after completion of their first course of antenatal corticosteroids **Denominator:** Total number of live births born before 34+0 weeks gestation Note, live births should include singletons and multiples. Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	N/A	REF5.20F									
								REF5.20G									
								REF5.20H									
5.21	Magnesium sulphate to be offered to women between 22+0 (where active management is agreed) and 29+6 weeks of pregnancy - and considered for women between 30+0 and 33+6 weeks of pregnancy - who are in established labour or are having a planned preterm birth within 24 hours.	**SBL Process Indicator 5c** Percentage of babies being born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth	N/A	Recording of magnesium sulphate administration for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of babies born before 30+0 weeks receiving magnesium sulphate within the 24 hours prior to birth **Denominator:** Total number of babies born before 30+0 weeks gestation Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	90%	REF5.21A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included demonstrating <90%. Action plan included identifying actions. Include data for outcome 5j(brain injury)
								REF5.21B	Report	ODN data	Q2 23-24	50					
								REF5.21C	Guideline/policy	Y&H IUT Guideline							
								REF5.21D	Audit	Precept local audit	Q2 23-24	50					
								REF5.21E	Audit	Precept local audit	Q2 23-24						
		SBL Outcome Indicator 5j Percentage of babies born below 32 weeks gestational age with brain injury as defined in the technical guidance	N/A		**Numerator:** Number of denominator with brain injury (NNAP definition) **Denominator:** Number of babies born <32 weeks gestational age who are admitted to a neonatal unit and experience their final neonatal discharge in the calendar year of analysis Preterm Brain Injury (NNAP definition) - include only the following forms of brain injury: a)Germinal matrix/ intraventricular haemorrhage b)Post haemorrhagic ventricular dilatation c)Cystic periventricular leukomalacia	Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	% To be discussed	REF5.21F	Other	preterm action plan							
								REF5.21G									
								REF5.21H									
5.22	All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis (Benzylpenicillin, where not contraindicated) to prevent early onset neonatal Group B Streptococcal (GBS) infection irrespective of whether they have ruptured amniotic membranes.	**SBL Process Indicator 5d** Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection	N/A	Recording of IV antibiotic prophylaxis for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of women who give birth (exc caesarean) <34 weeks and up to 36+6 weeks who receive IV intrapartum antibiotic prophylaxis **Denominator:** Number of women who give birth (exc caesarean) <34 weeks and up to 36+6 weeks This excludes planned caesarean births without labour. NB – this intervention should be considered up to 36+6 weeks. Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.22A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented	discrepnecy between local and ODN data	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included, however there is variation between local and ODN published. To discuss. Both data sets indicate <90%. Action plan included but this is not specific to antibiotics.
								REF5.22B	Report	ODN data	Q2 23-24	21					
								REF5.22C	Audit	Precept local audit	Q2 23-24	62					
								REF5.22D	Other	preterm action plan							
								REF5.22E									
								REF5.22F									
5.23	Babies born at less than 37 weeks gestational age should have their umbilical cord clamped at or after one minute after birth – this can have benefits for all babies. Perinatal multidisciplinary teams should work together to ensure this can reliably be delivered at all births.	**SBL Process Indicator 5e** Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth	N/A	Recording of umbilical cord clamping for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator**: Babies born at less than 34 weeks who have their umbilical cord clamped at or after one minute after birth **Denominator:** Babies born at less than 34 weeks Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report for babies born below 34 weeks who have their umbilical cord clamped at or after one minute after birth demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 75% of babies born below 34 weeks have their umbilical cord clamped at or after one minute after birth for high performing organisations with minimum ambition of 50%, with a clear action plan to achieve 75% reliability, for those organisations on an improvement journey.	75%	REF5.23A	Guideline/policy	Preterm pregnancy, labour & birth guideline			Partially implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Progress made. Ensure action plan focusses on DCC.
								REF5.23B	Report	ODN data	Q2 23-24	68					
								REF5.23C	Audit	Precept local audit	Q2 23-24	68					
								REF5.23D	Other	preterm action plan							
								REF5.23E									
								REF5.23F									
5.24	Babies born at less than 37 weeks gestational age should have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. Neonatal normothermia can have benefits for all babies.	**SBL Process Indicator 5f** Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth	N/A	Recording of temperature for babies on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator**: Babies born at less than 34 weeks who have their first temperature which is both between 36.5–37.5°C and measured within one hour of birth **Denominator**: Babies born at less than 34 weeks Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report for babies born below 34 weeks who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 80% for high performing organisations with minimum ambition of 65%, with a clear action plan to achieve 80% reliability, for those organisations on an improvement journey.	80% NB (NNAP 90%)	REF5.24A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data indicates <target. Action plan included.
								REF5.24B	Report	ODN data	Q2 23-24	68					
								REF5.24C	Guideline/policy	Y&H IUT Guideline							
								REF5.24D	Audit	Precept local audit	Q2 23-24	68					
								REF5.24E									
								REF5.24F									
5.25	Early maternal breast milk (MBM) - Babies born below 37 weeks gestational age should receive their own mother's milk, ideally within 6 hours, but aiming always within 24 hours of birth (except in rare situations where there are contraindications to MBM). Perinatal teams should work together to ensure consistent delivery of antenatal advice about MBM, with support (equipment, education, help) for mothers to express within two hours of birth.	**SBL Process Indicator 5g** Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth	N/A	Recording of MBM on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator**: Babies born at less than 34 weeks who receive their own mother's milk within 24 hours of birth **Denominator**: Babies born at less than 34 weeks Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report for babies born below 34 weeks who have early maternal breast milk demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	60%	REF5.25A	Guideline/policy	Preterm pregnancy, labour & birth guideline			Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	To review updates to Q2 data when ODN Q3 data is published to ensure improved DQ.
								REF5.25B	Report	ODN data	Q2 23-24	67					
								REF5.25C	Guideline/policy	Y&H IUT Guideline							
								REF5.25D									
								REF5.25E									
								REF5.25F									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
5.26	For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support.	Percentage of babies born <34 weeks who receive volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required	N/A	N/A	**Numerator**: Babies born at less than 34 weeks who receive volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required **Denominator**: Babies born at less than 34 weeks NB – For preterm babies who do not need invasive ventilation, consider nasal CPAP or nasal high-flow therapy as the primary mode of respiratory support. Guidance in line with: Quality Standard QS193 The use of volume targeted ventilation is recommended but this data is not currently recorded or presented with national datasets.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.26A	Guideline/policy	Preterm pregnancy, labour & birth guideline			Fully implemented	Audit to be completed	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.26B	Guideline/policy	Neonatal RDS							
								REF5.26C	Audit	uploaded		95%					
								REF5.26D									
								REF5.26E									
								REF5.26F									
5.27	For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth.	Percentage of babies born <30 weeks who are started on caffeine within 24 hours of birth	N/A	N/A	**Numerator**: Babies born at less than 30 weeks who are started on caffeine within 24 hours of birth **Denominator**: Babies born at less than 30 weeks Guidance in line with: Quality Standard QS193 Getting It Right First Time (GIRFT) recommendations The use of caffeine is recommended but this data is not currently recorded or presented with national datasets.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.27A	Guideline/policy	Preterm pregnancy, labour & birth guideline			Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.27B	Guideline/policy	Neonatal RDS							
								REF5.27C	Audit	uploaded		100%					
								REF5.27D									
								REF5.27E									
								REF5.27F									

Element 6 – Management of Diabetes in Pregnancy

Element description: Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (eg.continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Recommended Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
6.1	Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements.	**SBL Process Indicator 6a** Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only	N/A	N/A	The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse (DSN), Diabetes Dietitian, Diabetes Specialist Midwife (DSM).	Guideline evidencing an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc).	N/A	REF6.1A	Meeting minutes	Service review minutes	previously uploaded		Fully implemented		Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Trust confirm that model is in place as set out in evidence (JDC RR) however, post meeting it appears that the pilot of 2 separate clinics has ceased - to be reinstated. Confirmation there is a dietician available for each clinic. Maternal medicine midwife in post.
								REF6.1B	Meeting minutes	Service review minutes	previously uploaded						
								REF6.1C	Meeting minutes	Service review minutes	previously uploaded						
								REF6.1D	Meeting minutes	Service review minutes	previously uploaded						
								REF6.1E	Guideline/policy	Management of diabetes in pregnancy	previously uploaded						
								REF6.1F		Janines data							
6.2	Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) ...	**SBL Outcome Indicator 6f** Percentage of women with type 1 diabetes that have used CGM during pregnancy.	N/A	Local data as submitted for the NPID dashboard (2021/22 data planned to be released October 2023)	**Numerator**:Number of pregnant women who have type 1 diabetes that used CGM during pregnancy **Denominator:** Number of pregnant women who have type 1 diabetes Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.	Guideline evidencing the trust pathway for CGM and trust to share education package in place for women to support the use of CGM. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of >95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve >95% reliability, for those organisations on an improvement journey.	95%	REF6.2A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Partially implemented	need to work with Diabetes team and Obs team to pull data/manual audit. Need trainig evidence	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice.
								REF6.2B	Audit	in progress to be uploaded							
								REF6.2C									
								REF6.2D									
	and be provided with appropriate education and support to use this.	**SBL Process Indicator 6d** Demonstrate compliance with CGM training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes.	N/A		**Numerator**: Number of MDT diabetes team members who have a responsibility to interpret CGM that have completed annual CGM training **Denominator:** Number of MDT diabetes team members who have a responsibility to interpret CGM For quality improvement purposes this should be analysed by staff group e.g. DSMs, DSNs, Dieticians.	Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	90%	REF6.2E									
								REF6.2F									
								REF6.2G									
								REF6.2H									
6.3	Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g. intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved.	**SBL Process Indicator 6c** Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets.	N/A	N/A	N/A	Guideline evidencing the agreed method of objectively recording blood glucose levels and pathway if glycaemic targets are not achieved.	N/A	REF6.3A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Fully implemented		Fully implemented		
								REF6.3B									
								REF6.3C									
								REF6.3D									
								REF6.3E									
								REF6.3F									
6.4	Women with diabetes should have an HbA1C measured at the start of the third trimester and those with an HbA1C above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.	**SBL Outcome Indicator 6g** Percentage of women with type 1 and type 2 diabetes that have an HbA1C measured at the start of the third trimester.	N/A	Local data as submitted for the NPID dashboard (2021/22 data planned to be released October 2023)	**Numerator:** Number of pregnant women with type 1 and type 2 diabetes that have had a HbA1C measured between 24+0 and 30+0 weeks. **Denominator:** Number of pregnant women who have type 1 and type 2 diabetes Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.	Guideline evidencing this standard. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Stretch ambition would indicate a level of full implementation of >95% and minimum ambition of 80% with a clear action plan to achieve >95% reliability, for those organisations on an improvement journey.	80%	REF6.4A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Partially implemented	Audit being requested from Digital Midwife. Consider use of NPID data	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice. Guideline doesn't state HbA1c in third trimester
								REF6.4B									
								REF6.4C									
								REF6.4D									
								REF6.4E									
								REF6.4F									
6.5	Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic.	**SBL Process Indicator 6b** Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.	N/A	N/A	In circumstances where regular travel to a tertiary clinic is not possible, ongoing care should be planned via regular (4-6 weekly) MDT discussion with the MMC centre throughout the pregnancy.	Guideline evidencing an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.	N/A	REF6.5A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Fully implemented		Fully implemented		To include criteria for referral to MMN as evidence - not in the guideline
								REF6.5B									
								REF6.5C									
								REF6.5D									
								REF6.5E									
								REF6.5F									
6.6	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.	**SBL Process Indicator 6e** Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy.	N/A	N/A	N/A	Guideline evidencing an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise.	N/A	REF6.6A	Guideline/policy	Guidelines for Enhanced Maternity Care	previously uploaded		Fully implemented		Fully implemented		
								REF6.6B	Guideline/policy	Non Obs care guideline	previously uploaded						
								REF6.6C									
								REF6.6D									
								REF6.6E									
								REF6.6F									

Maternity Services Data Set (MSDS) v2.0 Technical Glossary
Version 2.24 Metadata File

Contents

Document version history

Version	Date Issued	Brief Summary of Change
1.0	30/09/2019	First published version, developed following feedback from NHS Digital clinical terminologists and NHS England and Improvement.
1.1	16/10/2019	Minor changes to add new SNOMED CT code for computerised CTGs, and amend minor typos.
1.2	21/11/2019	Minor changes to align with the March 2019 published SBLCBv2. Publication for NHS Digital Website.
1.3	04/02/2020	Minor updates throughout to formatting to use standard SNOMED CT notation. Additions to the following process outcome indicators, to provide alternative methods of submitting the required data: Element 1 (Process indicator i) Element 2 (Process indicator i, including Risk Factor Mapping), (Outcome indicator i) Element 3 (Outcome indicator ii) Element 5 (Process indicator i), (Process indicator iii) & (Outcome indicator i)
1.4	23/04/2021	Minor amendment to process outcome indicators, Element 5 (Process indicator i), to reflect that antenatal corticosteroids are administered to the mother before birth and recorded in the MSD202 or MSD302 table, and not the baby in the MSD405 table.
1.5	22/10/2021	Minor amendment to process outcome indicators, Element 3 (Process indicator i), to reflect the new SNOMED concept: 1361991000000102 |Provision of information leaflet about fetal movement (procedure)| being live. To be used for SBL E3 P1: Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.
1.6	22/06/2022	Minor amendment to the 'Notes' column in process outcome indicators, Element 1 (Process indicator ii), to reflect the following change in the Tolerance from Tolerance when matching booking date and date when CO monitoring took place **may be** considered when conducting analysis **(e.g. +/-3 days)** to read: Tolerance when matching booking date and date when CO monitoring took place **is** considered when conducting analysis **(+3 days)**

Saving Babies Lives Care Bundle Version 2

Maternity Services Data Set (MSDS) v2.0 Technical Glossary

The Saving Lives Care Bundle Version Two (SBLCBv2) has been developed to help reduce perinatal mortality across England. It sets out a series of measures based on five elements of care that are widely recognised as evidence-based and/or best practice. Data for many of these measures can be obtained from the Maternity Services Data Set (MSDS). MSDS v2.0 is a patient-level data set that captures information about activity carried out by NHS-funded maternity services relating to mothers and babies.

This technical glossary is designed to assist MSDS v2.0 data submitters in collecting and submitting data which will support the various process and outcome indicators specified in SBLCBv2. Each tab relates to a separate element of SBLCBv2, and details the relevant data items, values and (where relevant) SNOMED CT terms and codes that can be included in MSDS v2.0 submissions.

Please see the website links below for further information about SBLCBv2, MSDS v2.0 & SNOMED CT (syntax described in section 5.1):

https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

digital.nhs.uk/MSDS

https://confluence.ihtsdotools.org/display/DOCECL/Expression+Constraint+Language+-+Specification+and+Guide

Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by assessing exposure to carbon monoxide (CO) as appropriate to assist in identifying smokers (or those exposed to CO through other sources) and refer them for support from a trained stop smoking advisor.

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Recording of CO reading for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS Digital.	Number of case records submitted to MSDS where the CO reading field is complete	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother where MSD101.RPStartDate is in the reporting period and MSD101.AntenatalAppDateis in the reporting period and MSD202.RPStartDate is less than or equal to reporting period and (MSD202.ProcedureCode = '226571000000100' or MSD202.COMonReading >= 0)	Number of pregnancies with booking appointments in the reporting month submitted to MSDS	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING where RPStartDate is in the reporting period and AntenatalAppDate is in the reporting period	
Percentage of women where CO measurement at booking is recorded.	Number of pregnant women where a value (ppm) is recorded	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING inner join MSD201CareContactPreg on UniqPregID and Person_ID_Mother inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother where MSD101.RPStartDate is in the reporting period and MSD101.AntenatalAppDateis in the reporting period and MSD201.RPStartDate is less than or equal to reporting period and MSD202.COMonReading >= 0 and datediff(MSD201.CContactDate, MSD101.AntenatalAppDate) <= 3 days (StartDate: MSD101.AntenatalAppDate, EndDate: MSD201.CContactDate)	Number of pregnant women attending booking appointment	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING where RPStartDate is in the reporting period and AntenatalAppDate is in the reporting period	Tolerance when matching booking date and date when CO monitoring took place must be <=3days. Recommend using UCUM Unit of Measurement 'ppm'. Note: Each woman will only be counted once in the denominator.
Percentage of women where CO measurement at 36 weeks is recorded.	Number of pregnant women at the 36 week appointment where a CO value is recorded	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD201.RPStartDate is in the reporting period and MSD201.CContactDate is in the reporting period and MSD202.RPStartDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and MSD202.COMonReading >= 0	Number of pregnant women attending the 36 week appointment	Count of distinct UniqPregID from MSD201CareContactPreg where RPStartDate is in the reporting period and CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258)	To determine 36 week appointment, the 'Care Contact Date' in the MSD201 table is compared with the derived 'Gestational Age (Care Contact Date)' field in the MSD201 table. Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks). Recommend using UCUM Unit of Measurement 'ppm'. Note: Each woman will only be counted once in the denominator.
Percentage of women with a CO measurement ≥4ppm at booking.	Number of pregnant women at booking with CO measurement of 4ppm or above is recorded	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD201.RPStartDate is in the reporting period and MSD201.CContactDate is in the reporting period and MSD202.RPStartDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and MSD202.COMonReading >= 0	Number of pregnant women attending booking appointment	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING where RPStartDate is in the reporting period and AntenatalAppDate is in the reporting period	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element. Tolerance when matching booking date and date when CO monitoring took place must be <=3days. Note: Each woman will only be counted once in the denominator.
Percentage of women with a CO measurement ≥4ppm at 36 weeks.	Number of pregnant women at the 36 week appointment with a CO reading of 4ppm or above	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD201.RPStartDate is in the reporting period and MSD201.CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and MSD202.RPStartDate is in the reporting period and MSD202.COMonReading >= 4	Number of pregnant women attending the 36 week appointment	Count of distinct UniqPregID from MSD201CareContactPreg where RPStartDate is in the reporting period and CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258)	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element. To determine 36 week appointment, the 'Care Contact Date' in the MSD201 table is compared with the derived 'Gestational Age (Care Contact Date)' field in the MSD201 table. Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks). Note: Each woman will only be counted once in the denominator.
Percentage of women who have a CO level ≥4ppm at booking and <4ppm at the 36 week appointment.	Number of pregnant women with CO reading of 4ppm or above at booking appointment and less than 4ppm at the 36 week appointment.	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg as ca on cc.UniqPregID = ca.UniqPregID and cc.Person_ID_Mother = ca.Person_ID_Mother and cc.CareConID = ca.CareConID where cc.RPStartDate is in the reporting period and cc.CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and ca.RPStartDate is in the reporting period and ca.COMonReading < 4) inner join MSD101PREGNANCYBOOKING as bk on a.UniqPregID = bk.UniqPregID and a.Person_ID_Mother = bk.Person_ID_Mother inner join msd201carecontactpreg as cc1 on bk.UniqPregID = cc1.UniqPregID and bk.Person_ID_Mother = cc1.Person_ID_Mother inner join msd202careactivitypreg as ca1 on cc1.UniqPregID = ca1.UniqPregID and cc1.Person_ID_Mother = ca1.Person_ID_Mother and cc1.CareConID = ca1.CareConID where bk.RPStartDate <= reporting period start date and datediff(bk.AntenatalAppDate,cc1.CContactDate) between -3 and 3 and a.CContactDate > cc1.CContactDate and ca.COMonReading >= 4	Number of pregnant women with CO reading of 4ppm or above at booking appointment	Count of distinct UniqPregID from msd201carecontactpreg as cc inner join msd202careactivitypreg as ca on cc.UniqPregID = ca.UniqPregID and cc.Person_ID_Mother = ca.Person_ID_Mother and cc.CareConID = ca.CareConID where cc.RPStartDate is in the reporting period and cc.CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and ca.RPStartDate is in the reporting period and ca.COMonReading >= 0 inner join MSD101PREGNANCYBOOKING as bk on a.UniqPregID = bk.UniqPregID and a.Person_ID_Mother = bk.Person_ID_Mother inner join msd201carecontactpreg as cc1 on bk.UniqPregID = cc1.UniqPregID and bk.Person_ID_Mother = cc1.Person_ID_Mother inner join msd202careactivitypreg as ca1 on cc1.UniqPregID = ca1.UniqPregID and cc1.CareConID = ca1.CareConID and cc1.Person_ID_Mother = ca1.Person_ID_Mother where bk.RPStartDate <= reporting period start date and datediff(cc1.CContactDate, bk.AntenatalAppDate) between -3 and 3 and a.CContactDate > cc1.CContactDate and ca1.COMonReading >= 4	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element. For this measure we look at the cohort of women who had a 36 week appointment in the reporting period where CO reading was taken. i.e. a woman should have a CO reading taken at both booking and 36 week appointment to be considered for this measure To determine 36 week appointment, the 'Care Contact Date' in the MSD201 table is compared with the derived 'Gestational Age (Care Contact Date)' field in the MSD201 table. Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks). Tolerance when matching booking date and date when CO monitoring took place must be <=3days. May also consider the most recent appointment, in event of pre-term birth (i.e. no 36 week appointment takes place). Note: Each woman will only be counted once in the denominator.

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of fetal growth restriction (FGR).

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Percentage of pregnancies where an SGA fetus is antenatally detected and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital	Number of pregnancies where an SGA fetus is detected during the antenatal period	Count of distinct UniqPregID from MSD401.BabyDemographics left join MSD106DiagnosisPreg on UniqPregID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD401.RPStartDate >= MSD106.RPStartDate and MSD106.Diag = 267258002) union (MSD401.BabyDemographics left join MSD109FindingObsMother on UniqPregID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD401.RpStartDate >= MSD109.RPStartDate and MSD109.FindingCode = 267258002) union (MSD401.BabyDemographics left join MSD201CareContactPreg on UniqPregID left join MSD202CareActivityPreg on UniqPregID and CareConID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD401.RpStartDate >= MSD201.RPStartDate and MSD202.FindingCode = 267258002)	Total number of pregnancies submitted to MSDS	Count of distinct UniqPregID from MSD401.BabyDemographics where RPStartDate is in the reporting period and PersonBirthDateBaby is in the reporting period	Derived data item 'Unique Pregnancy Identifier' will be used when conducting analysis to ensure that pregnancies are not double counted where a mother may have her antenatal care with more than one provider.

Element 3 – Raising awareness of reduced fetal movement

Element description: Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Percentage of women who attend with RFM who have a computerised CTG	Number of women with reduced fetal movement identified at a care contact who have a computerised cardiotocogram (CTG)	Count of distinct Person_ID_Mother from Records from MSD202□ where MSD202.RPStartDate is in the reporting period□ and MSD202.FindingCode is in (276369006, 289432001, 249038009) #Reduced Fetal Movement□ □ APPENDED TO□ □ Records from MSD106 where□ MSD106.RPStartDate is in the reporting period□ and MSD106.DiagDate is in the reporting period□ and MSD106.Diag is in (276369006, 289432001, 249038009)) a Join to MSD202 on UniqPregID, Person_ID_Mother and RPStartDate where MSD202.FindingCode = 245761000000108 □	Number of women with reduced fetal movement identified at a care contact	Count of distinct Person_ID_Mother from (Records from MSD202□ where□ MSD202.RPStartDate is in the reporting period□ and MSD202.FindingCode is in (276369006, 289432001, 249038009) #Reduced Fetal Movement□ □ APPENDED TO□ □ Records from MSD106 where□ MSD106.RPStartDate is in the reporting period□ and MSD106.DiagDate is in the reporting period□ and MSD106.Diag is in (276369006, 289432001, 249038009) #Reduced Fetal Movement)□	

Element 4 – Effective fetal monitoring during labour (N.B. information not capturable in MSDS v2.0)

Element descritpion: Effective fetal monitoring during labour

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth	Number of singleton live births born before 34+0 weeks gestation who received a full course of antenatal corticosteroids within seven days of birth	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate Inner join to MSD302CareActivityLabDel on UniqPregID and Person_ID_Mother inner join MSD201CareContactPreg on UniqPregID, Person_ID_Mother, RPStartDate inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238 and ((MSD302.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD302.ClinInterDateMother is between 0 and 7)) or ((MSD202.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD201.CContactDate is between 0 and 7))	Total number of singleton live births born before 34+0 weeks gestation	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
Percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids	Number of singleton live births born before 34+0 weeks gestation and more than 7 days after completion of their first course of antenatal corticosteroids	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate Inner join to MSD302CareActivityLabDel on UniqPregID and Person_ID_Mother inner join MSD201CareContactPreg on UniqPregID, Person_ID_Mother, RPStartDate inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238 and ((MSD302.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD302.ClinInterDateMother is > 7)) or ((MSD202.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD201.CContactDate is > 7))	Identical to Element 5 Process Indicator 1 Denominator Total number of singleton live births born before 34+0 weeks gestation	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth	Number of singleton live births born before 30+0 weeks receiving magnesium sulphate within 24 hours prior to birth	Count of distinct Peson_ID_Baby from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RPStartDate Inner join to MSD302CareActivityLabDel on UniqPregID and Person_ID_Mother where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 210 and MSD302.ProcedureCode = '144351000000105' and MSD302.ClinInterDateMother is between the MSD401.PersonBirthDateBaby and 24h prior.	Total number of singleton live births born before 30+0 weeks gestation	Count of distinct Peson_ID_Baby from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RPStartDate where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 210	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
The incidence of women with a singleton pregnancy giving birth (liveborn) as a % of all singleton live births in the late second trimester (from 22+1 to 23+6 weeks)	Number of women who give birth to a singleton between (22weeks +1) and 23+6 weeks (only include singleton live birth)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth between 155 and 167	Total number of singleton live births (This should include singleton live birth > 22 weeks)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth >154	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
The incidence of women with a singleton pregnancy giving birth (liveborn) as a % of all singleton live births preterm (from 24+0 to 36+6 weeks)	Number of women who give birth to a singleton between 24+0 and 36+6 weeks (only include singleton live birth)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth between 168 and 258	Identical to Element 5 Outcome Indicator 1a Total number of singleton live births (This should include singleton live birth > 22 weeks)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth >154	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.

Element 6 – Management of diabetes in pregnancy (N.B. information not capturable in MSDS v2.0)

Element description: Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (e.g. continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes

NE&Y Regional Perinatal Quality Oversight Group Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: October –December 2023 Q3

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

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Oct	1:23.95	16%	
Nov	1:23.6	15%	100%
Dec	1:23.5	14%	100%

Maternity unit DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			Oct	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	15.5%	17.2%	17.2%
	Emergency	<15.2 %	36.1%	32%	32.3%
Preterm birth rate	≤26+6 weeks	0	1	0	0
	≤36+6 weeks	<6%	10.7%	9.4%	12.9%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	5.2%	4.5%	3.5%
Term admissions to NICU		<6%	3.39%	3.22%	4.45%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	3.2% 1.7%	1.8 1.22%	1% 0.86%
	Instrumental (assisted)	<6.05 %	5.3%	7.7	7.1%
Right place of birth		95%	99%	100%	100%
Smoking at time of delivery		<11%	13.2%	7.63%	10.1%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0% 0 %	0% 0%	0% 0%
	Area of deprivation		0%	0%	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2022/2023	Oct	42	140	0	1	0	0	2	1	1	0	0	0	0	0	0
	Nov	-	-	0	0	0	0	4	1	0	0	0	0	0	0	0
	Dec	36	101	0	0	0	0	1	0	0	0	0	0	0	0	0
	Q3															

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	34	-	31
2	Delay in elective work	7	-	4
3	Unable to give 1-1 care in labour	1	-	1
4	Missed/delayed care for > 60 minutes	0	-	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	-	0

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: October –December 2023 Q3

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

Maternity unit: DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			Oct	Nov	Dec
Caesarean Section rate	Elective		11.3%	13.2%	12.3%
	Emergency		33.1%	35.7%	29.2%
Preterm birth rate	≤26+6 weeks	0	0	0	0
	≤36+6 weeks	<6%	5.08%	5.42%	5.38%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	6.5%	5.4%	3.1%
Term admissions to NICU		<6%	0.84%	2.45%	2.43%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0	1.61 %	0	0.77%	1.6%	0.76%
	Instrumental (assisted)	<6.06 %	10.5%		5.6%		0	
Right place of birth		95%	100%	100%	100%
Smoking at time of delivery		<11%	5.6%	7.9%	12.3%
Percentage of women placed on CoC pathway		35%	0	0	0
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0	0	0	0	0	0
	Area of deprivation		0		0		0	

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	Oct	3	39	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nov	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dec	23	32	0	0	0	0	0	0	0	0	0	0	0	0	0

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	3	-	23
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

Assessed compliance With 10 Steps-to-Safety

		Oct	Nov	Dec
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V3			
7	Patient Feedback			
8	Multi-professional training			
9	Safety Champions			
10	Early notification scheme (HSIB)			

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

NHS

Evidence of SBLCB V3 Compliance

Element		October			November		December		
		self assessment	LMNS	CNST 50% self assessment	-	-	self assessment	LMNS	CNST 50% self assessment
1	Reducing smoking	60%	0%		-	-	80%	70%	
2	Fetal Growth Restriction	85%	65%		-	-	85%	80%	
3	Reduced Fetal Movements	100%	50%		-	-	50%	50%	
4	Fetal monitoring during labour	60%	20%		-	-	80%	80%	
5	Reducing pre-term birth	59%	29%		-	-	74%	67%	
6	Diabetes	67%	50%		-	-	67%	50%	

Assessment against Ockenden Immediate and Essential Action (IEA)

	Oct		Nov	Dec	
Audit of consultant led labour ward rounds twice daily					
Audit of Named Consultant lead for complex pregnancies					
Audit of risk assessment at each antenatal visit					
Lead CTG Midwife and Obstetrician in post					
Non Exec and Exec Director identified for Perinatal Safety					
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (80% of Staff)	PROMPT	CTG		>80% PROMPT	>80% CTG
Plan in place to meet birth rate plus standard (please include target date for compliance)					
Flowing accurate data to MSDS					
Maternity SIs shared with trust Board					

Maternity unit	October	November	December
Freedom to speak up / Whistle blowing themes	None	None	None
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Unexpected admission to NNU Staffing	Weight unexpectedly below the 10th centile PPH Unexpected admission to NNU PH <7.1 Injury to baby during CS	Unexpected admission to NNU Weight unexpectedly below the 10th centile PPH
Themes from Maternity Serious Incidents (Sis)	1 serious Incidents declared in October for maternity iatrogenic fractured humerus in the management of a shoulder dystocia	No Sis declared	No Sis declared
Themes arising from Perinatal Mortality Review Tool	October meeting	25 week antenatal stillbirth graded A and B Re-discussion a HSIB case for grading following receipt of the report agreed to keep initial grading C and A	2 cases graded – evolving theme of SGA and whether SFH should commence at 25 weeks as per NICE A and A A and B
Themes / main areas from complaints	Anaesthetic concerns Care delivery Attitude, behaviours and communication of staff	Anaesthetic concerns Care delivery Attitude, behaviours and communication of staff	No new complaints
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MNVP attended Governance meeting and shared presentation around the co-production work that has been ongoing Working with audit and guideline midwife	Staff attend MNVP meeting quarterly with goof attendance Ongoing co-production with MNVP leads	Ongoing engagement with MNVP
Evidence of co-production	Guideline production Governance meetings	Guideline production Governance meetings	Guideline production Governance meetings
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Face to face staff engagement meetings on CDS Meetings with staff listening to suggestions for improvement within the service Live SIMS ongoing Debrief being conducted with staff following incidents	Face to face staff engagement meetings on CDS Meetings with staff listening to suggestions for improvement within the service Live SIMS ongoing Debrief being conducted with staff following incidents	Face to face staff engagement meetings on CDS Meetings with staff listening to suggestions for improvement within the service Live SIMS ongoing Debrief being conducted with staff following incidents
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT and safety brief Ward briefs and emails Face to face discussions with staff Closing the loop proformas LMNS meetings	WHATS HOT and safety brief Ward briefs and emails Face to face discussions with staff Closing the loop proformas LMNS meetings	WHATS HOT and safety brief Ward briefs and emails Face to face discussions with staff Closing the loop proformas LMNS meetings

KPIs: Targets & Thresholds

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

Glossary of terms / Definitions for use with maternity papers

AN - Antenatal (before birth)

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

BAPM - British Association of Perinatal Medicine (neonatal)

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

Cephalic - Head down

CNST - Clinical Negligence Scheme for Trusts

CTG - Cardiotocography (fetal monitor)

CQC - Care Quality Commission (Our regulator)

Cooling - baby actively cooled lowering the body temperature

DoM - Director of Midwifery

EFW - Estimated fetal weight

FTSU - Freedom to speak up

G - Gravis (total number of pregnancies including miscarriages)

GIRFT - Getting it right first time (Benchmarking data)

HSIB - Health Service Investigation bureau

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

IUD - intrauterine death (in the uterus)

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

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

MSDS - Maternity dataset

NED - Non-executive director

NICU - neonatal intensive care unit

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

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

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

PFDR - Prevention of future deaths

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

PPH - Postpartum haemorrhage (after birth)

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

QI - Quality Improvement

RDS - respiratory distress syndrome (breathing problems)

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

RIP - rest in peace

SVD - Spontaneous vaginal delivery

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

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

Other information

Term is 37-42 weeks long

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

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

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

2401 - D TRUE NORTH SA2 & SA3 - PEOPLE & CULTURE

2401 - D1 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

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

5 minutes

REFERENCES

Only PDFs are attached

D1 - Chair's Assurance Log - People Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board

Subject:	**People Committee**	**Board Date: January 2024**
Prepared By:	Mark Bailey, Committee Chair & Non-Executive Director	
Approved By:	People Committee Members	
Presented By:	Mark Bailey, Committee Chair & Non-Executive Director	
Purpose	The paper summaries the key highlights from the People Committee meeting held on Tuesday 7th January 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Recruitment time: Significant Assurance subject to design change implementation. The Trust operates a blended approach to recruitment with approximately two thirds of the recruitment process managed within divisions and the final third within a central recruitment team. A reduction in time to recruit has been realised from improvement initiatives across the different stages and valuable work continues. A significant difference remains between central and divisionally managed recruitment time and from the data analysis it is agreed that the 31-day target from advert to unconditional offer requires the focus offered by a centralised recruitment model. Acknowledgement and appreciation of the work already taken to reduce current model times. Executive review has agreed that a significant design change to a predominantly centralised model will be necessary to meet the step change targets. Assurance of a funded and prioritised implementation plan for the centralised model is sought to address an anticipated increase in recruitment activity and to minimise the attendant cost pressures associated with temporary staffing. **Nursing Workforce review & Safe Staffing**: Whilst successful recruitment to posts is positive, it is noted that the number of staff transitioning from supernumerary / early years status remains at a significant level and will have an impact on the skill mix across areas who held higher proportion of vacancy, placing more reliance on substantive staff to provide ongoing support during this transition period increasing the reliance on practice development nurses, legacy mentors, stay and thrive colleagues, professional nurse advocates and support from the clinical education team.	**National Staff Survey:** Comprehensive study and engaged reflection on the Staff Survey outcomes and lessons. Consideration of strategic / operational 'people' implications and priorities. **Education:** Awaiting receipt of final report from NHSE Senior Leaders Engagement (SLE) annual visit - informal feedback very positive. DBTH Education Quality Framework (EQF) launched in October 2023; Q3 data analysis to be shared at the next PC. Benchmarking with other regional NHS education providers being developed. Learning dashboard being introduced to improve access to SET / SET+ data, enabling topic leads to drive compliance via speciality & divisional governance. **Speaking Up** Subject to January 2024 Board approval, launch of refreshed Speaking Up strategy which will emphasise partnership and assurance. **Workforce Planning** Implementation of the KPMG strategic workforce planning tool to support 2024/2025 planning. The tool is intended to become a core component in business case development, organisational change, and large-scale projects such as MEOC. **Research & Innovation** Development of a detailed 5-year business case starting in the financial year 2024 to support the research & innovation strategy.

Significant or Full Assurances to Provide	Decisions Made
DBTH recognised as Employer of the Year at the Doncaster Business Awards held by the Doncaster Chambers in December 2023. **People Strategy**: **Full Assurance** Comprehensive high-level summary of implementation of in-year actions in the strategy and forward view of the delivery plans. Linkage to operational performance and staff survey measures with in-year targets. **Engagement & Leadership**: **Significant Assurance** Strong participation numbers in the 2023 annual staff survey. DBTH Way sessions and introduced into leadership programmes and job description template. Long Service Awards programme refreshed with excellent feedback from the December celebration events which recognised colleagues having between 10 & 50 years NHS service. **Education:** **Significant Assurance** Statutory compliance at end November 2023 improved to 86.8% (83.4% in 2022) v. 90% target - amber rating. Realigned SET to the updated Core Skills Framework (CSTF) and increased capacity to deliver. Oversight and governance of SET+ which comprises nationally determined training not currently outlined CSTF. **Health & Wellbeing:** **Significant Assurance** Positive evaluation of pro-active and reactive interventions against national diagnostic framework. External HPMA awards recognition - DBTH range of offers and support to staff and as part of South Yorkshire ICB for menopause work across the system. **Equality, Diversity, and Inclusion update**: **Significant Assurance** Fully defined and monitored EDI plan presented in detail with all NHS EDI Improvement high impact actions (6 areas) incorporated. Evidence from mandatory reporting, year on year improvements in NHS staff survey results. External validation: RSM UK Consulting - DBTH seen as a leading organisation under the RACE Code accreditation. **Speak Up Strategy refresh & biannual report:** **Significant Assurance** Continued embedding and barrier break down with increased engagement informing refined strategy and strengthened process. Evidence of thematic learning. **Agency & Sickness Absence (Improvement Project):** Cost benefit from improvements to processes, systems, **Significant Assurance** governance, and practices in the management of agency/bank usage and sickness absence.	**Speaking Up Strategy (2024-28)** Supported for submission to the Board for approval.

Workforce Supply & Demand: **Significant Assurance** Update on focus on strengthened workforce planning governance and processes with alignment of focused divisional and specialist workforce planning sessions and deep dives with 2024/25 business planning. **Nursing Workforce review & Safe Staffing:** **Significant Assurance** Evidence of continuous improvement in vacancy reduction across unregistered and registered workforce in Adult Nursing, ODPs, Children's nursing and Midwifery. **Research & Innovation Strategy bi-annual report**: **Significant Assurance** Summary of Research and Innovation (R&I) activity over the last six months. Laying the foundations to ultimately attain University Teaching Hospital status. Confirmation of continued delivery of contract with the National Institute of Health and Care Research (NIHR) Clinical Research Network. R&I Strategy operationalised into a six-year delivery plan, supported by five Core Programmes.	

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

2401 - D2 PEOPLE UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

D2 - People Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**D2**
Report Title:	**People Update**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Zoe Lintin, Chief People Officer Sam Debbage, Director of Education and Research (section 6)		
Appendices:	N/A		

Report Summary

Executive Summary

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

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

- National staff survey
- The DBTH Way
- Succession planning and talent management
- Health and wellbeing
- University of BPP update
- Equality, diversity and inclusion

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

Recommendation:	The Board is asked to note the actions being taken, the progress being made and to continue to support the work programmes described.			
Action Require:	~~Approval~~	**Review and discussion**	**Take assurance**	~~Information only~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	***Everybody knows their role in achieving the vision***	***Feedback from colleagues and learners is in the top 10% in the UK***	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire & Bassetlaw ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	As presented at People Committee in January 2024, agreed this version would be presented to Board

Risk register:	Existing workforce-related risks
Regulation:	-
Legal:	-
Resources:	-
Assurance Route	
Previously considered by:	Aspects considered within reports to Executive team, Trust Executive Group and People Committee
Date:	December 2023/January 2024
Any outcomes/next steps	-
Previously circulated reports to supplement this paper:	-

1. Introduction

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

The People Strategy 2023-27 is underpinned by detailed delivery plans with progress and impact being overseen by People Committee. The staff survey results are a key measure of progress and an important indication of satisfaction at work.

As another indicator of the impact of our People Strategy, associated work programmes and hard work of all teams involved, we were delighted to be recognised as Employer of the Year at the Doncaster Business Awards held by the Doncaster Chambers in December 2023.

This report provides updates in relation to the following:

- National staff survey – preparations for local engagement and communications, following the publication of the results in late February/March 2024 (date is to be confirmed nationally)

- The DBTH Way – continued implementation and embedding of the framework into working lives at DBTH

- Succession planning and talent management – launch of the new approach to succession planning and pilot of the new talent management approach, which is adapted from the national Scope for Growth model

- Health and wellbeing – evaluation and review of the offer undertaken for 2024

- University of BPP update – change in the delivery model for pre-registration nursing provision

- Equality, diversity and inclusion – updates in relation to RACE Code accreditation, EDI action plan and the NHS England High Impact Actions

2. National staff survey

The 2023 national staff survey went live on 27 September and closed on 24 November 2023. Our ambition was to strive to exceed our Trust record of a 65% response rate for the 2022 survey, which was one of the highest for acute trusts in the country last year. In the final days of the survey our response rate was 66% and the final position will be confirmed when the results are shared. This represents a new highest response rate in the survey for DBTH.

We will continue with the approach of engagement sessions and improvement action planning which commenced in 2022, with positive feedback being received from managers and teams. This approach is becoming embedded as part of our year-round cycle of engagement. The People & OD team developed a suite of resources and template documents to support managers with facilitating the engagement sessions and with action planning and these will continue to be available.

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

3. The DBTH Way

The DBTH Way posters have been displayed across our three sites and the larger wall art is in place at DRI with dates to be confirmed for Bassetlaw and Montagu. The posters focus on the headline 'key words' and the wall art provides more detail, to show our commitment to patients and communities as well as each other as colleagues.

Two facilitated sessions were held with the Leadership Assembly in November 2023, exploring what the DBTH Way means for individuals as leaders, and these generated insightful discussions and actions. These followed sessions with Trust Executive Group and Council of Governors held last year. Two similar sessions were held with the People & OD and Education & Research directorates at their time out sessions in November and December. A rolling plan is being developed by the People & OD team to offer DBTH Way sessions to teams across the organisation, as part of the ongoing embedding work.

A new job description and person specification template has been drafted for use in recruitment and this includes the DBTH Way alongside our We Care values. Further plans in relation to recruitment include incorporating the DBTH Way into assessment sheets for interviews. The appraisal documentation is being updated to include the DBTH Way, in preparation for the start of the season in April 2024.

4. Succession planning and talent management

The new succession planning grid template and supporting briefing note have been launched with Trust Executive Group leaders in January 2024, following a pilot including the Executive Directors and the Chief People Officer's senior leadership team. This has been designed as part of our ongoing strategic work to introduce more robust talent management processes at the Trust. The succession planning approach will be undertaken at divisional and directorate senior leadership teams as a minimal requirement and can be cascaded further or used for other key roles in teams.

The wider talent management approach has now been developed, adapted from the national Scope for Growth model, and is being piloted in some senior leadership teams in the coming months. The approach and documentation will then be finalised, incorporating any feedback, and rolled out more widely across leadership teams. The model also supports career conversations, development discussions and appraisals.

5. Health and Wellbeing

The Trust's health and wellbeing offers for 2024 have been reviewed in light of the results of the survey undertaken by the Evidence Centre and in relation to the People Strategy and the national Health and Wellbeing Diagnostic Framework, which supports the evaluation of the outcomes of interventions. A detailed report was presented to People Committee in January 2024 and the Committee was assured.

360 Assurance are undertaking an audit in Q4, with a focus on whether the Trust's strategic approach to health and wellbeing Is in line with the NHS Health and Wellbeing Diagnostic Framework.

6. Change in the University of BPP delivery model

BPP is a private University which has been hosted in RDaSH for a significant number of years, delivering pre-registration nursing provision (both adult and mental health fields). DBTH have been a partner with BPP providing pre-registration nursing placements. Following a strategic development review, BPP has confirmed that from September 2026 they will only deliver the BSc (Hons) Nursing on one site, London BPP Waterloo. Therefore, the September 2023 intake will be the last cohort to progress through the programme in Doncaster. We have confirmation that BPP will remain in place and maintain the quality standards until the September 2023 cohort has completed their programme in September 2026. The impact of this for DBTH is a reduction in the number of nursing students training locally on a full-time programme. The BPP programme

is currently the only full-time pre-registration nursing programme to run out of Doncaster, with the cohorts remaining relatively small, ranging from 10 to 16 individual students. The potential onward impact of this change will be the number of newly qualified nurses. However, it should be noted that not all of the students have remained in Doncaster as registrants. Due to this change we are now reviewing the alternative pathways which are delivered locally and working with our partners to consider how these could be further maximised.

7. Equality, Diversity and Inclusion (EDI)

7.1 NHS England High Impact Actions

The detailed Trust EDI action plan was presented to People Committee in January 2024 and the Committee was assured by the progress being made and that plans are on track, including for those High Impact Actions with a March 2024 target deadline.

7.2 RACE Code

The Trust was represented at the RACE Equality Code discussion forum in December 2023, hosted by Karl George MBE (thought leader in race equality and Partner at RSM). DBTH was publicly recognised for our excellent work in how we have used governance and measurement to effectively demonstrate actions and provide assurance on EDI workstreams.

The following feedback was provided to the Trust by RSM, who awarded RACE Code accreditation, following a recent review of the accreditation including our wider EDI workstreams, action plan and reports: “Based on these and their supporting evidence on EDI work, they're doing a lot of good work. DBTH had only 7 outstanding actions, to provide a little more context, there are over 100 actions that can be picked up from the review, so to only have 7 is no small feat. On average, most reports feature at least 20/30 actions.”

7.3 Reciprocal Mentoring Programme (RMP)

The graduation celebration was held for the 2023 cohort of the RMP in November 2023, with good feedback provided by the delegates. The established and aspiring leaders have been selected for the 2024 cohort, which is planned to launch in February 2024. An evaluation of the programme has been conducted, including reviewing feedback and learning from elsewhere, to refresh the events and the focus for this year.

8. Recommendations

The Board can be assured that actions are being taken to continue to enhance our approach to colleague experience and workforce development with ongoing cultural improvement linked to our True North ambitions, and that good progress is being made in different workstreams.

The Board can also be assured that the People Committee is maintaining regular oversight of the delivery and impact of our People Strategy.

2401 - D3 FREEDOM TO SPEAK UP BI-ANNUAL REPORT & SPEAKING UP STRATEGY

Decision Item | Zoe Lintin, Chief People Officer | 10:40

Paula Hill, Freedom to Speak Up Guardian

10 minutes

REFERENCES

Only PDFs are attached

D3 - Speak Up Biannual Report & Strategy 2024-2028.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**D3**
Report Title:	**Speaking Up Biannual Report, including the revised Speaking Up Strategy 2024-2028**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Paula Hill, Freedom to Speak Up Guardian		
Appendices:	Appendix 1 – Speaking Up Strategy 2024-2028 (Final Draft) Appendix 2 – DBTH Speaking Up Data Infographic Appendix 3 – Additional Reading		

Report Summary

The purpose of this report is to provide an update on DBTH Speaking Up (FTSU) activity since the last Biannual Report in July 2023. The paper also presents the final draft of the revised DBTH Speaking Up Strategy for 2024-2028 for consideration and approval. The strategy (presented as Appendix 1) has been developed through extensive consultation and engagement with Speak Up Partners at all levels to establish the key areas for improvement. Engagement has also taken place with Staff Side representatives, Equality, Diversity & Inclusion (EDI) leads and staff networks, to ensure fairness and inclusion throughout.

2023 has seen several stark reminders of the role that Speaking Up plays in feeling safe to raise concerns in a timely and effective manner and how the cultural environment created by leaders has the ability to easily enable or deter this. This paper acknowledges the challenges this presents for DBTH alongside the positive actions that have been taken and the key achievements that have been made to date.

These include:

- ✓ Increased engagement, with multiple Big Conversations to help inform the Speak Up Strategy and Process. These events also considered how we create a culture of psychological safety and break down barriers to Speaking Up.
- ✓ Revised Speak Up Policy launched May 2023 and Process to be launched January 2024. Focus on inclusion, restoration and consistency.
- ✓ Revised Speak Up Strategy. Launch planned for February 2024, following Board approval. Focus on partnership approach and governance and assurance processes.
- ✓ Strengthened Speaking Up Partnership model and Speaking Up Forum representation, including an increased number of Speak Up Champions.
- ✓ Improved training and manager support offer. Pilots for levels 1, 2 and 3 training have taken place from October to December 2023 and monthly manager support session held across all three sites.

A detailed report was presented to the People Committee in January 2024; the Committee was assured and commended the Speaking Up Strategy to the Board. People Committee members considered and explored Speaking Up Guardian activity, including data themes and trends, which were also considered against local and national perspectives for comparison.

It is noted that DBTH has seen a sharp increase in the number of individuals Speaking up over the first three quarters of this year and details of who is Speaking Up and what they are Speaking Up about can be found in the data infographic presented as Appendix 2. However, it is important that we acknowledge the impact of the wider national picture, presently providing a heightened awareness of Speaking Up across all colleagues, and therefore we need to examine the figures further to ensure we understand what they are

telling us about concerns at DBTH. Data triangulation to support this understanding will continue to be a key focus of the Speaking Up and Just Culture data assurance group.

Learning from both internal and external Speaking Up cases, reviews and recommendations were discussed at the People Committee in January 2024, with a focus on proactive consideration of their impact on Speak Up services and culture at DBTH. This work will continue to be interlinked with the wider cultural work to enable and encourage all leaders to have the ability to listen to and hear difficult and challenging stories with humility and curiosity. There will also be an addition to the Sharing How We Care newsletter to allow us to share what we have heard from our people and what we have learnt. This will commence from January 2024.

Key internal and external documents have been developed, considered, or reviewed as part of the FTSU assurance process and these are highlighted for further reading in Appendix 3.

Recommendation:	Board members are asked to acknowledge and take assurance from the extensive work that is summarised in this report and support the approval of the Speaking Up Strategy for 2024-2028. We also ask that you personally continue to support the messages in the Strategy, providing a listening ear and compassionate challenge when things are not right, or others appear to need help. Speak up, Listen Up and Follow up.			
Action Require:	**Approval**	Review and discussion/ give guidance	**Take assurance**	Information only
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	***Everybody knows their role in achieving the vision***	***Feedback from colleagues and learners is in the top 10% in the UK***	***The Trust is in recurrent surplus to invest in improving patient care***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire & Bassetlaw ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	SA1, SA2, SA3, SA4
Risk register:	
Regulation:	N/A
Legal:	N/A
Resources:	N/A

Assurance Route	
Previously considered by:	The contents of this paper have been previously considered by the People Committee. The Strategy has been supported by Trust Executive Group and People Committee.
Date:	9 January 2024
Any outcomes/next steps	Commend the DBTH revised Speaking Up Strategy 2024-2028 for approval by the Board of Directors on 30 January 2024
Previously circulated reports to supplement this paper:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patients
People
Performance
Partners
Prevention

Speaking Up Strategy

2024 – 2028

Contents

Introduction

The DBTH Speaking Up Strategy for 2024-2028 is a revised strategy designed to help improve what we do in relation to Speaking Up, how we tell you about its impact and how this work will contribute and support positive cultural influence at DBTH.

This strategy has been developed through direct consultation with Speak Up Partners and informed by discussions with divisional/directorate leadership teams and engagement with a wide range of colleagues through cross site engagement sessions, training events and feedback processes. Engagement has also taken place with Staff Side representatives, Equality, Diversity & Inclusion (EDI) leads and staff networks, to ensure fairness and inclusion throughout the process.

Freedom to Speak Up (Speaking Up as it is known at DBTH) was introduced to the NHS in 2016, following the 2015 review by Sir Robert Francis in response to the Mid Staffordshire enquiry. The review highlighted the importance of cultures that embrace transparency and support raising concerns to improve patient safety and colleague experience. The early guidance that supported the implementation of Speaking Up has seen much revision over the past eight years.

In the light of continued learning from case reviews and changes to national policy, we have seen Freedom to Speak Up evolve as the relationship between Speaking Up, quality improvement and just and learning cultures has become better understood. Recent recommendations and guidance acknowledge how Speaking Up should be interwoven into organisational cultures and behaviours and therefore asks all Trusts to have a Freedom to Speak Up Strategy that clearly links to the Trust overall strategy and its related vision and objectives.

This revised strategy considers the extensive work that is being driven nationally and locally in relation to Just Culture, Speaking Up and patient and colleague safety and experience and looks to respond to this to complement existing workstreams at the Trust for example, in relation to Just Culture, EDI, and patient safety and quality.

A self-assessment of Speaking Up cultures, services, data, and learning was undertaken at DBTH in June 2023 which highlighted key areas of improvement and focus areas for consideration. The resulting actions are incorporated within this strategy, including developing skills and further exploring how we support people who may have cultural barriers to Speaking Up or who may be less confident or less likely to do so.

This work also emphasised the strength in the partnership approach to Speaking Up at DBTH and demonstrated how this provides different routes and support mechanisms for colleagues to Speak Up. It also highlighted the need to ensure there is a consistency in application of the Speak Up process and the triangulation of data and learning, to support identification of themes.

This strategy will be underpinned by a delivery plan setting out how each of the themes will be achieved, providing clear outcomes, qualitative and quantitative data measures and timeframes by which the strategy will be measured.

Progress against this strategy will be reported bi-annually to the People Committee and Board, in line with national guidance and best practice. Updates will also be provided as appropriate to Trust Executive Group.

Paula Hill, Speaking Up Guardian at DBTH

Our vision
The ambition of the Trust

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

We Care values

- **W**e always put the patient first
- **E**veryone counts – we treat each other with courtesy, honest, respect and dignity
- **C**ommitted to quality and continuously improving patient experience
- **A**lways caring and compassionate
- **R**esponsible and accountable for our actions – taking pride in our work
- **E**ncouraging and valuing our diverse colleagues and rewarding ability and innovation

The DBTH Way

We lead by example and role model the **DBTH Way** and our **We Care values**

We are

- Kind
- Inclusive
- Person centred
- Empowering
- Accountable
- Collaborative

We show

- Attentive listening
- Integrity and honesty
- Courage and positivity

Our aim at DBTH is to embed a cultural environment where Speaking Up, Listening Up and Following Up are integral to providing outstanding care and colleague experience, and where Speaking Up results in learning and improvement. Through the implementation of this strategy, we want to ensure that colleagues feel safe to Speak Up, are supported to do so, and that confidentiality is safeguarded. We acknowledge that fostering this environment of psychological safety is a crucial investment in all of our people (patients and colleagues, including learners).

Colleagues who are enabled to work in a culture that supports Speaking Up will demonstrate the Trust's values through their aligned behaviours and feel empowered to challenge behaviours that are not in keeping with these values, the DBTH Way and a Just and Learning Culture.

Therefore, we ask everyone to "**Speak Up to Make a Difference.**"

We aim to achieve this vision by delivering across the following themes.

Raising the profile of Speaking Up

If we are to achieve our vision, it is essential that all colleagues understand that Speaking Up is about sharing their concerns about anything that gets in the way of providing good quality care and colleague experience, and that this should happen at the earliest opportunity to prevent harm and allow learning. We want all colleagues to know there are multiple routes to receive support, advice and guidance.

To enable the above, we will prioritise the following actions (some are already underway):

- Develop a robust annual communication plan to maintain the profile of Speaking Up, ensuring visibility and reach across all colleagues, learners and volunteers.
- Utilising the National Guardian's Office (NGO) awareness raising toolkit and the content of level 1 NHS England training, we will ensure all new colleagues receive an induction including Speaking Up and wider cultural themes.
- Roll out the revised DBTH Speaking Up Policy supported by a local best practice 'policy on a page' to make this easily accessible.
- Visible pledges from leaders and managers at divisional and departmental level, therefore demonstrating that managers and leaders at all levels welcome and encourage Speaking Up.
- Use clear, effective and varied communications to publicise our range of partners to Speaking Up through the DBTH 'wheel of support', ensuring this information is accessible and easy for people to understand.
- Further develop and support a team of Speak Up Champions who will raise awareness in their local areas, ensuring up to date information and resources are available for colleagues who explore Speaking Up.
- Provide regular visibility sessions rotating across all areas and DBTH sites, ensuring the provision of information and supportive discussions for all colleagues and managers.
- Increase the understanding and awareness of Speaking Up, through monthly publications in Buzz, Managers' brief and Weekly round ups and continued use of the Hive with increased viability on social media and the DBTH app.

Success measures

- Consistently high attendance at corporate induction training and wider raising awareness sessions
- New resources will be visible in all divisions and directorates, across all sites
- Colleagues will report they know what Speaking Up is, and when, where and how to do it (staff survey results)
- Colleagues will understand the collaborative working structure with the Speak Up Partners team
- Increase in intranet and social media activity, measured through activation of the QR code and views.

Providing easily accessible, consistent, high quality Speak Up services

A partnership approach to Speaking Up is already recognised and encouraged at DBTH with the aim of fostering a positive, open and inclusive culture where people are aware of the different routes and support mechanisms available, feel safe to raise concerns and where those who do Speak Up are treated fairly and learning is applied. We are undertaking work to support consistency in approach across partners and the triangulation of data from different sources, as this may identify themes which are not directly apparent from a single contact.

To enable the above, we will prioritise the following actions (some are already underway):

- Work collaboratively with all partners across the Trust to support them to provide a consistent, fair and restorative Speaking Up process in line with our learning from feedback and experience.
- Provide a framework for how concerns should be responded to, when raised to different partners, to ensure a consistency in approach, actions and behaviours. This will be supported by the development of a managers/partners handbook.
- Ensure that all managers and wider Speak Up partners are clear about their roles and responsibilities in relation to Speaking Up and have the competence and confidence to receive and respond to concerns consistently and compassionately.
- Provide timely, ongoing support to all managers and wider Speak Up partners to enable the above.
- Devise a process for partners to provide anonymised numbers, themes and learning to enable the triangulation of data as part of the wider governance and assurance process.
- Ensure that key learning related to concerns are articulated to everyone impacted by the concern in an open and transparent manner, while respecting confidentiality.
- Strengthen the process for learning from concerns and ensure all partners know their responsibilities in following this through to improvement.
- Ensure that all learning and improvement informed by Speaking Up is celebrated.
- Ensure feedback is obtained concerning colleagues' Speak Up experience, to enable continuous improvement.

Success measures

- Launch of new Speak Up policy and training
- Increase in recorded numbers of cases that are being positively managed by SU partners
- Number of case studies shared reporting a positive experience across varied partners
- Improvement in staff survey questions relating to confidence in Speaking Up
- High compliance with Speak Up process demonstrated through regular audit and feedback
- Timely completion of cases from date raised to date closed and feedback received
- Increase in positive feedback received from those who have raised concerns
- High attendance at partners training and engagement sessions across all divisions/ directorates.

Embedding an open and transparent Speak Up culture

The DBTH People Strategy (2023-2027) and associated delivery plan introduced the Just Culture workstream, the DBTH Way, increased focus on diversity and inclusion and improved wellbeing offers. This work also provides collaboration with wider supporting cultural workstreams at DBTH including the national Patient Safety Incident Risk Framework (PSIRF).

As our Just Culture approach places equal emphasis on accountability and learning, we recognise that to improve our Speak Up culture we need to learn from experiences where Speaking Up has gone well and where it has not gone as expected. Where it has not gone well, we will consider the learning from these experiences to explore and learn. We therefore need all colleagues to engage in cultural learning activities, to enable them to feel psychologically safe and supported to Speak Up.

To achieve the above objective, we will prioritise the following actions (some of which are already underway):

- Speak Up partners will work alongside leaders across the Trust to raise awareness of and embed our Just Culture principles, utilising these to explore and implement improvements in Speak Up services.
- Provide Just Culture development sessions linked to our revised NHSE aligned Speak Up training at levels 1, 2 and 3.
- Encourage inclusion, engagement and professional challenge as part of role modelling our Just Culture principles, and We Care values.
- Facilitate focussed discussions on creating a healthy Speak Up culture and a culture of psychological safety, where healthy, early conversations are encouraged and welcomed as a learning opportunity.
- Encourage colleagues to talk about their Speak Up experiences (positive and negative), sharing these stories in line with the wider Just Culture work programme.
- Learn from listening to these stories and share how we use this insight to improve our Speak Up offer. These stories will also be used to inform our detailed Speak Up process, ensuring we consider restoration and team building in a way that is holistic and people centred.
- Recruit, train and support a diverse group of Speak Up Champions, who will play a crucial role in encouraging colleagues to Speak Up at the earliest opportunity to embed a culture of openness and honesty.

Success measures

- Development of the associated delivery plan to support this strategy
- Continued improvement in the annual staff survey questions relating to psychological safety
- Stories shared by colleagues reflecting that they feel physiologically safe to raise concerns and that they feel their concerns have been addressed fairly when they do
- Reduced number of Speak Up cases raised anonymously
- Reduced number of Speak Up cases raised externally
- Increased number of cases raised and facilitated openly.

Identifying and tackling barriers to Speaking Up

Fostering a culture of openness and psychological safety where everyone can feel confident and safe to speak up is crucial to delivering on our Speaking Up ambitions, as well as to achieving our Trust vision to be "the safest Trust in England, outstanding in all that we do". We hear examples where people stay quiet for fear that Speaking Up may lead to mistreatment or where they feel speaking up will be futile as it will not result in positive action. Overcoming these barriers is essential, for our culture at work and for these who use our services.

To achieve the above objectives, we will prioritise the following actions (some of which are already underway):

- Work collaboratively with our wider partners to embed inclusive messaging to embed our Just Culture principles and promote positive behaviours across the Trust. We will use varied communication methods and tools to connect with all colleagues and ensure our messages reach all groups.
- Introduce our revised training and development offer to explore how barriers to Speaking Up are developed, how they can be prevented and how they can be removed.
- Continue to enable a diverse range of colleagues to share their stores about combating barriers to Speaking Up to allow learning and improve Speak Up services.
- Grow our team of diverse Speak Up Champions from all areas of the Trust, across all professions and job roles.
- Continue to work with the EDI lead and staff networks to support those who, for whatever reason, may find it harder to Speak Up, ensuring that their voice is heard.
- Ensure that Speaking Up is available across all groups and shift patterns to ensure everyone has access and has a voice that counts.
- Work with the lead for Organisational Development, EDI and Wellbeing to improve our understanding of information in relation to the diverse colleagues who access Speak Up services.

Success measures

- Increased number of colleagues who Speak Up who are willing to share their protected characteristics.
- Increased number of Speak Up concerns initiated or signposted through staff network champions.
- Increased number of people Speaking Up at both Partner and Guardian level.
- Decrease in number of colleagues who report that their Speak Up attempts have not been heard or responded to in line with the Speak Up process.
- Decrease in number of colleagues who report detriment following Speaking Up.

Education, Learning and Improvement

DBTH acknowledges that learning is an essential part of Speaking Up and that by nurturing curiosity and being proactive to learn, we can help break down barriers to Speaking Up. We also understand that by welcoming the giving and receiving of information and feedback we can enhance our opportunity to improve. We believe that having a revised training and development offer, which incorporates levels 2 and 3 of the NHSE Speak Up training, will provide the opportunity to have good conversations that tie in Speaking Up to our wider people and cultural plans, having a greater impact on engagement, learning and practice.

To achieve the above objective, we will prioritise the following actions (some of which are already underway):

- Review the delivery of the HEE levels, 1, 2 and 3 training ensuring that joint DBTH cultural messages are delivered in line with national recommendations.
- Ensure that all new colleagues to DBTH receive Speaking Up information in line with the National Guardian's Office awareness raising toolkit as part of their corporate or vocational induction.
- Use a roadshow style approach, to allow broader engagement and exploration to embed learning.
- Work collaboratively with partners at Chesterfield Royal Hospital and Rotherham, Doncaster and South Humber Trust (RDASH) to demonstrate wider learning and evidence the benefits of different delivery models.
- Ensure all leaders, managers and wider partners receive training in line with Level 2 NHSE Speak Up training recommendations and local Just Culture principles.

Success measures

- Number of colleagues receiving the revised level 1 - Speak Up (induction) training.
- Number of partners receiving level 2 - Listen Up (partner) training.
- Number of senior leaders receiving level 3 - Follow Up training.
- Colleagues will have the appropriate skills to know when, where and how to Speak Up and this will be reflected in the annual staff survey responses.
- All Speak Up partners will report they have the appropriate tools to receive and respond to concerns in line with the revised Speak Up process.

Governance and Assurance Processes

In order to understand and demonstrate our performance against this strategy, we commit to a process of ongoing governance and assurance, ensuring that data trends are appropriately considered by the Speaking Up Forum, Just Culture Group and PSIRF Implementation Group, with triangulated anonymous data submitted to the People Committee and Board as part of the assurance process.

To achieve the above objectives, we will prioritise the following actions (some of which are already underway):

- Continue to systematically record all concerns raised through Freedom to Speak Up services, in line with guidance from the National Guardian's Office.
- Introduce a consistent method of reporting and recording concerns raised with wider Speak Up Partners, in line with the revised Speak Up process.
- Encourage divisional level consideration of Speak Up activity, including all learning and improvement.
- Review the annual staff survey results including identification of any 'hot spots' or blind spots.
- Review the Freedom to Speak Up evaluations following conclusion of any concerns raised.
- Regularly review themes or trends raised with wider Speak Up partners.
- Provide bi-annual high-level figures to the People Committee and Trust Board, reflecting themes and trends, making recommendations regarding changes to policy and practice in line with any associated learning.
- Establish the role of the Senior Independent Director (SID) as appropriate in supporting SU cases that are escalated in relation to perceived detriment.
- Monitor percentage completion of the revised Speak Up, Listen Up and Follow Up training packages.
- Review number of contacts with Champions and partners.
- Regularly monitor delivery against the national FTSU reflection and planning tool through a process of peer review.
- Continue to strengthen the Speak Up Governance Group (FTSU Forum), increasing representation across all divisions and directorates.
- Review national case reviews to ensure that any recommendations and learning are implemented, where appropriate.

Success measures

- Changes in employee relations metrics including grievances and suspensions
- Qualitative feedback on concerns raised through the FTSU Guardian and wider partners
- Improved triangulation and understanding of Speak Up data
- Improved position in national benchmarking data from the National Guardian's Office
- Improved staff survey results on colleagues' reporting concerns and feeling they are treated fairly.

NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

We care

Belong Thrive Here DBTH Develop

DBTH Speaking Up

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

A summary of data from Q1 to Q3 2023-24

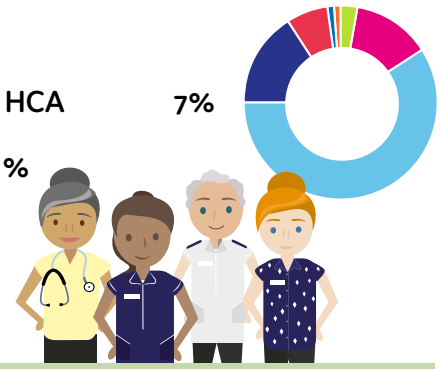
Appendix 2

How Speaking Up cases compare year-on-year:

- **47** cases to date in 2023/24
- **45** cases in 2022/23
- **97** cases in 2021/22
- **156** cases in 2020/21

Cases grouped by professions:

Allied Health Professionals	3%
Medical and Dental	13%
Registered Nurses and Midwives	59%
Administration and Ancillary	16%
Nursing Associates & HCA	7%
Corporate Services	1%
Not known	1%



Themes of concerns

Number of people who raised concerns about...

Patient safety/quality	44
Worker safety or wellbeing	65
Bullying or harassment	13
Inappropriate behaviour	3
Disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment')	3
Systems & processes (this theme is not captured nationally)	40
Raised their concerns anonymously	1

Summary of learning

- Continued potential for impact on patient safety due to changes in services and staffing
- Increased concerns relating to or causing an impact on stress and anxiety
- Systems and processes, including data protection

Receiving feedback

Of those who responded to the question:
'Given your experience, would you speak up again?'

100% responded 'Yes'

Common themes from feedback

- Service easy to access
- Guardian and Partners very supportive
- Not always equitable when trying to access additional or restorative support

Appendix 3 - Suggested additional reading

National documents:

NHSE letter to all Leaders, reflecting on the learning from the Countess of Chester case – August 2023

NGO response to the Countess of Chester case – September 2023

NHS Sexual Safety Charter – September 2023

Report on the Review of Ambulance Services (including the Increased recommendations for NHSE and CQC in relation to considering Speaking Up arrangements as part of their wider assessment and assurance processes) – Feb 2023

Revised guidance for Speak Up Champions and Ambassadors, enabling increased support to Guardians and Partners – November 2023

Letter to all NHS Leaders, highlighting the learning from the NGO annual Report for 2023 (delayed in early 2023 due to political party changes) – December 2023

NGO revised process for addressing concerns raised about FTSU Guardians – December 2023

DBTH documents created or revised:

Revised Speak Up Standard Operating Procedure SOP – Completed November 2023 – Launch January 2024

Speaking Up Strategy – Final Draft for approval January 2024 - Launch February 2024

Updated Reflection and Planning Tool - Completed June 2023 – Updated December 2023

Detailed People Committee Paper – January 2024

FTSU Forum minutes:

27.07.2023 – approved 28.09.2023

28.09.2023 – approved 23.11.2023

23.11.2023 – Approved 25.01.2024

The above minutes are routinely provided as part of the People Committee papers.

BREAK 10:50 - 11:00

2401 - E TRUE NORTH SA4 - FINANCE & PERFORMANCE

2401 - E1 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

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

5 minutes

REFERENCES

Only PDFs are attached

E1 - Chair's Assurance Log - Finance & Performance Committee (1).pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Finance and Performance Committee - Chair's Highlight Report to Trust Board

Subject:	**Finance and Performance Committee**	**Board Date: January 2024**
Prepared By:	Kath Smart, Deputy Committee Chair & Non-executive Director and Mark Bailey, Non-executive Director	
Approved By:	Finance and Performance Committee members	
Presented By:	Mark Day, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the **key highlights** from the Finance and Performance Committee meeting held on 25th January 2024	

Matters of Concern/Escalation Items (with Moderate, Partial **or** No Assurance)	**Major Actions Commissioned / Work Underway**
Urgent and Emergency Care – Partial Assurance Significant challenges remain in attaining and maintaining the required levels of performance for ED waits and Ambulance Handover. Noting that significant assurance can be gained from the managements understanding of the issues and design and deployment of initiatives and programmes to facilitate safe flow into and out of the acute service, the challenges of reducing length of stay and reducing high occupancy levels remain. System and partner level co-operation remains fundamental to creating capacity to realise an overall performance improvement and pace of change is slower than originally planned when the ECIST team provided support. Elective Activity – Partial Assurance Performance for Inpatient and Day case treatment remains a challenge given workforce, infrastructure and industrial action. The absence of a documented ERF plan for the yearend is creating a financial risk. Assurance is drawn in relation to the identification of improvement actions; however, it is evident that these will require cultural change including embracing the Getting it Right First Time (GIRFT) approach. Waiting List Clinical Prioritisation Audit - Limited Assurance One high and three medium risks have been agreed with auditors. Corrective action is committed for end March 2024. The High-risk item is the ability to effectively manage waiting lists based on patient prioritisation. Medium risks relate to aspects of the SOP including patient categorisation thresholds and patient record completion. Cost Improvement Plan – Partial Assurance Cost improvement plans analysed against original plans showing many are falling short of delivery. Reasons are understood and reporting is giving a current	Business Planning 24/25 & Budget Setting 24/25 Divisional / Corporate business planning for 24/25 aiming for no increases to the Trust cost base (excluding inflation). Expectation that commitments will be founded on delivering more activity, productivity, and quality through implementation of recurrent improvement schemes, adoption of best practice standards and partnership / transformational change. National guidance not yet finalised, and work is ongoing to develop workforce plans which are less mature than required at this stage. People Committee to assure on those workforce plans. Diagnostics – a focus needs to be maintained on demand management and effective utilisation of capacity in this area given the concerns identified previously and the critical part played in treatment pathways. Specifically work needs to be undertaken to ensure that DBTH CT scan high demand is reduced, to match clinical guidelines and the practice in other acute providers which are showing significantly lower demand. Electronic Patient Record (EPR) system - detailed evaluation of the capabilities and programme / cost considerations associated with the adoption of the STH/Cerner Electronic Patient Record (EPR) system. This will inform the action necessary at Board level against the existing approval for DBTH to pursue convergence to uniform software advocated in NHS England and SY ICS regional strategy. Place Allocations – work was shared relating to ongoing dialogue and evidence to demonstrate how funding allocations for Doncaster align to the health needs of the Doncaster population.

performance of £14m CIP plan delivery forecasting a £17m delivery.	
Significant or Full Assurances	**Decisions Made**
Financial Performance - significant assurance that financial management and control is delivering against plan, with the deficit position at month 9 being marginally favourable to plan and forecast driven by elective recovery fund performance. A year-end deficit of £25.8m is forecast which is £1m improvement to plan (ICB stretch is £4m); Risk remain with Industrial action impact and any change to ERF income. Cost Improvement has delivered £14.4m year to date but is not expected to reach the full year target. Several improvement areas provide opportunity in later years. Recovery, Innovation & Transformation Update – significant assurance on progress across a range of initiatives including the opening of the Mexborough Elective Orthopaedic Centre (MEOC) and the construction of the Bassetlaw Emergency Village. Outline proposals to progressively upgrade the Doncaster Royal Infirmary site have been positively received by stakeholders including NHS(E). Health Inequalities update – significant assurance - quarterly update on the plans to date & how these are being taken forward Board Assurance Framework - The Committee reviewed and were satisfied with the progress and updates, especially with updates to BAF 7.	Downstream Access Postal Service To utilise the Crown Commercial Service's Postal Goods & Services framework and award to an identified preferred supplier the contract to provide a downstream access postal service. This removes the burden of manually franking 2nd class mail from the postal hub and manages the franking, sorting, and delivery back to Royal Mail at the delivery stage. Terms of Reference for the Cash Committee and Capital Committee were approved

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

2401 - E2 FINANCE UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

E2 - Finance Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**E2**
Report Title:	**Finance Update (Month 9)**		
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 9.
Summary of key issues:	The Trust's reported deficit month 9 (December 2023) was £0.5m, which was £0.4m favourable to plan and £0.4m favourable to forecast. Year to Date (YTD) the Trust's reported deficit at month 9 was £24.0m, which was £0.8m favourable to plan and £0.5m favourable to forecast. The favourable variance in month is driven by a £0.5m over achievement on Elective Recovery Fund (ERF) performance. However, it should be noted that the ERF baseline in December was significantly lower than in previous months and that Independent Sector (IS) spend of c.£0.4m above plan was incurred to deliver this position. Pay spend is adverse to plan by c.£1.2m YTD, £0.7m of the YTD adverse variance is recharges which is offset with income, meaning the underlying pay position is £0.5m adverse to plan YTD. Within this are strike costs of £1.7m, which are offset by a £0.7m favourable variance on Admin staff (due to vacancies). Excluding recharges, pay spend is £1.1m adverse to forecast YTD. Winter costs have been £0.1m YTD above run rate. Non-pay spend is £0.1m adverse to plan YTD. Key areas of overspend includes drug expenditure (£1.7m), continued overspends related to the phasing of the independent sector usage (£0.5m) and Medical and Surgical equipment (£1.6m). Excluding reserves and recharges, non-pay spend is £0.5m favourable to forecast YTD which is positive and in month the Trust saw a £0.4m reduction in spend versus month 8. This was due to favourable movements in insulin pumps (£0.2m) and non-PbR drugs (£0.3m), both of which are offset with income. **Income and Expenditure Forecast** The Trust is currently forecasting to achieve a £25.8m deficit year end position (before the impact of any industrial action on costs and ERF performance) which is a £1m improvement against its planned deficit. This position is however still short of the £4m stretch target allocated to the Trust by the ICB (Integrated Care Board). The Board should note that at Month 9 reporting the Trust was asked to include its forecast outturn position at £22.8m (rather than £25.8m) to facilitate the ICB submitting its year end forecast position in line with its discussions with NHSE (NHS England). The Trust submitted its monthly return on this basis; however, it was made clear with the ICB this was not our current forecast position and that the ICB needs to resolve this stretch at a system level before next month end. An update will be provided at the Board meeting with regards to this. **Capital** Capital expenditure in month 9 was £5.6m against a plan of £3.9m giving an in-month over-performance of £1.6m. The YTD position is £28.2m against a plan of £33.2m showing an under-performance of £5.0m. The main underspends are against

	Community Diagnostic Centre (CDC) of £1.2m and Bassetlaw Emergency Village (BEV) of £2.8m. A revised plan for both CDC and BEV shows current spend is in line with year-end expectations. The Trust is forecasting to deliver its year end capital plan. **Cash** The cash balance at the end of December was £12.7m (November: £20.9m), meaning cash has decreased by £8.2m in the month. This is because of the Trust spending £5.6m on capital projects, as well as £3.4m increase in NHS accrued income, relating to ERF and variable drugs which should be paid in month 10. This is partly offset by the Trust receiving £1.3m in Revenue PDC cash support. **CIPs (Cost Improvement Programme)** In month, the Trust has delivered £1.6m of savings versus the plan submitted to NHSE of £2.6m and therefore is £1.0m adverse to plan. YTD the Trust has delivered £14.5m of savings versus the plan submitted to NHSE of £14.4m and is therefore favourable to plan by £0.1m. Whilst the Trust is ahead of plan YTD at this point, the phasing of the CIP programme has started to increase as shown by the in month adverse variance.
Recommendation:	The Board is asked to note: • The Trust's deficit YTD at month 9 (December 2023) was £24.0m, which was £0.8m favourable to plan and £0.5m favourable to forecast.

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

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

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

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

FINANCIAL PERFORMANCE

Month 9 – December 2023

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M9 December 2023

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance					YTD Performance				
	Actual £'000	Variance to budget £'000		Variance to forecast £'000		Actual £'000	Variance to budget £'000		Variance to forecast £'000	
Income	(44,978)	997	A	536	A	(407,083)	(2,370)	F	(2,073)	F
Pay	30,767	1,252	A	1,007	A	275,956	1,164	A	1,935	A
Non Pay	13,851	(2,956)	F	(2,033)	F	149,977	130	A	(306)	F
Financing Costs	881	298	A	74	A	5,556	309	A	(49)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	A	0	0	A	0	A
(Surplus)/Deficit for the period	**521**	**(409)**	**F**	**(416)**	**F**	**24,406**	**(767)**	**F**	**(493)**	**F**
Adj. for donated assets	(41)	(7)	F	0	A	(371)	(63)	F	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**480**	**(416)**	**F**	**(416)**	**F**	**24,035**	**(830)**	**F**	**(493)**	**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 / Unidentified	952	929	A	6,115	9,594	F	9,130
Cross Cutting - Pay - Job Plans / Agency	867	271	A	3,900	3,157	A	6,500
Cross Cutting - Elective - Theatres/OP/Diagnostics/LOS	365	30	A	2,203	449	A	3,250
Cross Cutting - Procurement	79	26	A	480	244	A	720
Cross Cutting - Major Contracts	121	338	F	710	749	F	1,000
Cross Cutting - RPA	56	0	A	333	0	A	500
Cross Cutting - Corp Pay/Benefits from PLACE	125	8	A	625	272	A	1,000
Total CIP	**2,564**	**1,601**	**A**	**14,366**	**14,465**	**F**	**22,100**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**295,075**	**310,136**	**15,061**
Current Assets	79,601	**62,455**	**-17,146**
Current Liabilities	-112,917	**-101,834**	**11,083**
Non Current liabilities	-16,014	**-15,614**	**400**
Total Assets Employed	**245,745**	**255,143**	**9,398**
Total Tax Payers Equity	**-245,745**	**-255,143**	**-9,398**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan £'000
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	
Cash Balance		12,730		12,730	1,900
Capital Expenditure	3,938	5,559	33,187	28,190	65,051

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,872.66	6,194.80	344.01	128.11	6,666.92
Previous Month	6,872.14	6,237.82	387.35	153.12	6,778.29
Movement	0.52	-43.02	-43.34	-25.01	-111.37

1. Month 9 Financial Position Highlights

Income and Expenditure

The Trust's reported deficit month 9 (December 2023) was £0.5m, which was £0.4m favourable to plan and £0.4m favourable to forecast. Year to Date (YTD) the Trust's reported deficit at month 9 was £24.0m, which was £0.8m favourable to plan and £0.5m favourable to forecast.

The favourable variance in month is driven by a £0.5m over achievement on Elective Recovery Fund (ERF) performance. However, it should be noted that the ERF baseline in December was significantly lower than in previous months and that Independent Sector (IS) spend of c.£0.4m above plan was incurred to deliver this position.

Pay spend is adverse to plan by c.£1.2m YTD, £0.7m of the YTD adverse variance is recharges which is offset with income, meaning the underlying pay position is £0.5m adverse to plan YTD. Within this are strike costs of £1.7m, which are offset by a £0.7m favourable variance on Admin staff (due to vacancies). Excluding recharges, pay spend is £1.1m adverse to forecast YTD. Winter costs have been £0.1m YTD above run rate.

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Income and Expenditure Forecast

The Trust is forecasting to achieve a £25.8m deficit year end position (before the impact of any industrial action on costs and ERF performance) which is a £1m improvement against its planned deficit. This position is however still short of the £4m stretch target allocated to the Trust by the ICB (Integrated Care Board). The Board should note that at Month 9 reporting the Trust was asked to include its forecast outturn position at £22.8m (rather than £25.8m) to facilitate the ICB submitting its year end forecast position in line with its discussions with NHSE (NHS England). The Trust submitted its monthly return on this basis; however, it was made clear with the ICB this was not our forecast position and that the ICB needs to resolve this stretch at a system level before next month end. An update will be provided at the Board meeting with regards to this.

Capital

Capital expenditure in month 9 was £5.6m against a plan of £3.9m giving an in-month over-performance of £1.6m. The YTD position is £28.2m against a plan of £33.2m showing an under-performance of £5.0m. The main underspends are against Community Diagnostic Centre (CDC) of £1.2m and Bassetlaw Emergency Village (BEV) of £2.8m. A revised plan for both CDC and BEV shows current spend is in line with year-end expectations. The Trust is forecasting to deliver its year end capital plan.

Cash

The cash balance at the end of December was £12.7m (November: £20.9m), meaning cash has decreased by £8.2m in the month. This is because of the Trust spending £5.6m on capital projects, as well as £3.4m increase in NHS accrued income, relating to ERF and variable drugs which should be paid in month 10. This is partly offset by the Trust receiving £1.3m in Revenue PDC cash support.

CIPs (Cost Improvement Programme)
In month, the Trust has delivered £1.6m of savings versus the plan submitted to NHSE of £2.6m and therefore is £1.0m adverse to plan. YTD the Trust has delivered £14.5m of savings versus the plan submitted to NHSE of £14.4m and is therefore favourable to plan by £0.1m. Whilst the Trust is ahead of plan YTD at this point, the phasing of the CIP programme has started to increase as shown by the in month adverse variance.

2. Recommendation

The Board is asked to note:

- The Trust's deficit YTD at month 9 (December 2023) was £24.0m, which was £0.8m favourable to plan and £0.5m favourable to forecast.

2401 - E3 POSTAL SERVICE CONTRACT

Decision Item | Jon Sargeant, Chief Financial Officer | 11:15

10 minutes

REFERENCES

Only PDFs are attached

E3 - Postal Service Contract.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**E3**
Report Title:	**Award of contract for Downstream Access Postal Service**		
Sponsor:	Jon Sargeant, Chief Financial Officer & Director of Recovery, Innovation & Transformation		
Author:	Howard Timms, Acting Operational Director of Estates & Facilities Paul Bird, Head of Facilities		
Appendices:	None		

Report Summary	
Purpose of report:	To provide details regarding options for downstream access postal service providers and seek approval to award the service contract to the preferred supplier.
Summary of key issues/positive highlights:	Royal Mail presently collects the mail output from DBTH via the post room hub based at DRI. Currently the 2nd class mail output is manually fed through a franking machine on site and deposited in crates for collection and sorting by the Royal Mail. Franking costs have seen huge increases in the past few years. 2nd Class franking rose by 16% in October 2023 after increasing by the same percentage in April 2023, this followed a 10% increase in 2022 and a 9% in 2021. Equating to a 51% increase in the Royal Mail's postage tariff in the last 3 years. Consumable costs for ink, labels, and sealing fluid have also drastically increased especially recently due to the worldwide supply chain issues and high inflation. Several providers offer a downstream access (DSA) postal service, which removes the burden of manually franking 2nd class mail from the postal hub and manages the franking, sorting, and delivery back to Royal Mail at the delivery stage. Downstream access postal service has been reducing Trusts' postage costs for many years and the switch to a DSA service will help DBTHFT mitigate the Royal Mail franking cost increases. Whistl is the leading DSA provider with 57% market share and serve over 100 NHS clients. Customers locally include The Rotherham Foundation Trust, Sheffield Children's Hospital, North Lincolnshire & Goole Foundation Trust, University Hospitals of Derby and Burton NHS and Bolton NHS Foundation Trust Many of the above have provided excellent testimonials when requested to comment on the service provided by Whistl. The benefits to DBTHFT of switching franking and sorting mail to a DSA provider are listed below: • Reduced cost per letter • Releasing time spent franking thousands of letters in the postal hub • Franking machine downtime and repair costs • Reduction in consumables costs such as ink • A future rationalisation of the use of 1st class mail requirements The estimated saving against our current spends based on annual 2nd class mail volumes is £120k per annum. Furthermore, the saving represented by removing time

	spent franking second class mail is 20 hours per week, 0.53WTE and represents an additional saving of £14.5k annually. The transition requires little change to proceed, the 0.53WTE reduction is being managed by a staff retirement at the end of December 2023, and the new service can be mobilised two to three weeks following account set-up. The contract term is for a period of 5 years and can be terminated at any time after 12 months with 30 days' notice. Whistl is an approved supplier on the Crown Commercial Service's (CCS) Postal Goods & Services framework, which means CCS has pre-vetted Whistl and its suppliers / subcontractors and confirmed it has all the qualifications and accreditations to provide a safe and secure service. Because of the above, we can have confidence in the service and the information provided. The annual contract value is £389,953 with a total contract value of £1.950m over the 5-year term. For comparison, the spend against our current service is £510k, with a 5 year spend of £2.55m.				
Recommendation:	The Board is asked to approve the service contract to the preferred supplier.				
Action Required:	**Approval**	~~Information~~	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	N/A
Corporate risk register:	N/A
Regulation:	In line with procurement guidelines and SFI's , direct award via national framework
Legal:	N/A
Resources:	N/A

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

EXECUTIVE SUMMARY

Royal Mail currently collects the mail output from The Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) via the postal room hub based at Doncaster Royal Infirmary (DRI). The second-class mail output is manually fed through a franking machine in the post room, and deposited in crates for collection, sorting, and postal delivery by the Royal Mail.

Mail franking costs have seen huge increases this year, second-class franking rose by 16% on the 3rd April 2023, followed by a further increase of 16% in October 2023. The previous 2 years have seen increases of 10% in 2022 and a 9% increase in 2021. Equating to a 51% increase in the Royal Mail's postage tariff in the last 3 years.

To negate the rising cost of postage the Facilities Management team at (DBTH) explored ways of reducing its second-class franking postage costs. Downstream access postal services have been reducing organisation's postage costs for several years, and this service has been shown to be reliable, compliant, and safe. It will provide savings against our current in-house franking and Royal Mail collection model.

The prospective service will also deliver other efficiencies and improvements compared to in-house franking such as less time spent by post room staff manually feeding thousands of letters through franking machines, potential problems related to franking machine breakdowns and franking machine consumable costs which have also seen spiralling price increases in the last few years.

Although the Trust has transferred some of its outpatient mailing volume to a digital solution as part of a different scheme, there remains over 700,000 second class letters that are franked and collected by Royal Mail annually.

The Trust has three options:

1) Do nothing and continue with the current process – exposed to Royal Mail price increases.
2) Continue with the current process and wait for more high-volume departments to be included in the off-site digital print and mail solution.
3) Approve the switch of second-class mail volumes to a downstream access postal provider and begin to make savings on the cost of postage compared to our current Royal Mail service immediately.

BACKGROUND

Royal Mail currently collects the mail output from The Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) via the postal room hub based at Doncaster Royal Infirmary (DRI). The second-class mail output is manually fed through a franking machine in the post room, and deposited in crates for collection, sorting, and postal delivery by the Royal Mail. The mail arrives in the DRI mailroom from across the three main sites of the Trust and satellite outpatient sites and clinics across the region.

A selected volume and type / class of mail processed at the DRI mailroom is shown below and is represented as the previous full financial year, and half year volumes to end September 2023.

Reference Period Apr 22 - Mar 23					Reference Period Apr 23 - Sep			
Mail Class	**Postage Used**	**# items**	**Average Cost**		**Mail Class**	**Postage Used**	**# items**	**Average Cost**
1st Class Inland Large Letter	£709.51	562	£1.26		1st Class Inland Large Letter	£972.84	692	£1.41
1st Class Inland Letter	£191,616.18	245,726	£0.78		1st Class Inland Letter	£116,218.80	129,132	£0.90
2nd Class Inland Large Letter	£1,402.78	1,356	£1.03		2nd Class Inland Large Letter	£807.42	724	£1.12
2nd Class Inland Letter	£375,679.11	736,861	£0.51		2nd Class Inland Letter	£204,996.09	347,451	£0.59
2nd Class Inland Small Parcel	£11.40	4	£2.85		2nd Class Inland Small Parcel	£32.89	11	£2.99
Total	**£569,418.98**	**984,509**	**£0.58**		**Total**	**£323,028.04**	**478,010**	**£0.68**

The cost of franking mail has increased rapidly over the past 3 years including two price increases this year in April and October making the cost of franking a second-class inland letter £0.69.

The Trust can switch to a downstream access (DSA) postal service which involves a provider collecting the unsorted mail from the DRI hub, taking it to a regional processing hub, franking, sorting, and delivering the mail back into the Royal Mail postal stream to be delivered by R.M. postal staff.

The DSA service typically mirrors the time for a second-class delivery of between 2 & 3 days from collect to delivery. The process timeline is demonstrated below: -

- **Day zero** – Collection of mail via small van fleet serviced by the regional depot. Mail machine processed, franked, and sorted at depot for onwards delivery to Royal Mail
- **Day 1** – Handover to Royal Mail inward mail centre
- **Day 2/3** – Final mile delivery by Royal Mail

The downstream access postal service providers are listed through the Crown Commercial Services procurement framework and can be engaged via a mini competition tender or the direct award route. The Trust approached three DSA suppliers to visit site and view the postal hub prior to providing quotes, all three visited sites, the three providers are SPS Swiss Post, DHL, and Whistl.

The prospective service will also deliver further efficiencies and improvements compared to in-house franking such as less time spent by post room staff manually feeding thousands of letters through franking machines, this releases 20 hours of post room staff time which will be removed from the WTE establishment and be a recurrent saving. Replacing the current large beam franking machine and replacing with a smaller unit, and the reduction of franking machine consumable costs, which have also seen spiralling price increases in the last few years.

OPTIONS

Following the visits to site, the three DSA suppliers provided their costs based on a daily collection from site and management of the process to delivery into the Royal Mail delivery stream. The costs take account of an assumed 85% rate at which letters are presented in a machine-readable state, with the remaining 15% being non-machine readable and therefore subjected to a higher hand sort tariff, the percentages are a conservative estimate for machine reading and are applied to all provider costs. The cost per item is summarised and calculated against volumes for comparison below.

2nd Class Letters annual volume	736,861
2nd Class Large Letters annual volume	1,356

Postal Service	Estimated Annual volumes	SPS Price	SPS Total	DHL Price	DHL Total	Whistl Price	Whistl Total	Royal Mail	Royal Mail Total
Letters 100g machine-readable Mailmark (assumes 85%)	626,332	£0.593	£ 371,414.79	£0.563	£ 352,750.10	£0.514	£ 322,197.63	£0.690	£ 432,168.98
Letters 100g non machine-readable (Assumes 15%)	110,529	£0.659	£ 72,838.71	£0.591	£ 65,344.83	£0.603	£ 66,612.60	£0.690	£ 76,265.11
Large Letters 100g machine-readable (assumes 85%)	1,085	£0.716	£ 776.72	£0.848	£ 920.13	£0.828	£ 898.58	£1.130	£ 1,225.82
Large Letters 100g non-machine readable handsort (assumes 15%)	203	£0.771	£ 156.82	£0.828	£ 168.46	£1.200	£ 244.08	£1.130	£ 229.84
Total Cost via Downstream Access			**£ 445,187.04**		**£ 419,183.51**		**£ 389,952.90**		**£ 509,889.76**
Annual Saving Versus Royal Mail Franking Cost			**£ 64,702.72**		**£ 90,706.24**		**£ 119,936.86**		

Following receipt of providers updated quotes to include the impact of the Royal Mail price increase effective October 2023, we asked for assurance relating to elements of the service delivery including;

- Data Protection, information security and cyber security.

- Business Continuity
- Capacity Planning, Managing Volumes, and Peak Planning.
- Managing loss of staff
- Account Support and Delivering Service Improvement.

References from the three potential providers were requested from their existing NHS customers, and returns were broadly positive for all providers although the reference opportunities for DHL were limited. It became clear during our research that SPS Swiss Post were reliant on DHL for their collections, and it could be suggested this being the reason they were the provider with the least potential savings against our current Royal Mail service.

The transition from the Trusts current mail collection service is seamless, requires no financial investment, is safe, and an established route for reducing inefficient and time-consuming processes without any change management issues. The Trust would simply remove the second-class franking step from our current operation, and an alternative vehicle will collect the second-class mail.

SUMMARY

Due to the increasing cost of franking second-class mail and collection by Royal Mail, the Trust have explored options to make savings or cost avoidance measures. The downstream access (DSA) postal service presents an opportunity to remove the inefficient practice of franking thousands of second-class letters a week, removing £14.5k from WTE staff establishment cost, and reduce the cost of second-class postage by £120k. The change in service requires no investment or change in practice for the staff groups of the wider Trust. The providers of the DSA service are global logistics organisations with highly efficient and established infrastructures.

The preferred provider based on cost savings, references, organisational experience, and scale would be Whistl. Whistl handle 3.2 billion items per annum, serve over 100 NHS customers, positioning them as a trusted and highly experienced service provider. The company process over 25 million items annually on behalf of the NHS.

Whistl are also the DSA carrier for the NHS Covid Vaccination Letters, a mailing programme that has been running since Q4 2020 with millions of items per annum sent to all UK adults on a rolling basis.

Due to the relatively straightforward change to the current process, which is isolated to the activities in the post room hub at DRI, the mobilisation timeframe of the change in service is within two to three weeks from account setup to go-live.

PROPOSED NEXT STEPS

- Approval to proceed in service change for second-class franked mail from Royal Mail to the preferred provider.
- Work with Procurement colleagues to proceed with the approved service change via the CCS framework.

2401 - E4 DIRECTORATE OF RECOVERY, INNOVATION & TRANSFORMATION UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

E4 - Recovery Innovation & Transformation Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	30 January 2024	**Agenda Reference:**	**E4**		
Report Title:	**Recovery, Innovation & Transformation Update**				
Sponsor:	Jon Sargeant, Chief Financial Officer & Director Recovery, Innovation & Transformation (RIT)				
Author:	Kirsty Edmondson-Jones, Director of Innovation & Infrastructure				
Appendices:	None				
Executive Summary					
Purpose of report:	To provide an update on the progress by the Recovery, Innovation and Transformation Directorate.				
Summary of key issues:	This report provides an update on the work of the RIT Directorate including: • Quality Improvement & Innovation • Capital inc Complex Schemes • Green Plan • Business Planning/PMO/Tenders • Performance/Transformation.				
Recommendation:	The Board is asked to note and take assurance from this report.				
Action Require:	~~Approval~~	**Information**	~~Discussion~~	**Assurance**	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	***Everybody knows their role in achieving our vision***	*Team DBTH feels valued and feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*	

Implications			
Board assurance framework:			
Corporate risk register:			
Regulation:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	These papers have previously been considered by TEG		
Date:	N/A	**Decision:**	N/A
Next Steps:	N/A		
Previously circulated reports to supplement this paper:	N/A		

1. INTRODUCTION

This paper outlines the progress with the work of the RIT since the last update. Updates are provided relating to the progress of complex capital schemes with Bassetlaw Emergency Village, CDC, and Montagu Elective Orthopaedic Hub (MEOC) all progressing on plan.

Ed Miliband MP officially opened the new MMH Endoscopy suite as part of the multi-phased CDC programme on 15th December and a 'Topping off' ceremony to mark the progress of the new BEV Emergency Department structure being watertight is planned for the 19th January.

The Mexborough Elective Orthopaedic Centre (MEOC) is set to open its doors and welcome its first patient on the 15th of January 2024. In its initial week, the centre plans to perform surgeries on 24 patients and this will ramp up to 52 patients per week as processes are embedded.

A 16-week project to develop options for a refurbishment approach to improving the infrastructure at the DRI was completed on 10th November as planned. With the help of technical advisers and subject matter experts, the team successfully prepared a variety of options for refurbishing the East Ward Block and for developing proposals for sub-£25 million projects including Critical Care, Maternity, and Theatres. We now await further feedback from DHSC on the process of bidding for these monies in 24/25.

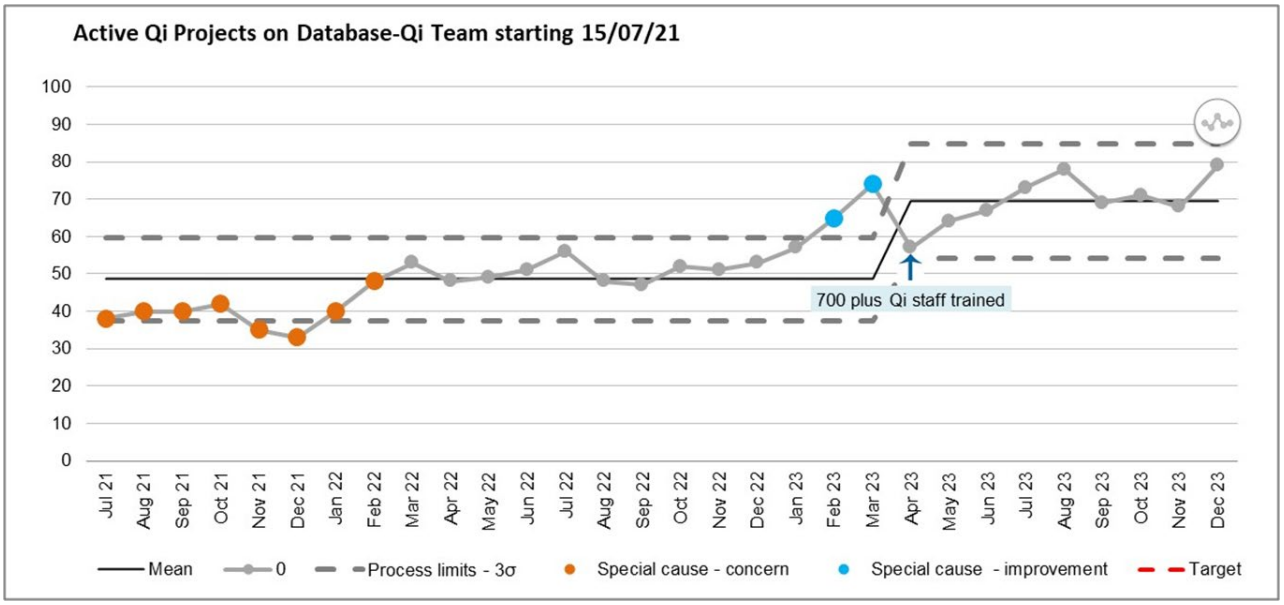
On Friday 22nd December communication was received regarding an opportunity to bid for funds as part of a £20m pot on monies to support LED lighting with a timescale for submitting expressions of interests opening on 4th January and closing by midnight on the 9th January. Bids needed to be developed and costed with associated energy savings identified and deliverable by end of March 24. Whilst the Trust did not have developed schemes, two expressions of interest (EOI) were submitted, one for LED lighting and one for solar. The assessment process is due to conclude rapidly by 12th January.

Following the approval of the Electronic Patient Record (EPR) Outline Business Case (OBC), NHS England requested that Doncaster and Bassetlaw Teaching Hospitals (DBTH) reconsider its initial preference and evaluate the possibility of aligning with Sheffield Teaching Hospitals (STH) and their Cerner system. An update is provided on the progress of this process so far, and the options available to the Trust in taking this forward.

Dr Kelly Mackenzie, our Consultant in Public Health and Health Inequalities Lead has recently been appointed to a joint post with the University of Sheffield and DBTH. This will be a Clinical Senior Lecturer in Public Health post with an honorary Consultant in Public Health post being held at DBTH. Kelly will be working 50% for the university and 50% for DBTH and aims to bring further academic opportunities and funding to DBTH to support the tackling health inequalities agenda. This joint academic role is an extremely positive development and presents some unique opportunities to progress the new DBTH Hi Strategy alongside valuable Hi research activity.

2. QUALITY IMPROVEMENT & INNOVATION

Since April 2023 the team have engaged with **1,127 people** (including training) and across **27** new teams / projects. There are currently **79 active Qi projects** registered on the DBTH Qi database.



The team are currently scoping **11** projects, have **10** projects in the planning and design phase, **six** in delivery and **11** have been completed. In addition there are 14 new requests for support. The team are also reviewing with SROs of major CIP programs if additional Qii support is required.

The team has been restructured to enable more Qii practitioner / Qii Business partner resource to support divisions.

WTE	Job description
1.0	Head of Qii
1.0	Qi Clinical lead & Head of Qi Academy
1.0	Senior Qi Practitioner
2.0	Qi practitioner / Qi programme Mgr
0.8	Qi project support
5.8	

WTE	Job description	Current Status
1.0	Head of Qii	In post
1.0	Senior Qi Practitioner	In post
3.6	Qi practitioner / Qi programme Mgr	In post
5.6		

Vacant Qii Practitioner / Qii Business position filled 11th December.

Discussions being held with Divisional Directors on how to align individuals within the Qii department to Divisions to act as a main point of contact to support Qii work.

Programmes update

Updates on major programmes of work that improvement are supporting are outlined in further detail below:

Patient Safety Incident Response Framework (PSIRF)

Initial implementation group meetings being held (project managed by PMO).

- All current state mapping completed
- Work on future state completed
- Thematic analysis b undertaken by project team to identify main areas of focus

Support for ED / AMU / Medicine

3 Strands of work currently taking place

- ED front door triage – working with ED & FCMS – 3 test of changes completed
- ED / AMU – communication – 4 'direct referral' routes test of change being extended to capture more information.
    - Smaller team met December 2023 to act on review of Stroke 'time to ward'.

- Triage within ED – planning meetings set up

Job Planning

- Initial problem statement & top-level process done
- Second meeting with CDs held12th September 2023

Place and System support

- Co facilitation of Medical Emergency Eating Disorder (MEED) collaborative held in Rotherham New York stadium – 8th September.
- Facilitation of Doncaster place **pain** referral models – Civic offices Doncaster – 14th September.
  - Lived experience session facilitated 25th October
  - Joint provider with lived experience future state design on 1st December 2023
  - Follow up meeting planned 19th January 2024.
- **Discharge to assess** workshop involving RDASH, DMBC, DBTH and voluntary sector planned 11th January 2024.
- **Audiology** pathway meeting held 21st November

Stock Rotation (non-clinical stock)

After the recent CQC findings of out-of-date stock on some wards, a Qii project has been set up as part of the response.

- The Qii team has visited 26 areas and have collated responses from 51 people on comments on the process from colleagues before the main event.
  - Qii events held 23rd October, follow up event held 4th December
  - PDSA of check lists in ED to check for date of stock, Questions added to Tendable to check for dates in stock

Length of Stay – Workstream 2 (ECIST plan)

Supporting action log for Length of stay reduction as part of Doncaster ECIST – Workstream 2

- Board rounds - 11 observations across Ward 25 & FAU concerning 140 patients carried out in November
  - 30 responses from questionnaire of what works well / what could be improved.
  - Qii event held for both areas December 2023
  - PDSA on ward 25 for sequence of Ward Board huddle, Ward round (following SHOP), then later Board round in January 2024.
- Discharge lounge DRI
  - Qii events to be planned with team on addressing barriers to discharge.
  - Initial analysis on time of discharge and numbers shows improvement.

Improvement Report outs and Qii Listening event

Qii Listening event held 7th December

- Focus on Visual Huddle Boards. 4 teams shared their experiences of setting up and sustaining the visual huddle board based on the three sections of people, performance, improvement.

Next report out dates planned :

- Thursday 18th January 2024 – 12:30 – 14:00
- Thursday 21st March 2024 – 12:30-14:00
- Thursday 16th May 2024 – 12:30-14:00
- Thursday 18th July 2024 – 12:30-14:00

Previous 10 improvement report out results in appendix A.

Training / Awareness

- **84 Qi Level 1** accredited to date this financial year (year target =60)
- **13 Qi Level 2** accredited to date this financial year (now 50 overall trained within the Trust)
- **464 Qi general awareness** this financial year
- June Qii drop in session DRI, July drop in session MMH held, September drop in BDGH held.

Quality improvement an innovation strategy

A draft Qii Strategy has been aligned to incorporate the newly published NHS Impact (published 19th April 2023). The Qii Strategy was presented in the November TEG. Following the incorporation of feedback from TEG the draft strategy will go to F&P in February for further feedback.

3. CAPITAL INC. COMPLEX SCHEMES

Bassetlaw Emergency Village

The BEV interior design work is progressing well and includes detailed designs for the CAU and ED areas which were discussed with staff stakeholder groups on 1st and 5th of December. Theme, graphic style, and colour palates have been co-developed with staff, with plans to test selected paint colours in a test area on 24th January to ensure these are still agreed before final sign off. Several workshops have been delivered in December for staff working in ATC, CAU and ED. The workshops were an opportunity to go into the new areas whilst still a shell and look at layouts with mock-ups and floors marked out to show locations of equipment. Whilst opportunities to change the room designs are now limited, there are opportunities to look at layout of non-fixed equipment in relation to ergonomic flow. Work is still ongoing to programme the decant, mobilisation and operationalisation of the BEV once built, and the second phase of the scheme which is to refurbish the existing ED areas. A new group has now been established led by Suzanne Stubbs to agree layout of SDEC (Same Day Emergency Care) as the further phase.

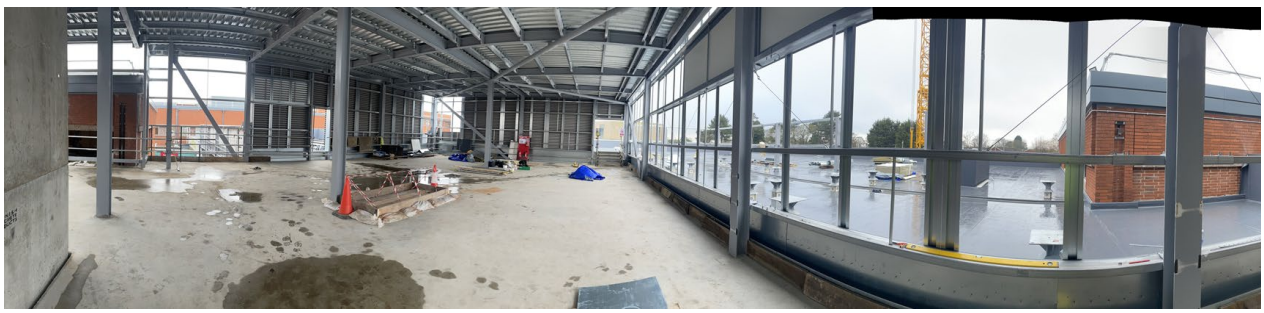
ED

CAU

ATC

Exterior

Plant Room and Roof



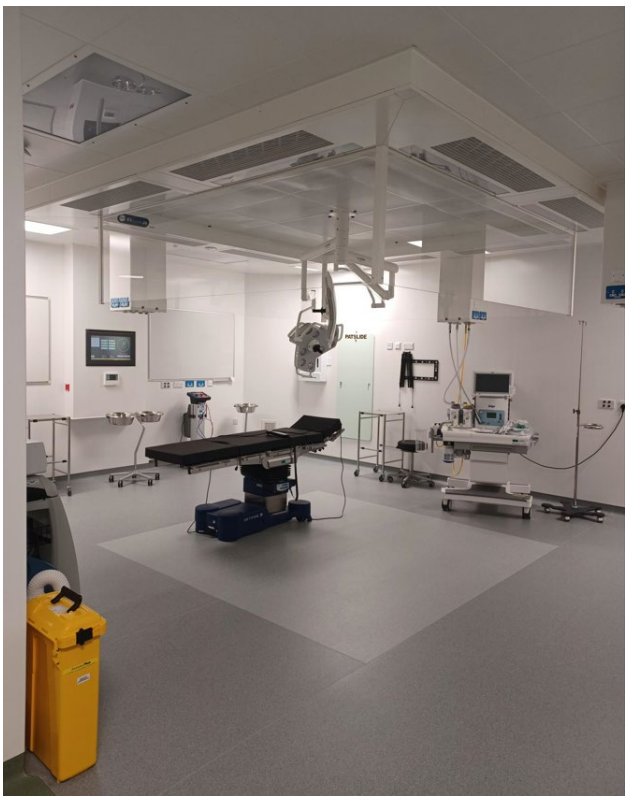
Colour Pallets Engagement

MEOC

The Mexborough Elective Orthopaedic Centre (MEOC) is opened its doors and welcomed its first patient on the 15th of January 2024. In its initial week, the centre plans to perform surgeries on 24 patients and this will ramp up to 52 patients per week as processes are embedded. In the first week, there have been some adjustments to the theatre schedule, as three full-day operating lists have been cancelled due to the unavailability of surgeons. Additionally, the number of lower limb surgeries planned per list is less than originally targeted, a decision stemming from the surgeons' preference for a more cautious approach in the initial weeks. Again, it is planned that this will rapidly ramp up.

In terms of staffing, MEOC is utilising a combination of in-sourced and newly recruited staff, with a greater reliance on in-sourced personnel in the first week. This is expected to shift towards a higher number of permanent recruits as recruitment intensifies throughout January and February. All necessary equipment has been delivered to the centre and is set to be fully commissioned and operational by the 15th of January. The final decontamination process is scheduled for the 9th of January, with microbiology test results expected by the 11th of January. Furthermore, consumables and instrumentation have already been delivered and are currently stored at MEOC. Final training and orientation for the staff are on course to be completed by the 12th of January, with IT and access to systems also set to be in place by this date.

On the administrative front, commercial agreements involving MEOC Partner Trusts are progressing well and are anticipated to be finalised for board approval in March 2024. The financial position for the 11 weeks through to the end of 2023/24 indicate a small surplus. Monitoring of income and costs is being implemented to ensure that any deviations from budget are highlighted early and responded to. The capital costs of MEOC have fallen within budget with a small contingency retained for any final items which are required and come to light through the first few weeks after going live. Consideration is now being given to moving from project management to operational management with the Consortium Agreement setting out the revised governance arrangements. To coincide with the operational launch of MEOC, comprehensive communication and engagement activities are being conducted to inform patients, staff, and General Practitioners about the centre's opening.



New Doncaster Royal Infirmary (DRI)

The Finance & Performance Committee was previously informed that the DRI Program Team undertook a 16-week project to develop options for a refurbishment approach to improving the infrastructure at the DRI. With the help of technical advisers and subject matter experts, the team successfully prepared a variety of options for refurbishing the East Ward Block and for developing proposals for £25 million projects including Critical Care, Maternity, and Theatres. The work was completed on 10th November 2023, as scheduled.

Subsequent discussions with DHSC received a positive response to the innovative approach proposed to address some of the worst infrastructure at DRI and enabling a rolling programme for the remainder of the site in line with emerging service strategies. Relocation and reconfiguration of Critical Care as one of the £25 million projects acts as both an enabler for the East Ward Block refurbishment and provides appropriate accommodation for some of our most vulnerable patients. DHSC are keen to support investment in Critical Care as a first step and we await to hear the result of their conversations regarding funding and timing. In the meantime, the project team has developed a brochure which summarises the detailed work undertaken, and the conclusions reached and will be used to share this with senior stakeholders across the ICB.

4. GREEN PLAN

DHSC £20m fund for LED lighting/Solar

On Friday 22nd December communication was received regarding an opportunity to bid for funds as part of a £20m pot on monies to support LED lighting with a timescale for submitting expressions of interests opening on 4th January and closing by midnight on the 9th January. Bids needed to be developed and costed with associated energy savings identified and deliverable by end of March 24.

Whilst the Trust do not have developed schemes, two EOI's were submitted, one for LED lighting and one for solar. The assessment process is due to conclude rapidly by 12th January.

Energy Saving Project Opportunity Report

The Trust has received the first draft of a report identifying a number of potential engineering and building projects requiring relatively moderate levels of funding that would help to improve energy efficiency within the Trust. Whilst the initial report provides only a high level overview of potential projects and payback periods at this stage, more detailed proposals are now being developed to aid future business case development. The table below provides an example of some of the types of schemes under consideration.

Opportunity	Description	Indicative Payback Period
Solar PV	The Trust has 2 small solar photovoltaic (PV) installations at DRI. A number of other roofs throughout the Trust have been identified as suitable for the installation of additional solar PV arrays, enabling an increased amount of the Trust's electricity demand to be met by renewable electricity generated on site.	Approximately 6 years
Improved Roof Insulation	Much of the building fabric within the Trust's estate is aged and in a poor condition, leading to high heat losses due to poor thermal insulating properties. Thermal imaging cameras have identified roofs where heat loss is particularly severe, and whilst large scale roof replacement requires significant investment, some improvement could be gained from the installation of thermal insulation in roof voids as an interim measure.	Approximately 5 years
Pump/motor control	Many of the pumps and motors used in the Trust's heating, cooling and ventilation systems are operating beyond recommended lifecycle and have only very basic control systems. Replacing aged plant and equipment and improving control systems to incorporate speed control would achieve a significant improvement in energy efficiency.	Approximately 2-3 years

ICB Sustainability Priorities 2024

Meetings are scheduled in January 2024 with the sustainability leads for the South Yorkshire ICB and Nottinghamshire ICB to discuss progress with the Trust's Green Plan and areas where regional support may be beneficial. The intention of these meetings is to help the ICB's agree regional priorities for the year ahead, leading to a more collaborative approach to improved sustainability in each region. Once agreed, an update on regional priorities will be provided in a future report.

National Approach to Energy Procurement & Energy Management

Energy is one of the most significant costs to the NHS nationally, especially following the unprecedented price increases experienced in recent years. An effective energy procurement strategy is therefore essential in helping to mitigate the rising cost of energy. NHS Trusts have the autonomy to decide on which strategy to adopt when procuring energy, which means that there are currently over 200 different energy procurement contracts within the NHS.

Rising energy costs have also been exacerbated by the nationally mandated requirement for Trust's to procure 'clean energy' generated from renewable sources as part of the NHS's objective to achieve net zero by 2045, as true clean energy incurs a premium compared to alternatives such as fossil fuels, nuclear and biomass generated supplies.

Recognising this challenge, NHS England have recently announced the development of a new national energy procurement framework in conjunction with Crown Commercial Services (CCS). The new framework

will adopt a long term buying strategy and pool resources nationally in an attempt to secure the best possible price for energy throughout the NHS.

This will allow a national strategy to be developed in terms of sustainable energy procurement to ensure that the carbon impact of energy used within the NHS is minimised. Additionally, the new agreement will also include the provision of energy management support to every ICS in an effort to improve efficiency and share best practice throughout the NHS.

Whilst this new initiative has only just been announced, it is anticipated that the move towards a central procurement strategy and the improved level of energy management support will help to reduce costs and expedite the transition towards net zero for Doncaster and Bassetlaw Teaching Hospitals and other Trust's throughout the country.

5. POSM/PMO/TENDERS

Transformation Programme Update

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

Transformation Highlight Reports

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

Workstream	SRO	CIP	Forecast v Target	Plan	Delivery	Change
Agency & Sickness Management	Zoe Lintin	**Medium**		**Low**	**Medium**	None
Workforce Job Planning	Tim Noble	**High**	£70k vs £500k	**Medium**	**High**	None
Theatre Productivity	Denise Smith	**High**	£199k vs £500k	**Low**	**Medium**	None
Outpatient Productivity	Densie Smith	**Medium**	£296 vs £500	**Medium**	**Meduim**	New line
Diagnostic Productivity	Denise Smith	**High**	£382k vs £750k	**Low**	**Low**	Forecast added
LOS	Denise Smith	**High**	£214k vs £1.5m	**Medium/ High**	**Medium/ High**	Forecast adjusted (down)
UEC	Denise Smith	**Medium/ High**		**Medium/ High**	**Medium/ High**	CIP Rag added
Data Assurance	Dan Howard			**Medium**	**Medium**	SRO changed
Benefits from PLACE		**High**	£0k vs £500k			None

RPA	Dan Howard	High	£0k vs £500k			SRO changed

The following RAG ratings are applied:

PLANS:

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

DELIVERY:

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

Planning

The Annual Business Planning cycle continues within DBTH. Successful planning sessions have occurred with many departments across the trust in November/December and a Peer Review workshop was held with all divisional representatives and corporate leads on the 18th December 2023 where initial priorities were highlighted and discussed prior to corporate templates being completed and draft plans being submitted to the Planning and Service Development team for review by 10th January 2024.

A Confirm and Challenge workshop will be held as part of the January Trust Executive Group where the high-level priorities of the divisions will be discussed, and Executive members will cross reference with the priorities they are aware of.

Finalisation of the plans will take place within February and produced for the March 2024 deadline in time for the NHSEI/ICB submissions April 2024.

Nottinghamshire Provider Collaborative have also been in touch to prepare a planning workshop for February 2024, where key priorities for the Nottinghamshire area will be defined, including our contributions for Bassetlaw District General Hospital. The Head of Planning and Service Developments and the Deputy Chief Executive for DBTH will feed into this process.

Doncaster Place are awaiting the national guidance, expected early January before setting out operational planning sessions within information teams, managing capacity and demand information within the system.

Business Case Support

The following major business cases (with complex values) have been supported over the last month:

- **Hydrotherapy –** This business case was reviewed at the November CIG and went on to the Charitable Funds Committee in December 2023 where it did not receive approval but the division was asked to review other potential funding opportunities and look at alternative charitable funding for the future.
- **Robotic Surgery –** This case was completed for a November CIG deadline and sent onwards to the charitable funds committee on the 7th December 2023, where approval in principle was given on the proviso that the case be split into two, one general surgery and the other urology surgery. The general surgery case was split with further information added regarding productivity and submitted to the Director of Finance. Subsequently the Charitable Funds Trustees have approved the case. The Urology case is hoped to go through governance early in 2024.
- **Stroke Rehabilitation Robotic Gym Extension –** The stroke rehabilitation robotic gym extension case was presented at the November CIG and then went onwards to December Charitable Funds Committee where it received full approval to proceed. Purchase of the therapeutic robotic suite has been

processed via an emergency PO to support a best value purchase and the capital team have commenced design and planning of the estates reconfiguration which will complete Autumn 2024.

- **2nd CT scanner at Bassetlaw –** this case was prepared for November CIG on a capital resilience basis only, however last-minute requirements from the national team to add in activity and workforce implications forced chairs action to enable an NHSE submission outside of the CIG dates in December 2023. The decision was taken after reviewing current information to submit the bid on a capital resilience basis only, with up-to-date kit and enabling capital costs and production of a workforce plan alongside the ICB/internal capacity and demand review for imagining when available.
- **Surgical Workforce –** identified via cost pressures, this case was submitted to November CIG and approved in principle with some follow up operational planning meetings, led by Dr Mallaband.

Jon Sargeant
Executive Director of Recovery, Innovation and Transformation / Chief Financial Officer
22 January 2024

2401 - E5 OPERATIONAL PERFORMANCE UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

E5 - Operational Performance Update.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**E5**
Report Title:	**Operational Performance Update**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer Lauren Bowden, Head of Performance		
Appendices:			
Purpose of report:	The report details Trust performance against the national access standards, summarises the key factors driving any underperformance, the actions in place to improve performance and identifies any risks to delivery.		
Summary of key issues:	**Emergency Care Access** • **4 hours:** In November 2023, there were 16,282 attendances to the Trust Emergency Department (ED), of these 5,499 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 66.23% against the standard of 76% • **12 hours:** In November 2023, there were 932 patients in ED > 12 hours from arrival (5.72% of attendances). • **Ambulance handover:** In November 2023, 40.9% of ambulance handovers took place within 15 minutes, 70.1% took place within 30 minutes and 87.2% took place within 60 minutes. **Diagnostics** • In November, 76.12% of patients had their diagnostic test within 6 weeks of referral, an improvement compared to 73.4% in October. **Elective Care** • **78 week waits:** There were 15 patients waiting over 78 weeks in November, a reduction of 9 compared to 25 in October. • **65-week waits:** There were 238 patients waiting over 65 weeks at the end of November, compared to 285 in October. **Cancer waiting times** • **Faster Diagnosis Standard:** In October 2023, the Trust achieved 80.8% against the standard of 75%. • **31-day from diagnosis to first definitive treatment (all cancers):** in October 2023, the Trust achieved 91% against the standard of 96%. • **62-day wait from referral from urgent referral to first definitive treatment for cancer:** in October 2023 and the Trust achieved 72.5% against the standard of 85%.		

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:	Strategic Risk 3
Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	Finance & Performance Committee		
Date:	25 January 2024	**Decision:**	Received for assurance
Next Steps:			
Previously circulated reports to supplement this paper:			

1. Introduction

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

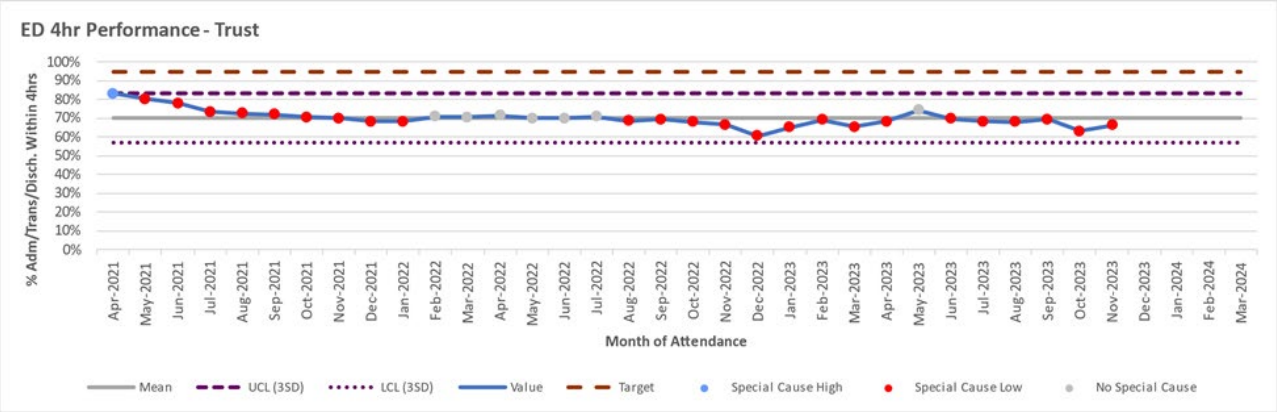
2. Background

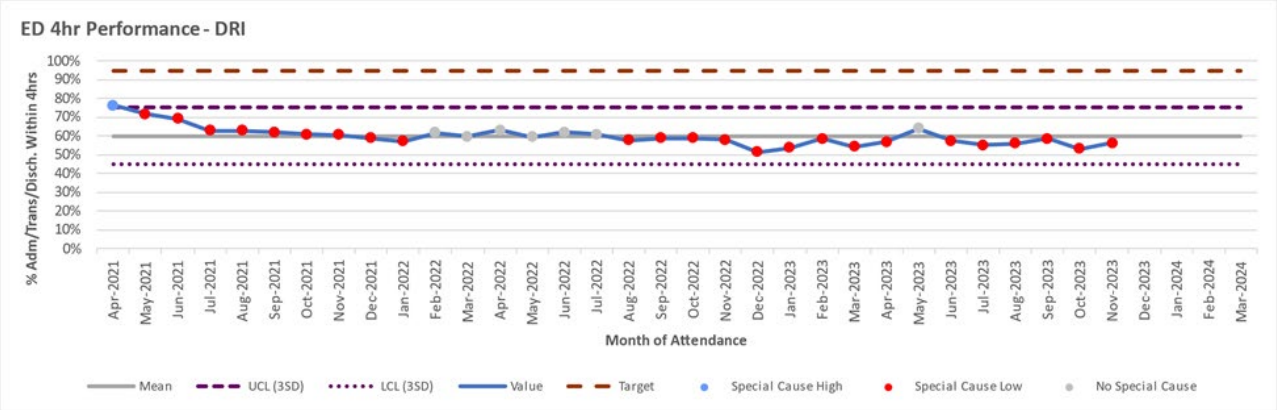
The NHS Standard Contract (2023/24) sets out the national quality requirements; these include waiting times for urgent and emergency care, diagnostics, elective care and cancer services.

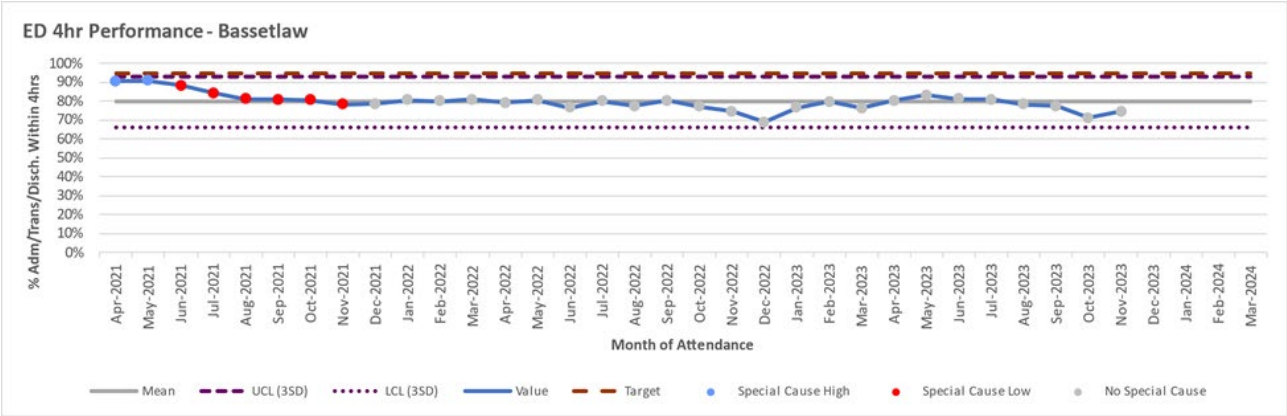
The NHS Priorities and Operational Planning Guidance summarises the national objectives for 2023/24, these include waiting time standards for urgent and emergency care, diagnostics, elective care and cancer services.

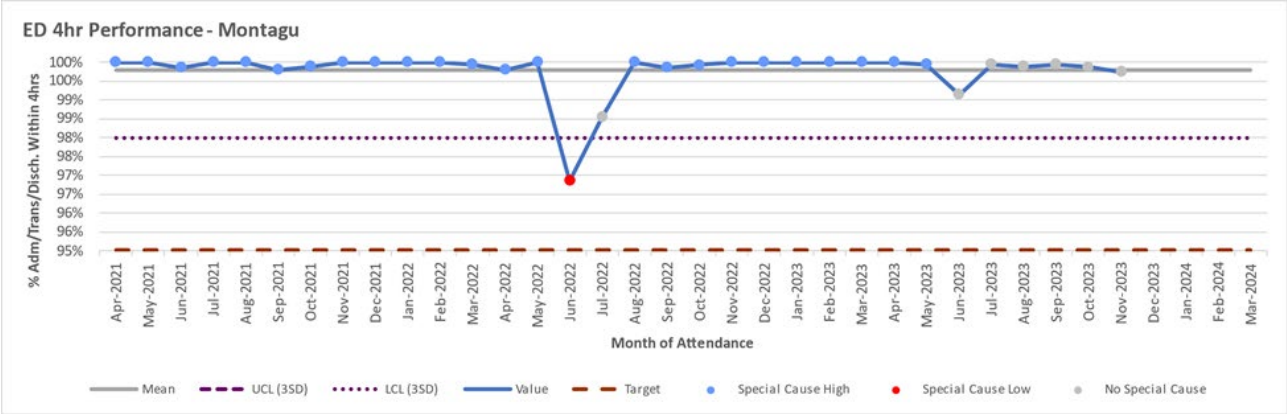
3. Emergency Care

3.1 Emergency access within 4 hours









Performance summary:

Trust: In November 2023, there were 16,333 attendances to the Trust Emergency Department (ED), of these 5,499 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 66.23% against the standard of 76%.

Bassetlaw: In November 2023 there were 5,074 attendances to BDGH ED, of these 1,290 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 74.58% against the standard of 76%.

Doncaster: In November2023 there were 9,627 attendances to DRI ED, of these 4,205 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 56.32% against the standard of 76%.

Mexborough: In November 2023 there were 1,581 attendances to Montagu Minor Injuries Unit, of these 4 patient was in the Department over four hours before admission, discharge, or transfer. Performance was 99.75% against the standard of 76%.

Key issues (new issues in red):

- Waiting for assessment in ED continues to be the main reason patients wait longer than 4 hours
- At times of peak demand, there is limited capacity in ED to assess and treat newly presenting patients, this is exacerbated by the number of patients waiting in ED for a bed
- Streaming to the primary care co-located service is < 20% of all attendances

Key actions (new actions in green):

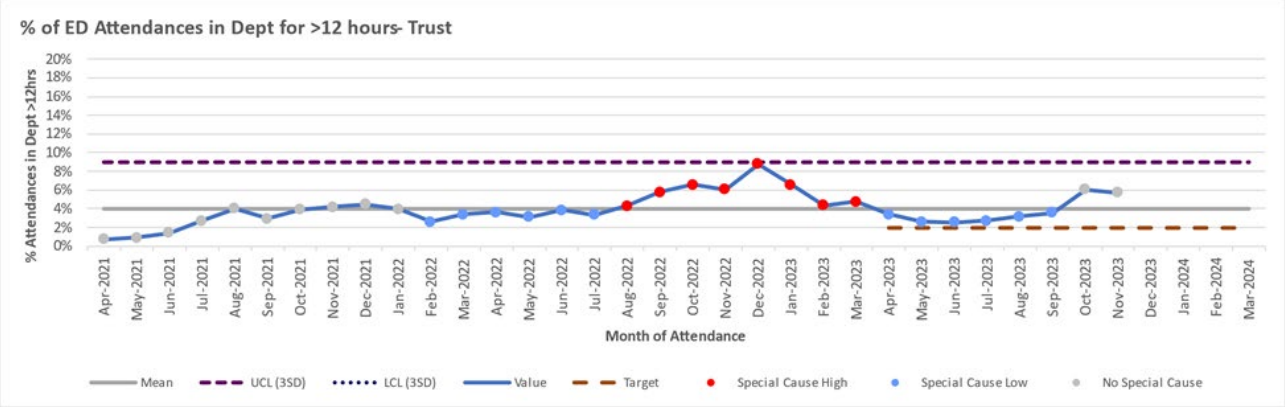
- Ensure all appropriate patients are streamed to the co-located primary care service
- Improvements in rotas to strengthen the skill mix and ensure staff numbers are matched to peak activity periods to support timely initial assessment

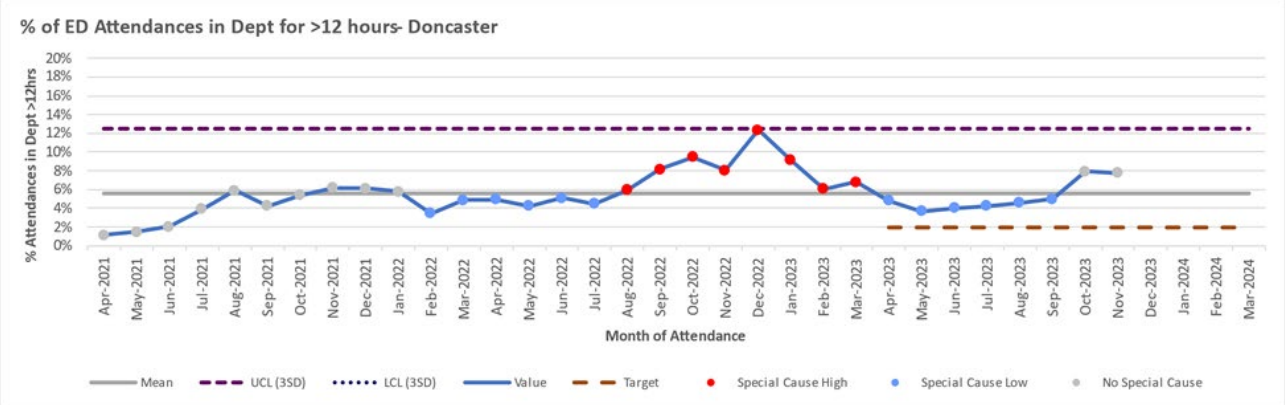
- Increased utilisation of the discharge lounge to support patient flow out of ED for patients requiring admission to a ward bed.

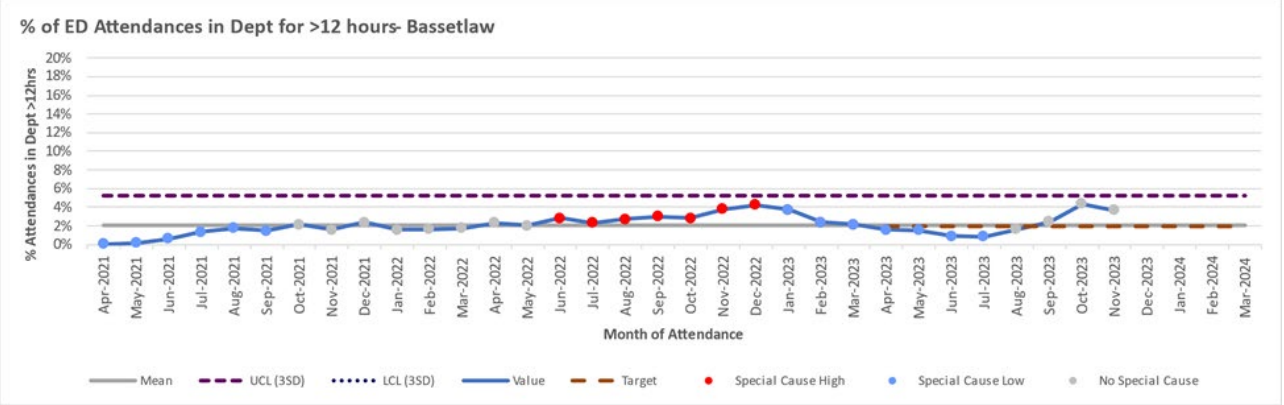
Key risks to delivery:

- Continued periods of industrial action
- Recruitment, retention and training of ED workforce to ensure appropriate skill mix to meet demand

3.2 Emergency access within 12 hours







Trust: In November 2023, there were 932 patients in ED > 12 hours from arrival (5.72% of attendances).

Bassetlaw: In November 2023, there were 185 patients in ED > 12 hours from arrival at Bassetlaw ED (3.65% of attendances)

Doncaster: In November 2023, there were 747 patients in ED > 12 hours from arrival to Doncaster ED (7.76% of attendances)

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

Key issues (new issues in red):

- A significant proportion of patients in ED > 12 hours from arrival were waiting for a medical bed
- Delays in initial assessment contribute to overall delays in ED > 12 hours

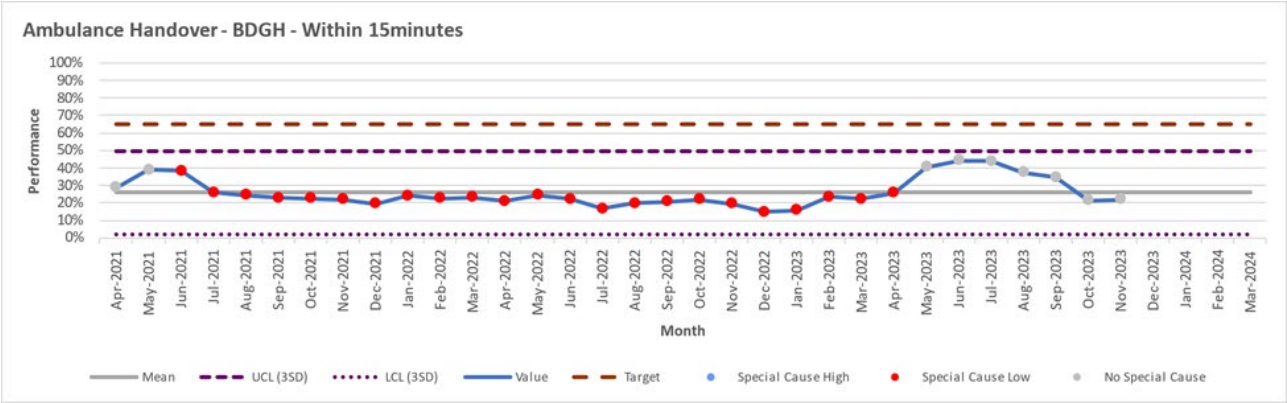
Key actions (new actions in green):

- Ensure all appropriate patients are streamed to the co-located primary care service
- Improvements in rotas to strengthen the skill mix and ensure staff numbers are matched to peak activity periods to support timely initial assessment
- Increased utilisation of the discharge lounge to support patient flow out of ED for patients requiring admission to a ward bed.

Key risks to delivery:

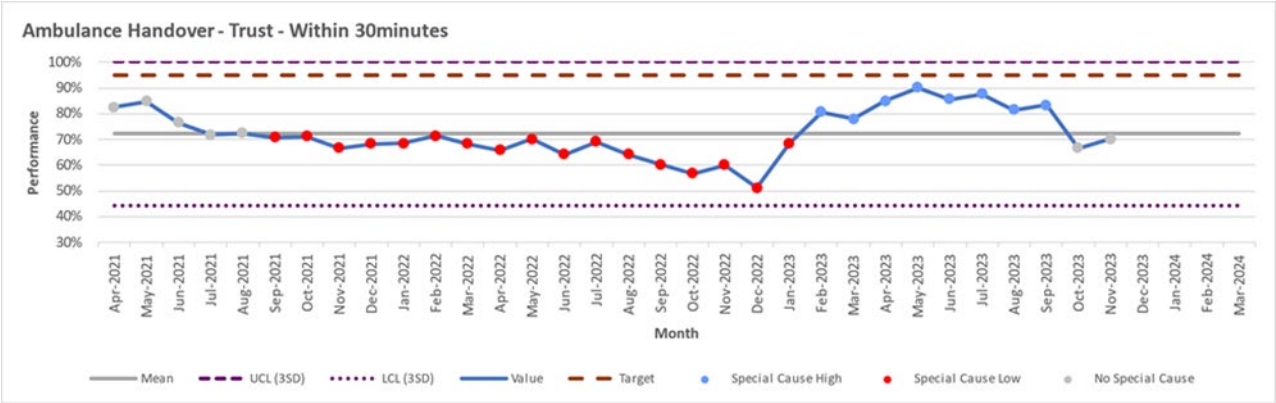
- Continued periods of industrial action
- Recruitment, retention and training of ED workforce to ensure appropriate skill mix to meet demand

3.3 Ambulance handover



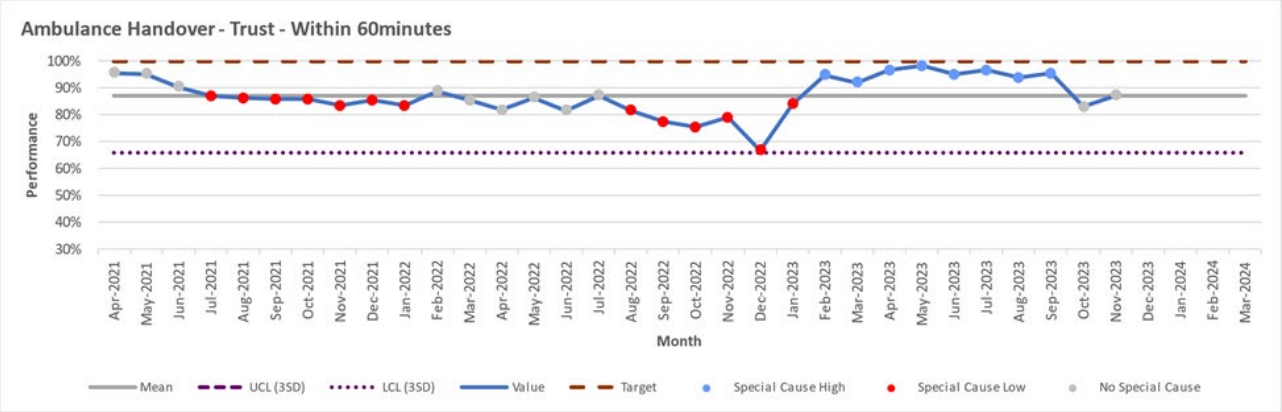
Performance Summary:

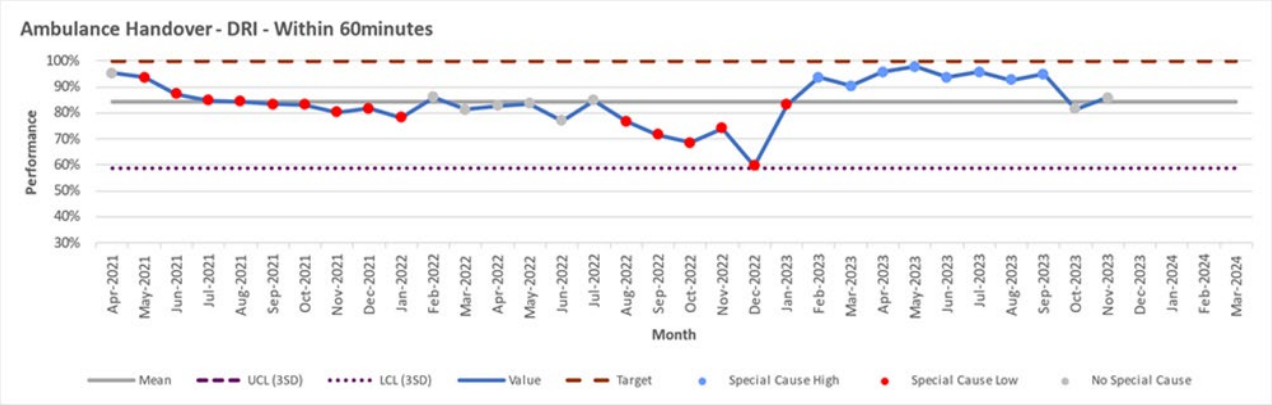
Ambulance handover within 15 minutes in November 2023 was 40.9% against the standard of 65%

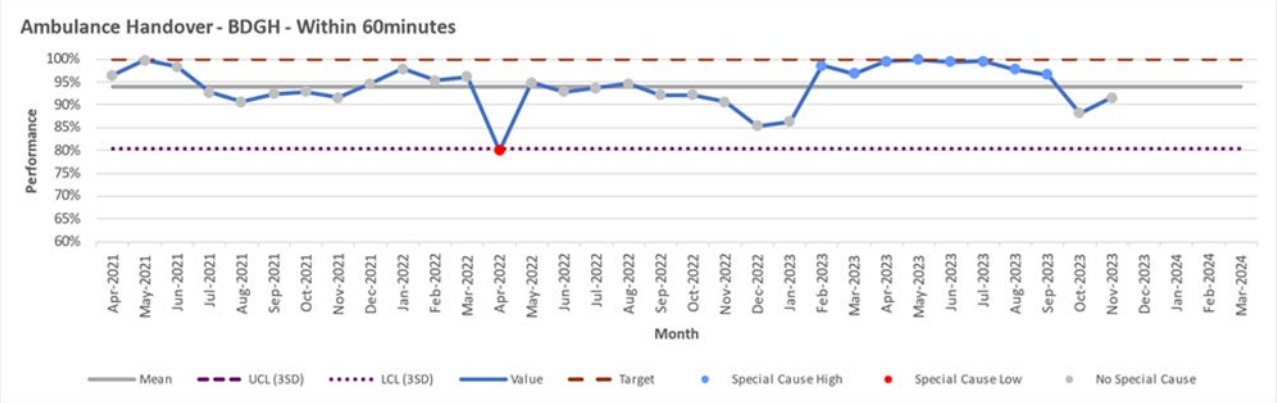


Performance Summary:

Ambulance handover within 30 minutes in November 2023 was 70.1% against the standard of 95%







Performance Summary:

Ambulance handover within 60 minutes in November 2023 was 87.2% against the standard of 100%

Key issues (new issues in red):

- 33% increase in ambulance conveyances in November 2023 (3,600) compared to November 2022 (2,708).
- Lack of capacity to take ambulance handover at times of peak demand when ED is crowded

Key actions (new actions in green):

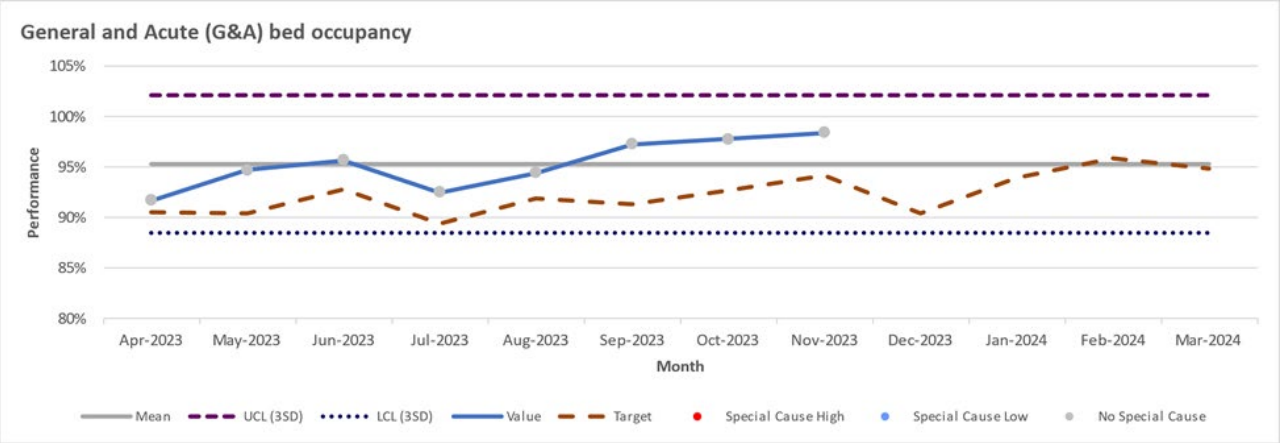
- The Early Senior Assessment model is embedded at Doncaster which enables patients waiting to be triaged and prioritised

- Collaborative working with YAS and the Trust continues, an Ambulance Resilience Co-ordinator is now in post and is based at DRI (in hours) 7 days a week
- Direct ambulance to SDEC / UTC pathways are now in place at Doncaster and Bassetlaw

Key risks to delivery:

- Continued periods of industrial action
- Continued high conveyance rates

3.4 General and Acute (G&A) bed occupancy



Performance summary:

Bed occupancy was 98% in November 2023 compared to 97.8% in October 2023.

Key issues (new issues in red):

- Underutilisation of the virtual ward
- High proportion of patients with a length of stay > 21 days
- Delays to discharge for patients on pathways 1 - 3

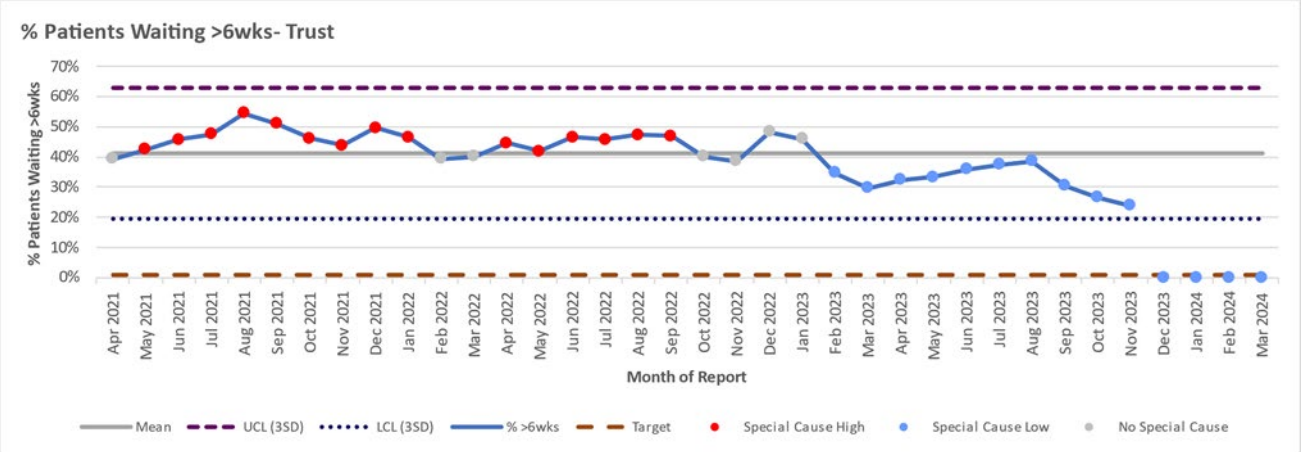
Key actions (new actions in green):

- Continued expansion of virtual ward pathways
- Weekly longer lengths of stay reviews undertaken
- Collaborative working with partners to reduce discharge delays for patients on pathways 1 – 3

Key risks to delivery:

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

4. Diagnostic waiting times



	Jul 2023			Aug 2023			Sep 2023			Oct 2023			Nov 2023		
	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks
Magnetic Resonance Imaging	3,577	1,721	48.1%	3,683	1,815	49.3%	3,010	1,140	37.9%	2,035	436	21.4%	1,563	134	8.6%
Computed Tomography	3,179	1,203	37.8%	3,203	1,508	47.1%	2,507	695	27.7%	1,512	132	8.7%	1,283	24	1.9%
Non-Obstetric Ultrasound	2,451	44	1.8%	3,055	38	1.2%	3,482	209	6.0%	3,256	401	12.3%	3,358	383	11.4%
Barium Enema	0	0		0	0		0	0		0	0		0	0	
Dexa Scan	798	361	45.2%	842	415	49.3%	834	429	51.4%	649	306	47.1%	564	219	38.8%
Audiology - Audiology Assessments	1,856	1,659	89.4%	2,082	1,745	83.8%	2,213	1,876	84.8%	2,062	1,645	79.8%	1,986	1,642	82.7%
Cardiology - Echocardiography	367	11	3.0%	324	15	4.6%	338	21	6.2%	283	2	0.7%	362	14	3.9%
Cardiology - Electrophysiology	0	0		0	0		0	0		0	0		0	0	
Neurophysiology - Peripheral Neurophysiology	229	63	27.5%	178	56	31.5%	171	19	11.1%	185	35	18.9%	236	54	22.9%
Respiratory Physiology - Sleep Studies	25	1	4.0%	32	3	9.4%	31	4	12.9%	23	2	8.7%	18	1	5.6%
Urodynamics - Pressures & Flows*	81	14	17.3%	96	10	10.4%	90	33	36.7%	90	23	25.6%	97	30	30.9%
Colonoscopy	326	0	0.0%	300	0	0.0%	299	0	0.0%	291	0	0.0%	292	0	0.0%
Flexi Sigmoidoscopy	113	1	0.9%	95	0	0.0%	114	0	0.0%	115	0	0.0%	82	0	0.0%
Cystoscopy	349	17	4.9%	394	14	3.6%	401	17	4.2%	446	15	3.4%	454	25	5.5%
Gastroscopy	281	1	0.4%	290	0	0.0%	254	0	0.0%	322	0	0.0%	283	0	0.0%
Total	**13,632**	**5,096**	**37.4%**	**14,574**	**5,619**	**38.6%**	**13,744**	**4,443**	**32.3%**	**11,269**	**2,997**	**26.6%**	**10,578**	**2,526**	**23.9%**

Performance summary:

Performance in November 2023 was 76.12%, compared to 73.4% in October 2023. The standard was achieved in the following diagnostic tests:

- CT
- Colonoscopy
- Flexi sigmoidoscopy
- Gastroscopy

A high proportion of patients waited > 6 weeks in the following diagnostic tests:

- Audiology assessments (82.7%)
- Dexa (38.8%)
- Urodynamics (30.9%)
- Neurophysiology (22.9%)

Key issues (new issues in red):

- Lack of capacity to meet demand

Key actions (new actions in green):

- A diagnostic improvement programme is in place, two of the key priorities are demand management of CT in line with clinical guidelines and effective utilisation of all diagnostic capacity

Key risks to delivery:

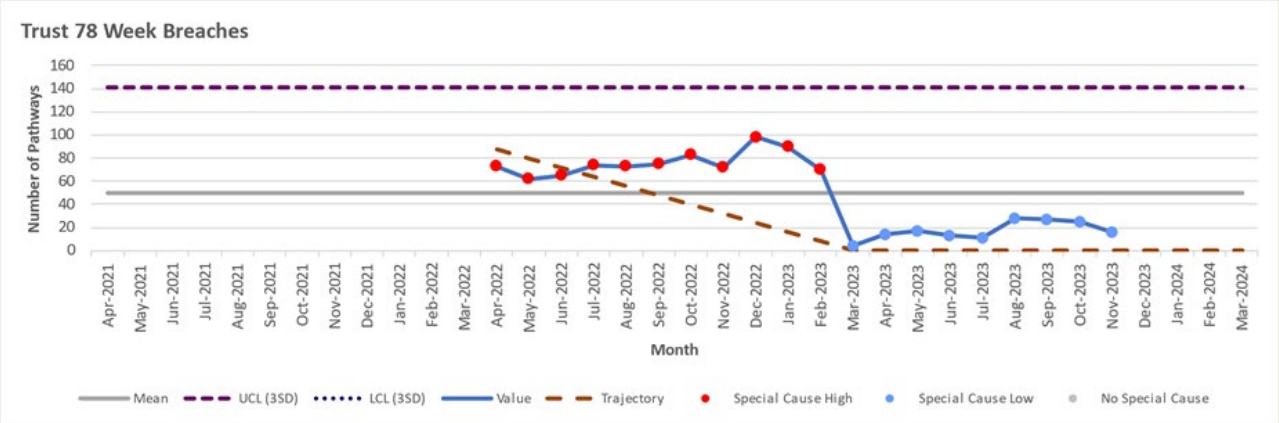
- Continued periods of industrial action

5. Elective Care

5.1 18 weeks referral to treatment

Performance in November 2023 was 61.2%, compared to 61.45% in October 2023.

5.2 Waits over 78 weeks for incomplete pathways



Performance summary:

In November 2023 there were 15 patients waiting > 78 weeks with the specialty level detail as follows:

- Trauma & Orthopaedics 7
- ENT 5
- Ophthalmology 3

Key issues (new issues in red):

- Patient choice
- National issue with lack of corneal transplant materials, patient selection is being directed by NHSBTS.
- Capacity pressures in ENT and T&O

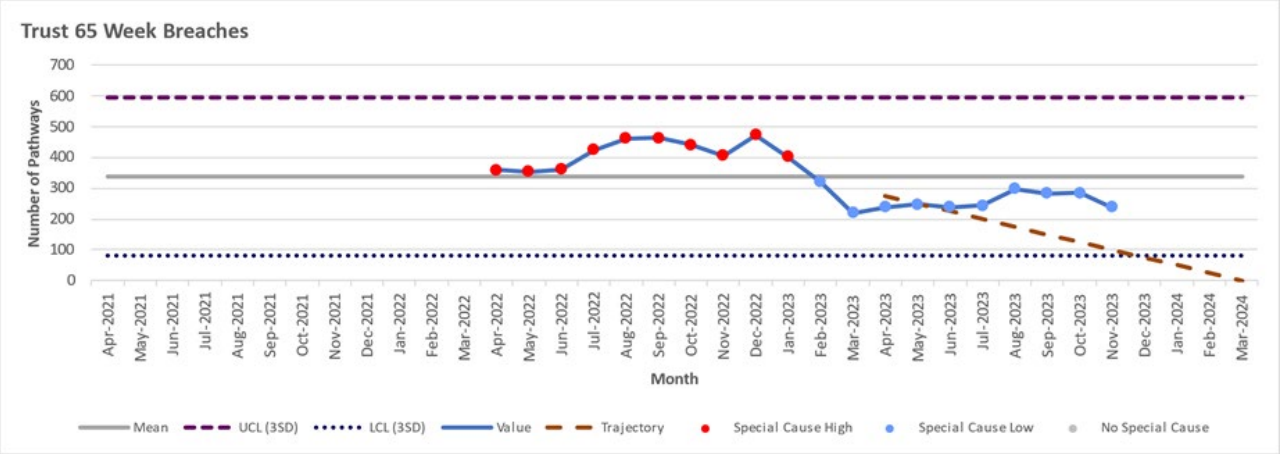
Key actions (new actions in green):

- Senior oversight of the waiting list to ensure patients are treated in order of clinical priority and long waiting times
- Additional internal capacity secured for Rhinology

Key risks to delivery:

- Further periods of industrial action
- Peaks in winter demand impacting on elective activity

5.3 Waits over 65 weeks for incomplete pathways



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22												
2022/23	359	354	362	425	462	464	441	407	473	403	321	220
2023/24	238	248	239	244	299	283	285	238				

Performance summary:

In November 2023 there were 238 patients waiting > 65 weeks.

Key issues (new issues in red):

- Senior oversight of the waiting list to ensure patients are treated in order of clinical priority and long waiting times
- Additional internal capacity secured for Rhinology

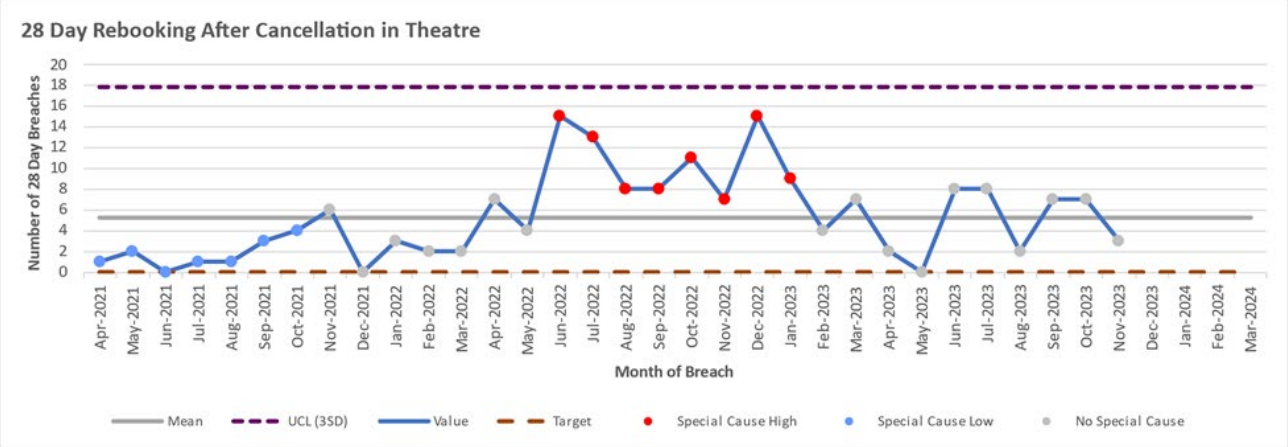
Key actions (new actions in green):

- Weekly oversight of all patients in the 65 week cohort
- Utilisation of capacity for clinically urgent and longest waiting patients

Key risks to delivery:

- Further periods of industrial action
- Peaks in winter demand impacting on elective activity

5.4 Breaches of the 28 day guarantee



Performance summary:

There were 3 breaches of the 28-day guarantee in November 2023, all were patients for Trauma & Orthopaedic surgery, two cases at Doncaster and one at Bassetlaw.

Key issues (new issues in red):

- Capacity to reschedule patients with 28 days.

Key actions (new actions in green):

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

Key risks to delivery:

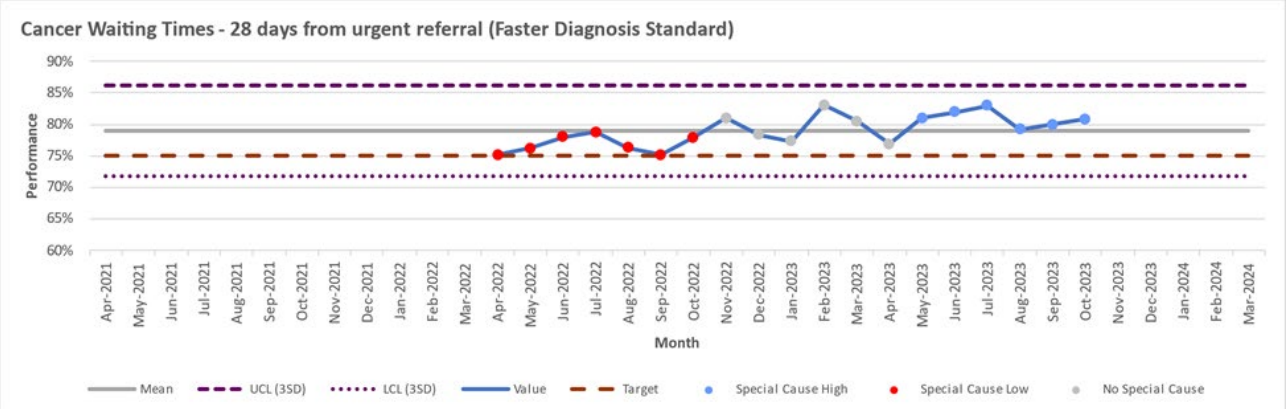
- Further periods of industrial action
- Peaks in winter demand impacting on elective activity

5.5 Urgent operations cancelled for a second time

There were no urgent operations cancelled in November 2023 for a second time.

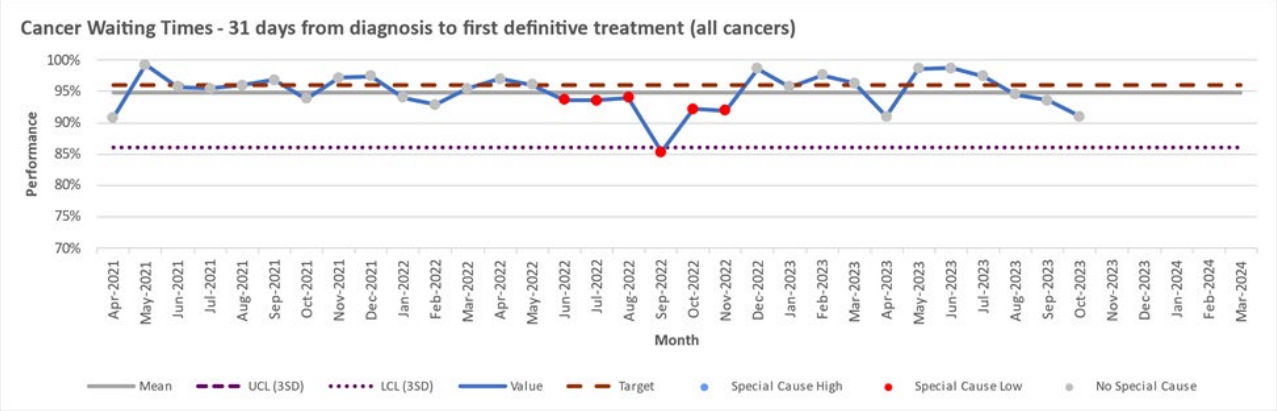
6. Cancer Waiting Times

6.1 28 days from urgent referral to receiving a communication of diagnosis for cancer or ruling out of cancer



Performance in October 2023 was 80.8% against the standard of 75%.

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



Performance summary:

Performance in October 2023 was 91% against the standard of 96%. Of the 167 patients, 15 were not treated within 31 days of diagnosis, as detailed below:

- Gynaecology 1 patient
- Lower GI 2 patients
- Skin 9 patients
- Urology 3 patients

Key issues (new issues in red):

- Gynaecology – patient choice for first outpatient at day 23 and surgery rearranged due to industrial action
- Lower GI – lack of elective capacity
- Skin – increased referral demand and impact of industrial action
- Urology – lack of elective capacity

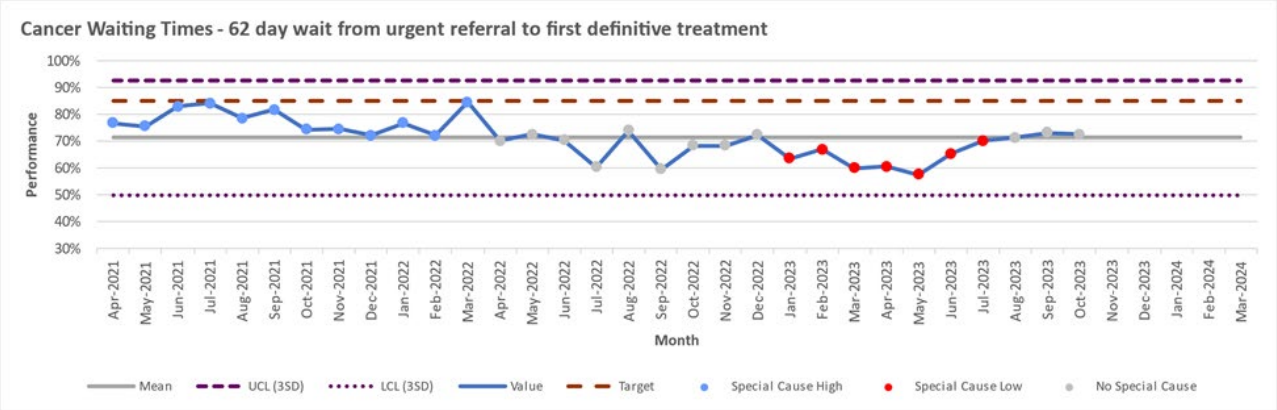
Key actions (new actions in green):

- No new actions identified, performance back on track following industrial action

Key risks to delivery:

- Further periods of industrial action
- Peaks in winter demand impacting on elective activity

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



Performance summary:

Performance in October 2023 was 72.5% against the standard of 85%. Of the 91 patients, 25 were not treated within 62 days of referral, as detailed below:

- Breast 0.5 breaches (1 patient)
- Gynaecology 8 breaches (10 patients)
- Haematology 1 breach (1 patient)
- Head & Neck 2 breaches (3 patients)
- Lower GI 4.5 breaches (3 patients)
- Skin 1.5 breaches (2 patients)
- Upper GI 1 breach (2 patients)
- Urology 6.5 breaches (8 patients)

Key issues (new issues in red):

- Complex diagnostic pathways and diagnostic capacity
- Patient choice Complexity of patient management and diagnostics
- Tertiary centre capacity
- Histology delays

Key actions (new actions in green):

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

Key risks to delivery:

- Further periods of industrial action
- Peaks in winter demand impacting on elective activity

7. Recommendations

The Trust Board of Directors is asked to receive the report for ASSURANCE.

2401 - F STRATEGY

2401 - F1 RESEARCH & INNOVATION STRATEGY UPDATE

Discussion Item | Zoe Lintin, Chief People Officer | 11:55

Professor Sam Debbage, Director of Education & Research
Dr Jane Fearnside, Head of Research
10 minutes

REFERENCES

Only PDFs are attached

F1 - Research and Innovation Strategy Update.pdf

F1i - Research and Innovation Strategy Update.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**F1**
Report Title:	**Research and Innovation Strategy update**		
Sponsor:	Zoe Lintin, Chief People Officer Lucy Nickson, Non-Executive Director		
Author:	Sam Debbage, Director of Education and Research Jane Fearnside, Head of Research		
Appendices:	Presentation		

Report Summary

Executive Summary

The presentation provides an update on the progression against the R&I strategy (approved by the Trust Board in January 2023). An external formal launch (with key academic, health, and research partners) was well received in June 2023. This was quickly followed with a complementary (specific) Nursing, Midwifery and Allied Health Professional Research and Innovation Framework.

The Teaching Hospital Board remains instrumental in the continued engagement with key partners across the place and with our South Yorkshire ICB Universities.

DBTH continues to be recognised as a strategic and responsive partner with the two ICBs (around the R&I agenda). We have purposively considered R&I within the most recent and innovative health developments including the Community Diagnostic Centre and the Mexborough Orthopaedic Centre of Excellence

Key successes to date include:

- Development of a Doncaster place-based approach to public involvement (community voices)
- Collaborative working with the Doncaster Health Determinants Research Collaborative (HDRC)
- Fulfilling our NIHR Clinical Research Network contract
- Maximising the Associate Principal Investigator schemes
- Growth in Maternal and Child Health portfolio including the establishment of our first Secure Data Environment (for our Born and Bred in Doncaster data)
- Developing R&I aligned to the Core20plus5 opportunities
- Highest recruiting site in the UK for the Magnet for Europe study (Principal Investigator: Karen Jessop, Chief Nurse)
- Highly commended for adopting the M21 Child constipation study

The priority for 2024/25 is the development of a comprehensive business model to deliver years 1 to 5 of the R&I strategy including continued expansion of the existing NIHR CRN research contract. The ambition remains to be recognised as a University Teaching Hospital (6% Consultant workforce in substantive joint Clinical Chair posts – this equates to approximately 20 and is contingent on sponsorship capabilities, job planning, MoUs; Research Capacity Funding (CRF) income of £200K per annum; and Research Excellence Framework (REF) returnable research).

Recommendation:	The Board is asked to support and acknowledge the activity across research and innovation.			
Action Require:	~~Approval~~	~~Discussion~~	**Take assurance**	**Information only**
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	***Everybody knows their role in achieving the vision***	***Feedback from colleagues and learners is in the top 10% in the UK***	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	BAF updated to reflect R&I strategy
Risk register:	N/A
Regulation:	N/A
Legal:	N/A
Resources:	Business model to be developed during 2024/25

Assurance Route	
Previously considered by:	Aspects discussed at People Committee, Teaching Hospital Board and Trust Executive Group
Date:	July 2023
Any outcomes/next steps	Detailed assurance provided through the People Committee. Full business case to determine level of investment and reporting process.
Previously circulated reports to supplement this paper:	N/A

Research and Innovation update

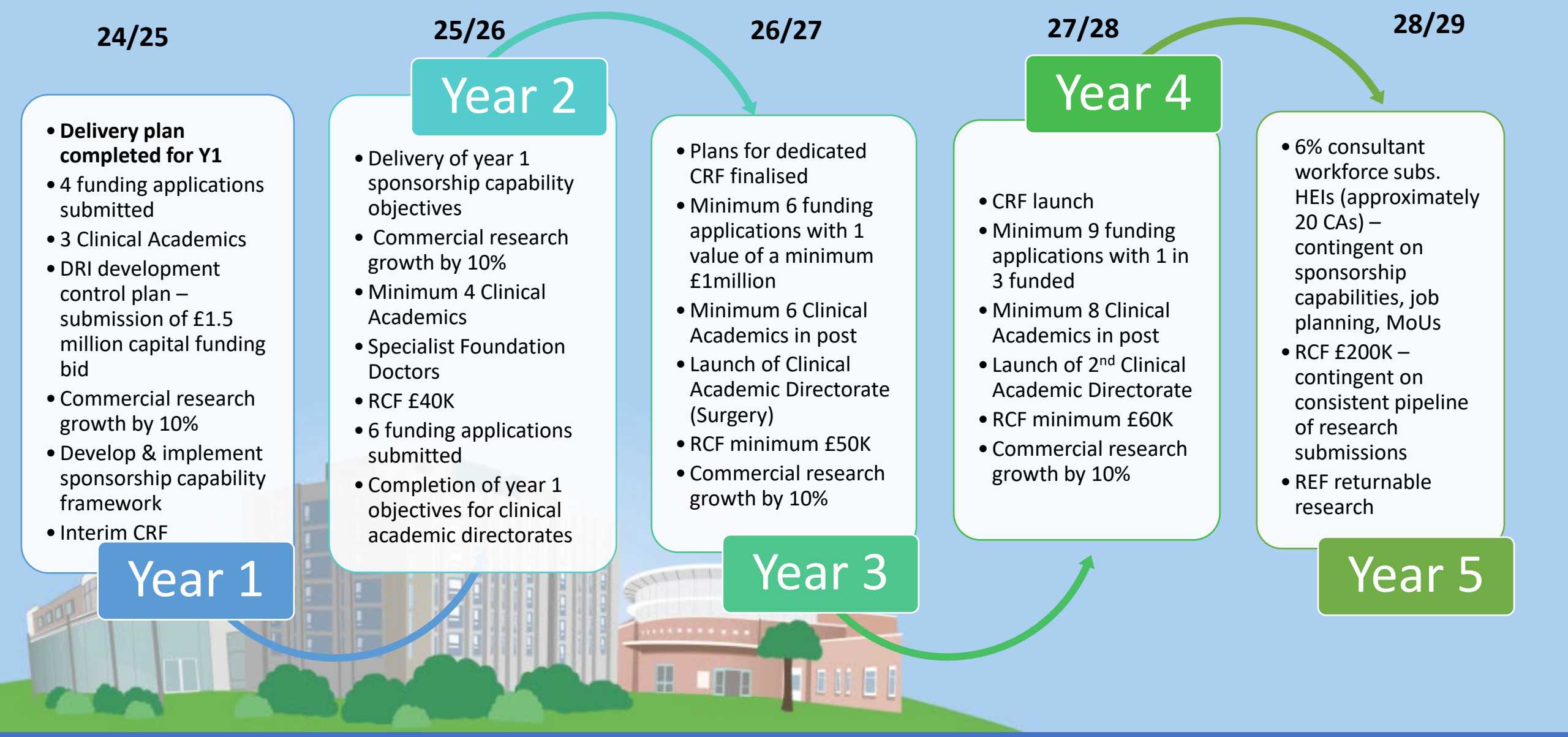
Professor Sam Debbage, Director of Education and Research
Dr Jane Fearnside, Head of Research

- University Teaching Hospital status
- Launch of R&I Strategy June 2023
- Growth of place-based R&I activity
- Working across the system
- Emerging opportunities for R&I growth

Key achievements

- Fulfilling our NIHR Clinical Research Network contract
- Maximising the Associate Principal Investigator scheme
- Growth in Maternal and Child Health portfolio
- Core20plus5 opportunities

Key achievements



Achieving our milestones

www.dbth.nhs.uk

Embedding our community voices at place

- Initial set up with DBTH, City of Doncaster Council and RDaSH to support and grow place based public involvement and community engagement
- Hosted by HDRC with membership from across the region with representatives from Ethnic Minority Research Inclusion (EMRI), Clinical Research Network (CRN), SY ICB
- Aims to grow a research ready community building on resources such as Community Connectors, Well Doncaster data repository, facilitator training and reverse mentoring
- Community event planned for Spring 2024 to showcase outputs

Embedding our community voices with in DBTH

The Magnet model

Aim – To obtain Magnet accreditation

- Portfolio research study
- Twinned With Hackensack in the U.S
- Evaluate hospitals against 74 standards

Involved

- Devising councils to be led by frontline nursing staff.
- Completing multiple staff surveys
- Completing multiple gap analysis

Results

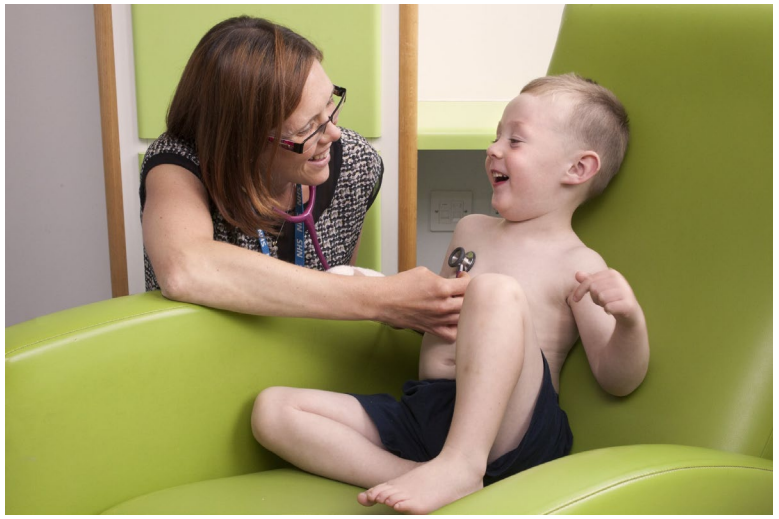
- Feasibility rather then accreditation
- National Learning collaboration and benchmarking
- Implementation of Shared Governance across all 3 sites.
- Implement Trust and Staff benefits

Highest recruiting site in the UK

Case Study: Magnet for Europe

www.dbth.nhs.uk

- Supports the Trust's ambition to improve child health
- New Principle Investigator to support commercial research & strategic priority
- European First Screened Patient
- Significant commercial income for DBTH
- Patient benefit: "the study has enabled access to tests that we have been waiting on the NHS for ages. It has been a relief to rule out other conditions." Parent quote.



Case Study: Commercial Research, M21 Child Constipation study

Thank you, any questions?

2401 - F2 DONCASTER & BASSETLAW HEALTHCARE SERVICES LTD UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

F2 - Doncaster & Bassetlaw Healthcare Services Ltd Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page				
Meeting Title:	**Board of Directors**			
Meeting Date:	30 January 2024		**Agenda Reference:**	**F2**
Report Title:	**Doncaster and Bassetlaw Healthcare Services Update**			
Sponsor:	Jon Sargeant, Director - Doncaster and Bassetlaw Healthcare Services Ltd Mark Bailey, Chair - Director - Doncaster and Bassetlaw Healthcare Services Ltd			
Author:	Mark Olliver, Managing Director - Doncaster and Bassetlaw Healthcare Services Ltd			
Appendices:	None			
Executive Summary				
Purpose of report:	To provide the Board of Directors with an update on current financial performance and operational matters of interest			
Summary of key issues:	**Financial Summary** • Doncaster and Bassetlaw Healthcare Services is performing favourably to budget • The pre-tax profit position currently sits at 79k, against a budget of 37k • Costs are controlled effectively, with admin expenses favourable to budget by 92k **Operational Matters** Following attendance at the Charitable Funds Committee, Doncaster and Bassetlaw Healthcare Services is now supporting the Trust in developing a compelling charity offer			
Recommendation:	The Board is asked to note and take assurance from the report.			
Action Required:	~~Approval~~	~~Discussion~~	**Take Assurance**	**Information**
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving our vision*	*Team DBTH feels valued and feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	Not applicable
Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	Not applicable		
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

1. EXECUTIVE SUMMARY

This briefing document aims to provide the Trust Board with an update on the performance of Doncaster and Bassetlaw Healthcare Services.

The board are asked to note the dividend payment of 250k, made to Doncaster and Bassetlaw NHS Foundation Trust. This payment highlights the performing strength of Doncaster and Bassetlaw Healthcare Services. The Subsidiary Board expect this performance to continue in both the medium and long term, utilising the new strategic framework currently in place.

2. FINANCIAL UPDATE

Table 1 – Year to date trading performance for Doncaster and Bassetlaw Healthcare Services

Year to date (£k)	Actual	Budget	Variance
Turnover	7,323	7,426	(103)
Cost of Sales	(6,721)	(6,773)	52
Gross Profit	**602**	**653**	**(51)**
Admin Expenses	(524)	(616)	92
Profit before tax	**79**	**37**	**41**
Tax	(17)	(10)	(7)
Profit after tax	**61**	**27**	**34**

Table 2 – Assets and Liabilities register

As at 31st December 2023	
Current Assets	£k
Inventory	399
Accounts Receivable	1,705
Prepayments	705
VAT Receivable	468
Cash	233
Total	**3,510**
Current Liabilities	
Accounts Payable	1,877
Accruals	867
Corporation Tax payable	31
Intercompany	66
Total	**2,841**
Net Assets	**669**
Share Capital	550
I&E Reserve	119
Total Capital Employed	**669**

From a financial perspective, Doncaster and Bassetlaw Healthcare Services continues to demonstrate good financial grip. The business presents an extremely proficient level of control over non-pay expenditure and this has been consistent over all trading years since incorporation.

3. STRATEGIC PLAN 2023-26

WOS Strategic Plan 2023-26				
Purpose				
Inspiring and supporting NHS Trusts, Health Organisations and Communities to deliver innovation and operational excellence				
Strategic Pillars				
Pharmacy Excellence	**Education and Resource**	**Homecare Services**	**Digital Innovation**	**Social and Charitable Cause**
		Expand		
Multi site expansion	QIMET A@E Partners	Metoject pilot	Smart ER pilot rollout	Consultancy and support
Tender successes	QIMET speciality expansion	Metoject rollout	Smart ER development	
Delivery service excellence	Gastro/Gynacology			
E prescribing implementation	QIMET partner Trust focus			
		Explore		
Enhanced service provision	QIMET expansion international	Service Exploration	Identify digital concepts	Volunteering opportunities
Digital Innovation	Develop new courses	Homecare Agency status	Align with technical partners	Links with Universities
JV and Partnerships	Enhanced University focus	Logistical abilities and	Conduit for digital healthcare	Community Partnerships
Remote Pharmacy provision	Recruitment Agency 'niche'	service implications	Dr Online Pharmacy with partners	NHS Charitable return
Wholesale activities		Other private services	Identify and initiate innovation	
			through stakeholder management	
		Financial Consideration		
Parent Trust priorities	Resource expenditure NHS	Current Trust expenditure	Cost pressures within the NHS	Commercial innovation to
wider NHS implications	Current resourcing shortfall	Resource requirements		maximise revenue
Future ICB activity	Target Trusts	In house expertise		
		Enablers		
Stakeholder Management	Stakeholder Management	Stakeholder Management	Stakeholder Management	Stakeholder Management
Trust Prescribing policies local	Tactical Networking	Medical Director recruitment	Digital commercial partners	Trust collaboration
Trust departmental support	NHSi case studies	CQC alignment	Business credibility	Workforce NHS scheme
	Recruitment events and visibility	Current ICB plans	Investment / Equity purchase	Charity collaboration
		Links to primary care		
		Reasoning		
Clinical Excellence	Support NHS resourcing activity	Exploit private healthcare	New Age healthcare	Trust charity revenue
Seamless care	Collaboration	Financial efficiency	Patient centric approach	Brand awareness
	Social Impact	Market opportunities	Health promotion in modern era	
	Brain share between borders			
	Brand development			

4. STRATEGIC OPERATIONS

Following the realignment of the strategic plan (presented above), the business Senior Leadership Team SLT are now working to convert this into a robust annual operations plan. Good progress is already being made across the 5 strategic pillars and the board are asked to note some highlights listed below:

Pharmacy excellence and homecare services

The business is currently working with the Trust pharmacy team to improve both financial and clinical efficiencies across homecare services. Initial operational trials concerning the supply of Metoject injections, within the rheumatology department, have been very successful. As a result, discussions are now taking place to explore further services, including but not limited to some homecare services within haematology.

Education and Resource

Initial conversations have taken place with the Trust Education, Research and Innovation Team, to discuss potential alignment opportunities with Doncaster and Bassetlaw Healthcare Services. In particular, it was highlighted that the current Mediplex contractual arrangement is not necessarily demonstrating best value or efficiency (for the department). Following conversation, Doncaster and Bassetlaw Healthcare Services offered to review the existing arrangement and contract. Once documents have been received, the business will assess the existing commercial arrangement and, where possible, offer competitive solutions.

5. SOCIAL AND CHARITABLE CAUSE

To support in the delivery of this strategic pillar, Doncaster and Bassetlaw Healthcare Services attended the Charitable Funds Committee in December 2023 and presented a paper accordingly.

The paper provided an alternative solution for the charity, one where the business would effectively manage the day-to-day operations of the charity.

Following discussions, an agreement was made and the business is now supporting a 'Task and Finish' group to implement the changes as appropriate.

It is expected that full operational accountability will begin from 1st April 2024. To support this cause, the Managing Director is currently working up the following:

- Job description and person specification for the 'Head of Charity' role
- Recruitment process for the 'Head of Charity' role
- Building Service Level Agreement documents for all functional support teams at the Trust that provide charity services i.e. Finance and Communications/Marketing
- Creating a suite of outcomes and/or measures, to demonstrate business performance and accountability.

6. CONCLUSION

Doncaster and Bassetlaw Healthcare Services continues to look for opportunities of growth and expansion. Through the new strategic framework, an operational plan is being developed to support the focused and timely delivery of the 5 strategic pillars.

The business continues to evidence strong financial management and the board are now committed to taking the business to the next level. Through continued alignment with the Trust, the business can and will support Doncaster and Bassetlaw Teaching Hospitals Foundation Trust in delivering improved efficiencies and focussed innovation.

Mark Olliver
MD Doncaster and Bassetlaw Healthcare Services
January 2024

2401 - G GOVERNANCE & ASSURANCE

2401 - G1 TRUE NORTH, BREAKTHROUGH & CORPORATE OBJECTIVES Q3 2023/24

Discussion Item | Richard Parker OBE, Chief Executive | 12:05

10 minutes

REFERENCES

Only PDFs are attached

- G1 - True North Breakthrough & Corporate Objectives Q3 2023-24.pdf
- G1 - Appendix 1 Q3 Executive Objectives.pdf
- G1 - Q3 Executive Objectives.xlsx

Report Cover Page				
Meeting Title:	**Board of Directors**			
Meeting Date:	30 January 2024	**Agenda Reference:**	**G1**	
Report Title:	**True North, Breakthrough and Corporate Objectives 2023/2024- Quarter 3**			
Sponsor:	Richard Parker OBE, Chief Executive Officer			
Author:	Richard Parker OBE, Chief Executive Officer			
Appendices:	Appendix 1 Q3 Executive Objectives			

Report Summary				
Executive Summary This paper provides the quarter 3 update to the Board of Directors on progress towards the delivery of the 2023/24 Corporate Objectives.				
Recommendation:	The Board of Directors is asked to note the content of the paper and appendix and advise on any changes, or actions, which may need to be taken to ensure that delivery of the objectives ensure that progress is being made towards the delivery of the Trusts Strategic Vision and the risks identified in the Board Assurance Framework.			
Action Require:	Approval	**Discussion**	~~Take assurance~~	~~Information only~~
Link to True North Objectives:	**TN SA1:** ***To provide outstanding care and improve patient experience***	**TN SA2:** ***Everybody knows their role in achieving the vision***	**TN SA3:** ***Feedback from staff and learners is in the top 10% in the UK***	**TN SA4:** ***The Trust is in recurrent surplus to invest in improving patient care***
Is the content of this paper is aligned to the strategic direction of:	**South Yorkshire ICS** Delivery of the Corporate Objectives supports the delivery of ICB and System priorities.		**Nottingham & Nottinghamshire ICS** Delivery of the Corporate Objectives supports the delivery of ICB and System priorities.	

Implications	
Board assurance framework:	The Corporate objectives reflect the work needed to deliver the Board of Directors strategic direction and mitigate known and reasonably foreseeable risks.
Risk register:	Delivery of the Corporate Objectives for 2023/2024 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2023/2024 identify actions which will be taken to maintain and improve, the Trusts CQC Good rating at the next assessment. Demonstrating compliance with the standards expected to be achieved for a *Good* rating in the Safe Domain and an *Outstanding* rating in the Caring Domain.
Legal:	The Corporate Objectives for 2023/2024 aim to maintain the Trusts progress and compliance with statutory responsibilities.

Resources:	The resources needed to deliver the Corporate Objectives for 2023/2024 were identified as part of the planning processes for 2023/2023.
Assurance Route	
Previously considered by:	Executive Team. Corporate Objectives are reviewed at Board Committees and aligned to the Board Committees review of the BAF prior to quarterly submission to the Board of Directors.
Date: Board Committees	
Any outcomes/next steps	Specific Objectives will be reviewed at Board Committees with overall progress reported to the Board of Directors: • Quarter 3 - January 2024 • Quarter 4 - April 2024
Previously circulated reports to supplement this paper:	2023/2024 Corporate Objectives, True North and Breakthrough Objectives, Board of Directors Papers, and Performance Reports.

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the progress which has been made during quarter 3 towards the delivery of the 2023/24 Corporate Objectives.

2. BACKGROUND

During quarter 3 (Q3) the previously identified challenges have continued with a significant period of industrial action immediately after the Christmas and New Year period. Industrial action continues to impact upon the work to restore activity and waiting times to the pre pandemic levels.

In addition to the previously reported work which has been undertaken within the Trust and with partners across our two integrated care systems, and Places on Urgent and Emergency Care recovery, Elective and Diagnostic recovery and Cancer Recovery work was concluded on the system, Place and local winter plans. With the limited opportunity to increase the acute bed bases at DRI and BDGH the key feature of the winter plan has been to ensure flow through the emergency departments and discharge pathways.

During quarter 2 the Trust underwent an unannounced and well led inspection by the CQC which involved Maternity, Emergency Care, Medicine, Surgery and Cancer services and Diagnostics and Imaging. At the time of writing the draft report for factual accuracy checking remains outstanding but once received will provide confirmation of the current position in respect of whether the Trust has achieved the objective of maintaining, and/or improving the CQC rating; demonstrating compliance with the standards expected to be achieved for a *Good* rating in the Safe Domain and an *Outstanding* rating in the Caring Domain.

In addition to the submission of a quarterly update to the Board of Directors on progress on the delivery of the objectives and alignment to the BAF the Board's Committees; Finance and Performance (F&P), Quality and Effectiveness (QEC), People Committee (PC), Charitable Funds Committee (CFC) and Audit and Risk Committee (ARC), continue to ensure that delivery is subject to assurance and where required escalation.

3. PROGRESS DURING Q3

The progress the CEO and each Director has made towards the delivery of their agreed objectives are identified in appendix 1. At the end of Q3 4 objectives are assessed as complete with all other objectives assessed as on track.

4. RECOMMENDATIONS

The BoD is asked to discuss the contents of this paper and appendix 1 and advise upon any necessary amendments to improve the delivery of the Trusts True North.

CEO BREAKTHROUGH & EXECUTIVE OBJECTIVES 2023/2024

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Name: CEO Breakthrough Oversight Objectives	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Ensure that the completion of internal audit actions achieve the standard required to demonstrate significant assurance	Richard Parker	CEO01	ARC	Oversight objective for SA1 (DCEO lead for objective delivery)	30/01/2024			Progress on delivering the agreed actions from internal audit reports is being maintained with an 82% follow up rate and an 86% implementation of actions rate. Discussions related to the 23/24 internal audit programme are underway and it is expected that the final programme will reflect the previously identified areas, closure of previously identified actions and feedback from the recent CQC inspection programme	On track	The current first follow up rate is 69% with the overall implementation rate at 81% (10/1/2024). Five actions have fallen due in the quarter and action is being taken to ensure closure and to ensure delivery of the required follow up actions.	On track
Ensure that the Trust maintains a clear focus on the delivery of safe and sustainable services and with Place and System partners has robust plans to manage the expected pressures of the winter period	Richard Parker	CEO02	BOD	Oversight objective for SA1 (DCEO lead for objective delivery)	30/01/2024			Work continues within both Integrated Care Systems and Places to deliver a robust winter plan to reduce the known and reasonably foreseeable risks associated to the delivery of urgent and emergency care, surgical and diagnostic recovery and the health and wellbeing of colleagues. Key programmes of work include the use of virtual wards, morning discharges to maintain flow, admissions avoidance, and reductions in the number of patients who experience delayed transfer of care once medically fit for discharge.	On track	Despite a significant increase in ambulance conveyance rates, very high levels of bed occupancy and significant industrial action performance metrics are better than at the same point in 22/23.	On track
Ensure that a structured programme of development and team building is in place to facilitate a high performing Executive team	Richard Parker	CEO03	PC	Oversight objective for SA2 &SA3 (CPO lead for objective delivery)	30/01/2024			A facilitated Team building programme is in place.	On track	Executive Director Team building is in place with regular time allocated to facilitated development sessions.	Complete
Ensure that the Trust has appropriate succession planning and leadership development in place to ensure business continuity across all key Executive, Director, and Senior Leadership roles	Richard Parker	CEO04	PC	Oversight objective for SA2 &SA3 (CPO lead for objective delivery)	30/01/2024			Work is being undertaken to establish robust programmes to support delivery of this objective and acting up, and business continuity cover is identified for each Executive Director.	On track	The work to strengthen the Trusts development offer across the Trust is moving forward and the work on succession planning is being enhanced with the commencement of 'scope for growth' conversations which will be incorporated into the 24/25 appraisal process.	On track
To build upon the successes of internal and external communication & health and well-being support to develop a modern business as usual approach to colleague and public involvement and engagement	Richard Parker	CEO05	PC	Oversight objective for SA2 & SA3 (CPO lead for objective delivery)	30/01/2024			The Trust has a comprehensive programme and suite of support offers and has recently been shortlisted for national awards. Most recently the comms Team have been nominated for the Best In-house team for the corporate communications aware 2023 with other shortlisted teams coming including Ikea, YouGov and Adidas. DBTH are the only shortlisted team from the NHS.	On track	As reported to the Board the Trust has seen a significant increase in external recognition across a number of areas with proactive communication internally and externally. The winter communication programme continues.	On track
Ensure that the positive work which happens across the Trust is increasingly recognised at local and national level	Richard Parker	CEO06	PC	Oversight objective for SA2 & SA3 (DCEO lead for objective delivery)	30/01/2024			In 2023 the Board is aware that the Trust has been shortlisted for a number of local and national awards.	On track	As reported to the Board the Trust has seen a significant increase in external recognition across a number of areas	On track
To ensure that the Trust works with System, Place and elected representatives to identify a deliverable program of work which reduces the risk associated to the infrastructure, and provides modern, fit for purpose facilities for patients and colleagues	Richard Parker	CEO07	F&P	Oversight objective for SA4 (DOF & COO leads for objective delivery)	30/01/2024			Work to develop appropriate plans and cases for funding continues and a business case has continued, and with advice from colleagues at the Department of Health and Social Care, NHSE and the Integrated Care System a specific business case is being prepared for additional capital to support the reduction of back log maintenance.	On track	The work on options for the development of the DRI site have continued alongside of the delivery of major capital schemes to enhance patient care; Bassetlaw Emergency Care Village. Mexborough Elective Orthopaedic Centre and the Mexborough Community Diagnostic Centre. South Yorkshire and Bassetlaw Pathology Final Business case approved by all of the Acute Trusts.	On track
Work with partners to ensure the delivery of the Acute Federations commitment to maximise the benefits of Electronic Patient Records	Richard Parker	CEO08	F&P	Oversight objective for SA4 (DOF & COO leads for objective delivery)	30/01/2024			The Trust is working with all of the Acute Trusts in South Yorkshire to develop an ICS wide EPR solution with maximises the use of resources to enhance the quality and safety of patient care.	On track	Partnership with a purpose' work at our PLACE's and ICB's continue and Q3 has seen the approval of the South Yorkshire and Bassetlaw Pathology programme by the five acute Trust Boards. Scoping work for further partnership opportunities is being undertaken by the Acute Federation Team. As part of the development of the South Yorkshire and Bassetlaw Pathology network the single Local Laboratory Information System (LIMS) roll out is progressing.	On track
Ensure that the strategy for a modern vibrant DBTH charity is completed and implemented	Richard Parker	CEO09	CFC	Oversight objective for delivery by DBTH Charitable Funds Trustees	30/01/2024			Work continues to identify a new strategy for the DBTH Charity.	On track	Work to develop a clear strategy and delivery model for the DBTH Charity has continued as reported to the Board.	On track

Deputy CEO

Name: Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Working with the CEO, take a lead role in working with Partners at Place, Collaborative to identify and achieve opportunities to ensure safe, sustainable services and Place and Systems Objectives and Outcomes for 2023/ 24.	Zara Jones	DCEO01	BOD	DBTH to be an active partner at Place, Collaboratives and System to provide safe and sustainable care and the delivery of the agreed quality and performance standards. Monitored through Board report updates and via regular report into Board sub committees.	30/01/2024	Continuing to support Nottingham & Nottinghamshire's system, attending meetings and have brought strategy document through Trust Board	On track	Clear partnership strategy for DBTH to be created to set out clearly our intent and how we will best engage in the variety of ICS and other partnership activities (building on the work to date). This will provide clarity of how our approach to partnership working will also support delivery of other DBTH strategies.	On track	**Nottinghamshire ICS / Bassetlaw Place:** -'Fresh eyes' and challenge into Bassetlaw Place Partnership via Exec Cabinet meetings and 1-1s with leads -Input into provider collaborative and Exec group discussions re. role and functions / priority areas -Member of ICB and ICS exec groups as DBTH CEO representative **South Yorkshire ICS / Doncaster Place:** -Meeting with Place leads and input into Place plans and CEO/Chair forum discussions -Connections with strategy directors / deputy CEOs across neighbouring acutes -SYB Pathology Exec lead role for DBTH -Planned sessions with Barnsley and Rotherham to agree partnership options -Input into Acute Fed Strategy PPG to drive overall strategy and objectives and tangible actions.	On track
Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff	Zara Jones	DCEO02	BOD	Plans will be in place for services which reduce inequalities and improve outcomes.	30/01/2024	Working with Place teams on joint plans for Doncaster Place in particular. As part of the Doncaster Place and Health and Well Being Committees focus on reducing Health Inequality three priority areas have been identified and submitted to the programme lead.	On track	Clear partnership strategy for DBTH to be created to set out clearly our intent and how we will best engage in the variety of ICS and other partnership activities (building on the work to date). This will provide clarity of how our approach to partnership working will also support delivery of other DBTH strategies.	On track	**Nottinghamshire ICS / Bassetlaw Place:** -'Fresh eyes' and challenge into Bassetlaw Place Partnership via Exec Cabinet meetings and 1-1s with leads -Input into provider collaborative and Exec group discussions re. role and functions / priority areas -Member of ICB and ICS exec groups as DBTH CEO representative **South Yorkshire ICS / Doncaster Place:** -Meeting with Place leads and input into Place plans and CEO/Chair forum discussions -Connections with strategy directors / deputy CEOs across neighbouring acutes -SYB Pathology Exec lead role for DBTH -Planned sessions with Barnsley and Rotherham to agree partnership options -Input into Acute Fed Strategy PPG to drive overall strategy and objectives and tangible actions.	On track
Ensure that the Trust Corporate and Clinical Governance systems and processes achieve the delivery of the Trusts strategic objectives.	Zara Jones	DCEO03	BOD	The Trust has a refreshed Corporate and Clinical Governance strategy which identifies the continued development of corporate and clinical governance strategies.	30/01/2024	Specific work will be undertaken from Q3.	On track	Fresh eyes review being undertaken by DCEO who joined DBTH in October. Key recommendations will be shared with TET, TEG, ARC and BoD as appropriate. Clarity of the link between our governance systems and processes and our decision making architecture will be set out as part of this work, linking back to our BAF and delivery of Strategic Objectives.	On track	•2024/25 Board business cycle changed following NED and Exec engagement •Supported Medical Director to resolve limited assurance actions for Clinical Audit •Supporting Medical Director and Chief Nurse to re-structure clinical governance approach. Plan in place to take update to February QEC •Taken on leadership for Corporate Policies systems and processes. T&F group established to address limited assurance actions by year-end •Board BAF approved and development of clear roles and responsibilities for other forums in respect of risk management. To be rolled out and embedded •Internal Audit Governance Review in Q4 will support further developments.	On track

Name: Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Working with the CEO ensure that internal and external audit recommendations are completed within the agreed timeframes.	Zara Jones	DCEO04	ARC	Compliance with the closure of audit recommendations will be at, or above the peer group average or 75%.	30/01/2024	Delivery of this objective will be led by the CEO to ensure that work on internal actions completed on time. At July ARC there should be 8 of 9 actions complete as per report to Trust Executive Group in June. Working with External Audit to implement a plan to ensure that any lessons from the submission of the 2022/23 annual report and accounts are acted upon for the 2023/24 submission.	On track	All historic (KPMG) actions now all closed. Actions outstanding are all 360 assurance. The Trust's follow up rate in 2023/24 is currently 82% first follow up and 86% overall implementation... a much improved position. 1 stage IAO action x 2 , follow-up & embedding of BAF at Board & Committees. External Audit Annual Report received at ARC 19/10/23.	On track	Reported @ DOF07 from Q3	On track

Medical Director

Name: Medical Director	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Move the job planning process to match the service to demands. Ensuring that specialities job plans are manageable, less reliant on additional time, locum and agency cover, support leadership development, recruitment and retention and clinical engagement in the Trusts achieving its strategic objectives to provide high quality, safe and sustainable care.	Tim Noble	MD01	F&P / QEC	Divisions and Directorates will have the capacity, capability and support to ensure the delivery of the operational and strategic plans in an effective and efficient way.	30/01/2024	Work is ongoing with the Deputy Director of Finance, and supported by the Project Management Office (PMO) to recover job planning performance during 2023/24 in line with internal audit timescales, along with identifying project areas to achieve job planning efficiencies,. Medical Directors are supporting job planning of Divisional Directors and Clinical Directors in Division of Surgery. The Trust's job planning policy has been refreshed, using the BMA published policy as the basis for adaptation specific to DBTH. This will be shared with Clinical Directors and Divisional Directors for feedback before wider circulation for Executive level, and Local Negotiating Committee (LNC), agreement and sign off. Divisional level trajectories are currently in development and these will be monitored through Performance, Overview and Support meetings (POSM). A job planning workshop was delivered on 5 July 2023 to the operational teams including Deputy COO, Divisional General Managers and Business Managers. This generated a lot of discussion around the job planning process to match service demands and greater divisional management involvement.	On track	Work is ongoing with senior finance colleagues, supported by PMO, to identify job planning efficiencies. MDs are supporting focussed job planning discussions within surgical division now the new Divisional Director (DD) is in post. Following consultation with DDs and CDs, the Trust's updated job planning policy will be shared at exec level and with the LNC for agreement and sign off. Divisional level trajectories have been set and performance monitored at POS meetings. Divisional General Managers are now more involved in the process and are sighted on job plan changes enabling this to be embedded within the business planning process.	On track	Work is ongoing with senior finance colleagues, supported by PMO, to identify job planning efficiencies. MDs are continuing to support job planning discussions and mediation process. Divisional level trajectories have been set and performance monitored at POS meetings. Divisional General Managers are now more involved in the process and are sighted on job plan changes enabling this to be embedded within the business planning process.	On track
Support specialties and Divisions to optimise recruitment and retention processes with a specific focus on smaller services and difficult to recruit to areas.	Tim Noble	MD02	PC	Divisions and Directorates will have plans in place to ensure that recruitment and retention strategies proactively mitigate reasonably foreseeable workforce challenges in an effective and efficient way.	2023-07-26	Work continues with Divisions and the Chief People Officer's team on medical workforce challenges. Alongside job planning, there is a focus on supporting the assessment of medical workforce supply as part of the wider multi-disciplinary team; ensuring job plans are manageable, with less reliance on additional time, locum and agency cover. This includes working with divisions and specialties to understand demand analysis, to ensure the focus is on work that needs to be delivered, strategically scaling specialties to enable us to deliver objectives. Specific examples include supporting development of options for operational models moving towards paediatrics provide 24/7 on-site rotas, and supporting the potential development of 'hot weeks' in acute services.	On track	Work continues with Divisions and the Chief People Officer's team on medical workforce challenges. Alongside job planning, there is a focus on supporting the assessment of medical workforce supply as part of the wider multi-disciplinary team; ensuring job plans are manageable, with less reliance on additional time, locum and agency cover. A SOP is now in place to support divisions with a standardised approach to ensuring services are covered appropriately, maintaining patient safety. Work is ongoing with divisions and specialties to understand demand analysis, to ensure the focus is on work that needs to be delivered. The Medical Director for Workforce provides update reports to the People Committee.	On track	Work continues with Divisions and the Chief People Officer's team on medical workforce challenges. A SOP is now in place to support divisions with a standardised approach to ensuring services are covered appropriately, maintaining patient safety. A further SOP to be developed to support the Grip and Control process for medical staff. The Medical Director for Workforce provides update reports to the People Committee.	On track
Maintain and improve governance frameworks to ensure that effective learning is used to support the delivery of safer care.	Tim Noble	MD03	QEC	The Trust will maintain and improve our NHSE and CQC ratings by achieving improvements in quality and outcomes.	30/01/2024	The clinical governance framework has recently been reviewed and updated and is in the process of full implementation, with well-established assurance and controls in place. Risk Management Board is now well established which ensures the Trust has a robust and reliable risk management system which learns and disseminates good practice to mitigate current and reasonably foreseeable future risks	On track	Implementation of the new clinical governance framework is underway with the MD office and Chief Nursing team working closely together, supported by PMO. This collaborative approach will ensure that the action plan and implementation process (on Monday.com) support effective learning in delivery of safer care for patients. Risk Management Board is now well established which ensures the Trust has a robust and reliable risk management system which learns and disseminates good practice to mitigate current and reasonably foreseeable future risks.	On track	Implementation of the revised clinical governance framework is underway, A new Terms of Reference have been drafted for the 'Effective' domain of the clinical governance framework. Work ongoing to deliver the governance of clinical audit action plan with a number of actions completed. A progress report to be presented to February's QEC. Risk Management Board continues to mature and monthly risk reports continue to evolve in line with this development.	On track
Ensure that medical appraisal and revalidation systems and processes maintain high professional standards and the delivery of safe and sustainable care.	Tim Noble	MD04	QEC	There will be Trust wide improvement in the culture, care and compassion to drive improvement in patient and colleague feedback.	30/01/2024	The revalidation team manage the medical appraisal system, record appraisal due dates and completion dates, send doctor reminders, link with ESR team to ensure all activities are recorded correctly and provide monthly reports Lead appraiser in post who assures the quality of appraisals and documentation Lead appraiser, AMD and EMD provide an independent review of doctors' appraisal documentation and other evidence in order to determine their application for revalidation meets the standards set by the GMC to enable a recommendation to be made. The team are in the process of implementing a new electronic web-based medical appraisal system which will automate a lot of the current manual processes making it easier for users to complete their appraisal documentation and upload other supporting information	On track	The revalidation team continue to manage the medical appraisal system, record appraisal due dates and completion dates, send doctor reminders, link with ESR team to ensure all activities are recorded correctly and provide monthly reports. 96% of appraisals were completed in the last financial year. Lead appraiser in post who assures the quality of appraisals and documentation. Lead appraiser, AMD and EMD provide an independent review of doctors' appraisal documentation and other evidence in order to determine their application for revalidation meets the standards set by the GMC to enable a recommendation to be made. Interim Responsible Officer arrangements have been put in place in the absence of the Executive Medical Director. Progress is being made on the implementation of the electronic web-based medical appraisal system.	On track	Ongoing progress to implement the new medical appraisal system which will be fully live by the end of Q4. The revalidation team continue to support the medical appraisal process, updating records and compliance rates. Interim Responsible Officer arrangements continue to ensure Trust compliance.	On track
Working with the Chief Nurse ensure the achievement of the three year delivery plan for maternity and neonatal services	Tim Noble	MD05	BOD / QEC	Work closely with Chief Nurse, Divisional Director and Director of Midwifery to ensure the delivery of the 11 outcomes to ensure that services and safer, more personalised and more equitable.	30/01/2024	The single delivery plan was published at the end of March 2023 and the Chief Nurse discussed this in detail at the May Board Level Safety Champions meeting with Midwifery and Neonatal services. In June the Local Maternity and Neonatal System agreed a document to measure progress would be produced to ensure that as a system we are measuring the same outputs. Progress is monitored via the oversight committee in maternity services but includes Quarterly review against the maternity self assessment tool, commenced implementation of Saving Babies lives version 3 care bundle, Senior leadership team commenced the national perinatal culture and leadership programme and involvement in the PSIRF implementation at Trust and LMNS level. Ongoing recruitment as previously described at relevant trust committees.	On track	The Local Maternity and Neonatal service (LMNS) are working on an assurance document to incorporate all elements of the three year delivery plan. This document will be reviewed by the Director of Midwifery once received. Maternity safety champions visits and meetings are becoming more established with Neonatal Colleagues engaged. The MNVP chair attended the September meeting and now has a standing invitation.. The leadership team continue to engage with the NHSE perinatal culture programme and also the Trust programme that is running alongside it. The Newly Qualified Midwife cohort is now approx. 30 WTE and expected to commence work in the next 2 months.	On track	A template for submitting evidence towards the single delivery plan has been developed by the LMNS. An initial assessment has been submitted, further work has been paused to focus on Yr5 CNST submission. Work will recommence in January 2024 and be overseen by the divisional CNST and Ockenden oversight committee.	On track
Ensure that mortality indicators are quality assured, peer reviewed and benchmarked. Optimising learning to improve patient care and outcomes.	Tim Noble	MD06	BOD / QEC	Benchmarked Hospital Standard Mortality Ratio (HSMR), Standardised Hospital Mortality Index (SHMI) will show improvement.	30/01/2024	The mortality data assurance group was established at the beginning of 2023 to review mortality indicators, benchmarking against others and undertaking peer review. Through this investigatory process, the Medical Examiners' Office and the Structured Judgement Review processes were found to be robust. Further work is needed to improve quantitative factors that are impacting on performance, such as clinical coding differences, ensuring depth of coding, case mix and pathway changes to ensure that the appropriate information is fully captured, as well as information extracts for mortality reports, along with improved senior medical engagement in the SJR process. Since this process commenced, the Trust's reported mortality rate has fallen in the past 4 consecutive months.	On track	The mortality data assurance group was established at the beginning of 2023 to review mortality indicators, benchmarking against others and undertaking peer review. Through this investigatory process the Medical Examiners' process was found to be robust. There is a process in place for Structured Judgement Reviews, however the completion rate is poor. Work has commenced on improving this through identification of clinicians trained in the SJR process across the Trust and introducing a method of protecting time to complete the reviews. In terms of HSMR, the Trust has seen 8 consecutive months on a downward trend.	On track	HSMR indicators continue to show an improving trajectory. There was a slight increase in July, whilst the reasons for this are not apparent, HSMR is below 100 for September. SHMI is reducing with a lot of background work in the Coding Department in terms of co-morbidity coding. On the whole, mortality performance is improving.	On track
Support the delivery of the Trust Strategic Direction through the delivery of safe, resilient, efficient clinical pathways which are compliant with NICE guidance and evidence based practice and aligned to the Place, ICS and Acute Fed clinical networks	Tim Noble	MD07	QEC/ F&P	Demonstrate clear improvements in efficiency and effectiveness to achieve and where possible exceed national, system and local benchmarking.	30/01/2024	Work ongoing with support from PMO and clinical leads to establish a GIRFT Steering group as a forum to monitor and drive forward GIRFT actions. Good progress is being made with virtual ward and extending eligibility criteria to a number of services. The aim is to increase utilisation of the virtual ward capacity making full use of community resource to relieve pressure in the system ahead of winter. Progress has been made with the new patient pathway tracking system in terms of testing, training and demonstrations across the Trust. Once implemented, this will support clinical prioritisation particularly for non-admitted pathways where visibility and tracking of patient pathways has been difficult. Medical Director supporting the radiology service to review pathways and criteria to manage demand into the service which has increased significantly.	On track	Work on GIRFT actions with divisions is ongoing, recent meetings have included finance business partners to identify financial opportunities. Good progress is being made with virtual ward and extending eligibility criteria to a number of services. The aim is to increase utilisation of the virtual ward capacity making full use of community resource to relieve pressure in the system ahead of winter. Digital Transformation team are leading on implementation of the new patient pathway tracking system in terms of testing, training and demonstrations across the Trust. Once implemented, this will support clinical prioritisation particularly for non-admitted pathways where visibility and tracking of patient pathways has been difficult. Medical Director supporting the radiology service to review pathways and criteria to manage demand into the service which has increased significantly. The MD team are developing a Clinical Harm policy to support this area of work to ensure patients are not disadvantaged due to pathway delays.	On track	Ongoing support to divisions to implement the GIRFT Further Faster programme. Ongoing meetings to improve virtual ward utilisation, which continues to be monitored daily. Plan to implement orthopaedic VW pathway end of January 2024. Digital Transformation team are focussing on pilot areas to test the new patient pathway tracking system in terms of testing, training and demonstrations across the Trust. Once fully implemented, this will support clinical prioritisation particularly for non-admitted pathways where visibility and tracking of patient pathways has been difficult. Medical Director working with COO to providing ongoing support to the radiology service to manage service capacity and demand. The MD team are developing a SOP to operationalise the Clinical Harm policy.	On track

Chief Financial Officer/ Director of Recovery, Innovation and Transformation

Name: Chief Financial Officer/ Director of Recovery, Innovation and Transformation	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Work with the Corporate and Divisional Directors to ensure the delivery of the Trust revenue plan	Jon Sargeant	DOF01	F&P / A&R	Ensure the delivery of the Trust's financial plan.	30/01/2024	Control environment in place, with escalation meetings in place. Currently the trust is on plan, but with risk concerning higher levels CIP starting later in the year.	On track	At end of Q2 we were on plan. Significant risks in terms of CIP delivery & operational pressures means significant work required to deliver plan for this year.	On track	Current forecast shared with F&P and to deliver the original plan, potential to improve by £1m to a 25.8m deficit	On track

Name: Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Ensure delivery of the large scale business cases for the Bassetlaw Emergency Care Village and the Montagu Elective Orthopaedic Centre.	Jon Sargeant	DOF02	F&P / A&R	Approval of business cases.	30/01/2024	Despite difficulties with engagement with Partner Trusts the MEOC design has been signed off and work has started on the Mexborough site and in the Module Co factory. A revised governance structure has been implemented and the MEOC project board has met twice. BEV is moving at pace with orders raised initially at risk to maintain the timeline. Scheme received final approval on June 30th and MOU signed to allow drawdown of PDC.	On track	major schemes moved on and capital programmes all running to time and budget. MEOC expected to be handed over on Dec 6th for final commissioning with expectation that unit be available from January 8th.	On track	Topping out ceremony held in January 2024 for Bassetlaw Emergency Village. Montagu Elective Orthopaedic Centre (MEOC) opened in January as planned, with all partner Trusts using the facility	On track
Ensure the delivery of the Electronic Patient Record Business case.	Jon Sargeant	DOF03	F&P / A&R	Approval of business cases.	30/01/2024	The original plan and procurement for the EPR started to plan. Subsequently the procurement has been paused whilst the convergence issue is resolved with partners in the ICS.	On track	Now working with colleagues in NHSE and ICB to joint business case production. the change in direction has caused delay in timetable for delivery of a FBC to January Board meeting.	On track	Funding has been moved to a profile that fits with the ICS convergence strategy. Business case production is underway and will be presented to the board by the end of the financial year	On track
Refresh the Trusts financial controls to ensure the delivery of the Trusts financial plan. Identifying opportunities to improve the Trusts financial position to support the delivery of safe, sustainable, efficient and effective care.	Jon Sargeant	DOF04	F&P / A&R	Financial controls will be in place to ensure that the Trust resources are used to maximum effect	30/01/2024	SFI's and SO's updated for July ARC. Review of key controls undertaken in April and May. Grip and control meetings re-introduced.	On track	Completed.	Complete	Reviewed earlier in the year and have now had a second review with NHSE and ICB including a full balance sheet review. All of which has confirmed the Trust's position.	Complete
Support the delivery of capacity and capability for improvement to demonstrate compliance with NHS Impact.	Jon Sargeant	DOF05	F&P / A&R	The Trust will build upon the work already undertaken to demonstrate compliance with the actions and outcomes of NHS Impact.	30/01/2024	Initial plan taken to TEG and QI Business partners have been advertised to support divisions	On track	Resources in place to support internal projects. Trusts approach is compliant with NHS Impact. Board workshop October 31st.	Complete		Complete
Complete the Final Business Case for a New Hospital or an alternative strategy if funding from the New Hospital programme is unavailable.	Jon Sargeant	DOF06	F&P / A&R	The Trust will join the new hospital programme or begin the development of an alternative strategy to provide improved facilities for patients and colleagues.	30/01/2024	Board discussion held and next steps paper going to F&P.	On track	work currently underway to complete the potential bid against potential spending in the forthcoming review	On track	Bids and plan shared with NHSE and DHSC. Work now commencing on 'Glassworks' project	Complete
Working with the CEO ensure that internal and external audit recommendations are completed within the agreed timeframes.	Jon Sargeant	DOF07	A&R	Compliance with the closure of audit recommendations will be at, or above the peer group average or 75%.	30/01/2024	Reported @ DCEO04 @ Q1	On track	Reported @ DCEO04 @ Q2	On track	Whilst the position had improved 5 high risk actions are now overdue	On track

Chief People Officer

Name: Chief People Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Ensure the delivery of the year 1 priorities in the new People Strategy	Zoe Lintin	CPO01	BOD / PC	Achieve the success measures in the delivery plan.	30/01/2024	Detailed delivery plans for each theme developed together with an agreed assurance reporting format for People Committee and through to Board. V1 of delivery plans presented at PC on 2 May and assurance report presented at PC on 4 July. Delivery plans on track. PC assured.	On track	People Strategy assurance reports presented at every People Committee meeting, highlighting key actions in previous 2 months, actions planned for next 2 months, success measures and risks/escalation. Underpinned by detailed delivery plans. PC assured in Q2 meetings.	On track	People Strategy assurance reports presented at every People Committee meeting, highlighting key actions in previous 2 months, actions planned for next 2 months, success measures and risks/escalation. Underpinned by detailed delivery plans, which are on track with improvements demonstrated. PC assured in Q3 meetings.	On track
Ensure the delivery of year 1 priorities in the new Research and Innovations Strategy	Zoe Lintin	CPO02	BOD / PC	Achieve the success measures in the delivery plan.	30/01/2024	Delivery plan drafted and presented at Teaching Hospital Board for partner engagement and input. Assurance overview presented at People Committee on 4 July (PC assured). Successful external launch of the Research & Innovation Strategy on 29 June with partners. Board presentation scheduled for July.	On track	Further iteration of the delivery plan developed, following engagement with external partners. Agreed to use the same method of assurance reporting to People Committee as the People Strategy. Bi-annual reports/presentations to PC & Board July & January. Teaching Hospitals Board retain oversight at every meeting.	On track	Assurance reporting now in place, with oversight at Teaching Hospital Board. Bi-annual report on Research & Innovation Strategy presented at People Committee on 9 January and to be presented at Board on 30 January. PC assured.	On track
Ensure development of a Trust wider strategic workforce plan including ambitions on development of new roles, supported by annual business planning processes and education programmes.	Zoe Lintin	CPO03	PC	Completion of the strategic workforce plan with appropriate success measures.	30/01/2024	Workforce planning and Learning Needs Analysis integrated into business planning processes. First deep dive workforce planning workshops held. Implementation of strategic workforce planning tool progressing with stakeholder engagement and scenario modelling - project on track. Reports on Workforce Supply & Demand to May & July People Committee (PC assured)	On track	Focused workforce planning support sessions introduced to complement deep dive workshops. Moved into third (& final) stage of the implementation of Strategic Workforce Planning tool, approach drafted to incorporate the tool within 2024/25 business planning processes. Quality improvement approach undertaken on 2023/24 business/workforce planning round, internally within DBTH and externally in collaboration with system partners. Workforce Supply & Demand reports presented at every People Committee meeting (PC assured in Q2 meetings)	On track	Implementation phase of Strategic Workforce Planning tool continues, with planning undertaken for 'business as usual' including using the tool in major projects etc. Revised workforce planning approach incorporated within 2024/25 business planning processes. Learning from quality improvement work undertaken, internally within DBTH and externally in collaboration with system partners. Workforce Supply & Demand reports presented at every People Committee meeting including demo of the tool at 9 January meeting - PC assured in Q3 meetings.	On track
Launch the new DBTH Way Framework. Embedding as 'Life at DBTH, including recruitment, appraisals, and the leadership development offer.	Zoe Lintin	CPO04	BOD / PC	Implementation of the framework	30/01/2024	DBTH Way framework approved by Trust Executive Group and Board in May. Launched in June/July with further communications planned for Sept. Embedding plan being developed, with actions over a period of time.	On track	Communications launch continued over the Summer and included on all communications channels & the Hive. Email signature banner introduced, DBTH Way session included in corporate induction. Posters and large display boards being introduced at all 3 sites in early October. Facilitated sessions exploring what DBTH Way means for individuals & leaders held with Council of Governors and Trust Executive Group, with sessions planned for Leadership Assembly in November. Engagement & Leadership reports presented at every People Committee meeting (PC assured in Q2 meetings)	On track	DBTH Way posters and display boards introduced at all 3 sites, wall art displayed at DRI and planning for other sites. Facilitated sessions exploring what DBTH Way means for individuals & leaders held with Leadership Assembly and some teams. DBTH Way embedded within revised leadership development prospectus. Job description template revised to include DBTH Way. Engagement & Leadership reports presented at every People Committee meeting (PC assured in Q3 meetings).	On track
Ensure the delivery of key organisational development/ cultural change programmes including flexible working and just culture, speaking up strategy and equality, diversity and inclusion plan.	Zoe Lintin	CPO05	PC	Implementation of agreed change programmes	30/01/2024	Flexible Working - well-attended Qi event on 13 June, project leads identified for each pillar of the workstream with volunteers from across the organisation, Steering Group recently established. Just Culture - Steering Group established with leads and action plan, Board pledges being rolled-out. EDI - action plan refreshed to incorporate NHSE High Impact Actions. Speaking Up - policy launched, engagement work ongoing. Regular reports to PC on all aspects (PC assured)	On track	Flexible Working - steering group meeting regularly, action plan built on Monday.com and project leads progressing actions. Just Culture - continued roll-out of pledges, ongoing programme of review of key HR policies including language, development sessions held with several teams. EDI - completion of Cohort 1 of new Board Development Delegate Programme with positive feedback & Cohort 2 commenced in Sept. Speaking Up - 'big conversations' and drop-in sessions continued, strategy in development phase, report to July Board. Regular reports to PC on all aspects (PC assured)	On track	Flexible Working - steering group meeting monthly, follow-up Qi session held in November and well attended with new actions identified. Just Culture - ongoing review of key HR policies including language, development sessions held with several teams. EDI - graduation held for 2023 cohort of Reciprocal Mentoring Programme and planning for refreshed programme for 2024. Speaking Up - 'big conversations' and drop-in sessions continued, strategy drafted and shared with Trust Executive Group, People Committee and Board. Final draft of Speaking Up Strategy supported by TEG and People Committee, to be presented to Board on 30 January as part of bi-annual report. Regular reports to PC on all aspects (PC assured in Q3 meetings).	On track
Embed a new approach to year-round colleague engagement to achieve continued improvement in staff survey and learner survey feedback results and high participation in surveys.	Zoe Lintin	CPO06	PC	High participation in surveys & improving outcomes	30/01/2024	National staff survey results published in March. Engagement sessions with teams ongoing throughout Q1 to discuss local results and identify improvement actions - in line with new approach. Local improvement plans developed with summary plans at divisional/directorate level. Oversight through People & OD and overview of plans presented at People Committee on 4 July (PC assured). Trust-wide communications on improvement actions also ongoing with more planned in Q2.	On track	Engagement sessions and improvement/action planning on 2022 results continued during Q2. Preparations & communications/ engagement plan developed for 2023 survey, to build on new approach - survey went live 27/09/23. Completion rate at 43% at 13/10, survey closes end Nov. Engagement & Leadership report presented at every PC meeting (PC assured in Q2 meetings)	On track	National staff survey conducted in Q3, highest response rate for DBTH achieved (surpassing 2022, which set a new record for the Trust). Results will be published in Q4, date tbc. Planning underway to support engagement sessions with teams and improvement planning. Engagement & Leadership report presented at every PC meeting (PC assured in Q3 meetings).	On track

Chief Operating Officer

Name: Chief Operating Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Ensure the Trust has robust emergency planning, resilience and response arrangements in place, including an annual work plan and assurance process	Denise Smith	COO01	ARC	Effective EPRR plans will be in place	30/01/2024	Annual review of 2022/23 complete. Annual work plan for 2023/24 developed	On track	Annual Assurance self assessment completed. Annual workplan in place. Focus continues on remedial actions to achieve compliance with core standards	On track	Delivery of annual workplan continues with focus on areas of non-compliance against core standards.	On track
Ensure the delivery of the urgent and emergency care improvement plan, in collaboration with system partners	Denise Smith	COO02	F&P	The Trust will deliver the national standards	30/01/2024	UEC improvement plan for Doncaster in place, SROs agreed and Project Charters complete. Project Groups established, improvement activities supported by ECIST	On track	ECIST support formally withdrawn. No additional resource identified, impact on pace of change noted. SROs across Doncaster Place providing leadership.	On track	Associate COO (UEC) in place Jan - Mar 24 to increase leadership capacity & capability. New DLT (UEC) in place. SRO for priority 3 (Ward Process) has transferred to COO. Steady increase in update of VW, led by MD.	On track
Ensure the delivery of access standard improvement trajectories, activity and improvement plans related to diagnostic services.	Denise Smith	COO03	QEC	The Trust will deliver the national standards	30/01/2024	Diagnostic deep dive completed. Diagnostic improvement plan agreed, project charter in place, project group established.	On track	Improvements in DM01 performance noted in Endoscopy and Non obstetric ultrasound. iRefer implemented in medical imaging, benefits realisation includes reduced CT demand and improved compliance with clinical guidelines	On track	Improvement in DM01 performance noted through Q3. Diagnostic improvement programme continues to focus on strategies to manage CT demand. iRefer implemented in primary care and high proportion of compliance noted to date.	On track
Ensure the delivery of access standard improvement trajectories, activity and improvement plans related to elective care.	Denise Smith	COO04	F&P	The Trust will deliver the national standards	30/01/2024	Outpatient and Theatre improvement plan agreed, project charter in place, project group established.	On track	Delivery of 78 week waits in the majority of specialties. 65 week modelling complete.	On track	Reduction in 78 / 65 week breaches noted. Theatre improvement programme continues to focus on delivery of 85% theatre utilisation and improving compliance with GIRFT HVLC booking standards.	On track
Ensure the delivery of access standard improvement trajectories, activity and improvement plans related to cancer care.	Denise Smith	COO05	F&P	The Trust will deliver the national standards	30/01/2024	Elective Care Improvement Support Team invited to undertake a review. Leadership and management of the Cancer Services Team moved to Chief Operating Officer. Weekly reporting of key metrics in place and monthly cancer services meeting established	On track	Sustained delivery of FDS and 31 day diagnosis to treatment standards. Improvements noted in 62 day standard	On track	Sustained delivery of FDS standard. Deep dive into breaches of the 62 day standard to be undertaken to identify key actions for improvement at tumour site level.	On track
Develop, agree and implement robust plans to manage 2023/24 winter pressures	Denise Smith	COO06	F&P / PC	Winter plans will be in place by Q3 to reflect divisional plans Winter plans linked to the Integrated Care System and PLACE plans.	30/01/2024	Review of winter 2022/23 complete. Initial scoping for winter plan 2023/24 complete	On track	Winter planning priorities developed, in conjunction with divisional and corporate teams. Doncaster Place winter plan in development. Focus on robust escalation to maintain patient flow	On track	Winter plan implemented and in progress.	On track

Name: Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status
Chief Nurse											
Name: Chief Nurse	**Person**	**Reference**	**Oversight**	**Expected Outcomes**	**Date of next update required for Board**	**Q1 update**	**Q1 Status**	**Q2 update**	**Q2 Status**	**Q3 Update**	**Q3 Status**
Working with the Executive Medical Director ensure the achievement of the three year delivery plan for maternity and neonatal services	Karen Jessop	CN01	QEC	Work closely with Executive Medical Director, Divisional Director and Director of Midwifery to ensure the delivery of the 11 outcomes to ensure that services and safer, more personalised and more equitable.	30/01/2024	The single delivery plan was published at the end of March 2023 and the Chief Nurse discussed this in detail at the May Board Level Safety Champions meeting with Midwifery and Neonatal services. In June the Local Maternity and Neonatal System agreed a document to measure progress would be produced to ensure that as a system we are measuring the same outputs. Progress is monitored via the oversight committee in maternity services but includes Quarterly review against the maternity self assessment tool, commenced implementation of Saving Babies lives version 3 care bundle, Senior leadership team commenced the national perinatal culture and leadership programme and involvement in the PSIRF implementation at Trust and LMNS level. Ongoing recruitment as previously described at relevant trust committees.	On track	the Local Maternity and Neonatal service (LMNS) are working on an assurance document to incorporate all elements of the three year delivery plan. This document will be reviewed by the Director of Midwifery once received. Maternity safety champions visits and meetings are becoming more established with Neonatal Colleagues engaged. The MNVP chair attended the September meeting and now has a standing invitation.. The leadership team continue to engage with the NHSE perinatal culture programme and also the Trust programme that is running alongside it. The Newly Qualified Midwife cohort is now approx. 30 WTE and expected to commence work in the next 2 months.	On track	A template for submitting evidence towards the single delivery plan has been developed by the LMNS. An initial assessment has been submitted, further work has been paused to focus on Yr5 CNST submission. Work will recommence in Jan 24 and be overseen by the divisional CNST and Ockenden oversight committee.	On track
Develop and commence the implementation of a comprehensive Nursing, Midwifery and Allied Health Professional Quality Strategy that improves patient outcomes and experience.	Karen Jessop	CN02	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	30/01/2024	Quality Strategy has been developed and draft discussed in various forums across the Trust, the Head of Patient Experience has shared with Healthwatch and patient representatives. All Divisions were asked to engage with their teams in relation to the content and Allied Health Professionals (AHPs) have been consulted via the Director of AHPs. The Quality Strategy (draft) was shared and discussed at Quality and Effectiveness Committee on 6th June 2023 and at a Chief Nurse listening event. Next steps are to agree final sign off and development of detailed delivery plans	On track	Following feedback from the NEDs and other stakeholders during the Quality and Effectiveness committee in June a final version of the strategy was presented to Trust Board of Directors in September and approved. A senior responsible officer has been identified for each theme, (some of the DNs only commenced in post within the last few weeks) and they will be responsible for providing detailed delivery plans of each strategic theme. A prioritisation of the outcomes over the 4 years of the plan is underdevelopment.	On track	Objectives for year 1 agreed at chief nurse time out day in December. Work has begun by each SRO to set up working groups to incorporate the objectives. Annual business planning cycle will include strategy theme under quality. High level work plan and reporting being created at workshop in late January for onward reporting to QEC. Quality will be monitored also via quality steering group. A Maternity document has been produced to align with the Trust wide objectives but provide specific measures for Midwifery	On track
Develop and implement a ward to board assurance process, incorporating peer review,	Karen Jessop	CN03	BOD / QEC	Work closely with Medical Director and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Medical Director and Director of Midwifery to review findings, agree recommendations and develop action plan. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered.	30/01/2024	The Accreditation framework has now been drafted and shared widely for comments. Engagement sessions with colleagues have taken place. The accreditation process links with Tendable and the planned Quality Dashboard, to enable good triangulation of data. The draft accreditation documentation is being trialled in 4 clinical areas. Peer assessment questions are being developed to ensure consistency of the peer assessment process and the full launch is planned for September when the first peer visits will take place. A CARE excellence study day is being planned to support teams in relation to both the Quality strategy and accreditation.	On track	Accreditation questions drafted and undergoing final review before piloting in maternity and acute. These will then be uploaded to tenable. Care excellence study day in progress Some slight slippage in roll out of pilot, due to the feedback on questions and uploading to tenable Implementation meetings continue Chaired by the Chief Nurse and with good attendance from internal and external stakeholders	On track	Question set finalised and approved at CNEG January 2024. Pilot of process has taken place in two areas. Schedule for wider roll out of accreditation developed. Quality Dashboard phase 1 now live. Question sets for peer review process now all on tenable	On track
Achieve implementation of the Patient Safety Response Framework (PSIRF) in line with the National Implementation timescales.	Karen Jessop	CN04	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	30/01/2024	The PSIRF implementation group meets monthly with further task and finish groups established as required, the key stakeholders include active participation from place colleagues. The Trust links with both ICB safety groups to support plans/progression with shared learning. The 6 transition phases are monitored and measured on Monday.com and are aligned with the NHSE recommended plans. Phase 1 - Orientation is complete 2. Diagnostic and Discovery, progress made as planned, including joint launch of the Just Culture with P&OD 3. Governance and Quality - all existing incident management processes in divisions mapped by QI and recommendations for future incident triage and action management are being developed 4. PSIR Planning - Thematic analysis now underway with support from the University of Sheffield. Once complete the PSIR plan will be drafted to present to Board and divisional clinical governance meetings to consider the data and identify key priorities. Progress has already been made with using PSIRF methodology in Falls and the Skin integrity improvement streams	On track	North of England Commissioning completed the external validation of thematic analysis of Patient Safety Incidents and Patient Experience Data to support the identification of the Patient Safety incident profile to inform the Patient safety incident response plan Draft of the Patient Safety Incident response Policy and Plan circulated for comments and to be presented for approval at relevant Trust committees Meeting planned with SYICB to discuss formal transition dates Business case in draft for training requirements, Family Liaison Officers and Patient Safety Partner roles, for submission to relevant Trust committees PSIRF communication plan implemented including, 4 trust wide PSIRF teams listening events, attendance by team at a wide range of Trust committees, production of comms materials including an animation, and PSIRF page on the HIVE. Training at level 1 and level 2 advertised and waiting compliance figures.	On track	The Trust transitioned to PSIRF on 1 December 2023. Still have some SI's in progress under old framework, so some "double running" anticipated until at least end of Feb 24. PSIRF workbook completed and distributed. Divisions recruiting to quality post to support the PSIRF process. Business case approved for training and procurement has commenced for train the trainer (learning responses) and wider PSIRF training for stakeholders including board development session. Family Liaison Officer JD and PS signed off and proceeding to recruit. Patient Safety Partner conversation taking place across acute fed re a "system approach". PSIRP and Policy both live.	On track
Embed safe staffing principles for nursing and midwifery, incorporating the use of relevant professional evidence based decision support tools to ensure safe, evidence based nursing and midwifery staffing levels across the Trust.	Karen Jessop	CN05	BOD / QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	30/01/2024	Established a comprehensive "safe staffing" report in line with national quality board guidance that is reported regularly via the People Committee NHS England regional colleagues undertook a review of DBTH processes at our invitations that report has now been received, a summary of recommendations and actions will be reported to the People Committee Risk has been identified in relation to establishment skill mix, added to the risk register and mitigations in place with a plan to be presented and approved by executive colleagues to resolve. Twice daily staffing meetings are established across the Trust on both sites, 7 days a week to support safe staffing decision making. Safer Nursing Care Tool data collected in November has been reviewed and scrutinised by external CNO safe staffing fellows and the second biannual data collection has been completed in June, these data will be analysed and once completed, presented to the Trust Board following ratification through trust processes and in alignment with National guidance.	On track	Safe staffing report submitted bi-monthly to People Committee in line with National Quality Board guidance. Biannual establishment reviews for Children and Young People, ED and Adult Inpatients and assessment areas have commenced and up to date SNCT licenses held by DBTH to utilise the evidence based tools Plan in place for "update" training and inter reliability assessments for all involved in SNCT data collection Trust processes now include clear evidence of the use of Professional judgement and involvement of every ward/dept leader, collated using the nationally recommended documentation June 2023 data collection complete for Adult IP and assessment areas, draft report review in progress by CN, Exec and People committee presentation planned for Q3 Support requested from PMO team for data analysis, to establish a more efficient process for the November data collection and subsequent analysis Safe Care pilot to be completed in Q3 with ongoing work to refine data reporting processes in relation to availability of divisional information for effective rostering and use of red flags.	On track	Valid Safer Nursing Care Tool (SNCT) Licences held by DBTH for ED, CYP and Adult Inpatient and Adult Assessment areas, including for the recent updated tools. Inter reliability assessments to ensure appropriate data collection using to tools undertaken during November 2023 for Adult tools in view of the updated tools for Adult area. A database is held to evidence training undertaken within the Trust and externally. Safer Nursing Care Tool data collection was completed in June 2023 across adult inpatient areas and a bi annual safe staffing report presented to the Trust Board following ratification through trust processes and in alignment with National Guidance. Safer Nursing Care Tool data collected in June 2023 (Adult Areas) July 2023 (ED) and August 2023 (CYP) and repeated across all areas across November / December 2023. This data will be analysed and once completed, presented to the Trust Board following ratification through trust processes and in alignment with National guidance. Twice daily staffing meetings are established across the Trust on both sites, 7 days a week to support safe staffing decision making and are embedded as business as usual for ED, Adult and Paediatric inpatient areas.	On track

2401 - G2 BOARD ASSURANCE FRAMEWORK (RISKS 1-7) & TRUST RISK REGISTER 15+

Discussion Item

Fiona Dunn, Director Corporate Affairs / Company Secretary & All Executive Dir

20 minutes

REFERENCES

Only PDFs are attached

- G2 - Board Assurance Framework & Trust Risk Register.pdf
- G2 - Appendix A - BAF.pdf
- G2 - Appendix A BAF.xlsx
- G2 - Appendix B - TRR15+ - January 2024.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**G2**
Report Title:	**Board Assurance Framework (BAF) & Trust Risk Register (TRR15+)**		
Sponsor:	Zara Jones, Deputy Chief Executive Officer		
Author:	Angela O'Mara, Deputy Company Secretary		
Appendices:	Appendix 1 - BAF (risk 1-7) Appendix 2 - TRR15+		

Report Summary

The refreshed Board Assurance Framework (BAF) has been updated to meet the recommended requirements from the Head of Internal audit opinion during 2022/2023 to clearly articulate the strategic risks that could impact on the strategic objectives.

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

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

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

- Quality & Effectiveness Committee – 1st August & 5 December 2023
- People Committee – 5th September & 7 November 2023
- Finance & Performance Committee – 27 November 2023
- Audit & Risk Committee – 16 January 2024

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

Further work on the BAF development will include alignment of the levels of assurance to the new four level model now described within the guidance section of the BAF, consistency in the recording/audit trail of completed actions, refreshed target dates, clarity on the required steps to achieve a reduction in the risk score and the reporting of target risk scores on the summary page.

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

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

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

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

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

We recognise we have more work to do to bring down the overall number of extreme risks (15+) through the work of the Risk Management Board and broader actions to ensure staff are trained in how to identify and assess risks in a consistent manner.

Summary

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

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

Recommendation:	The Board is asked to note the updated BAF strategic risks for 2023/ 2024 (appendix 1) & updated Trust Risk Register (TRR15+)			
Action Required:	~~Approval~~	~~Discussion~~	**Take assurance**	~~Information~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	***The Trust is in recurrent surplus to invest in improving patient care***
Is the content of this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**Nottingham & Nottinghamshire ICS**	
	N/A		N/A	

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

Assurance Route	
Previously considered by:	The Executive team Board Committees
Date:	Sub committees

Any outcomes/next steps	The BAF's will be reviewed at Board Committees as determined by the Committee, with oversight of the full BAF reported to the Board of Directors: • Quarter 3 - January 2024 • Quarter 4 - April 2024
Previously circulated reports to supplement this paper:	During 2022/2023 draft BAFs, and development work has been undertaken by the Board and Trust Executive Group.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

January 2024


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

BOARD ASSURANCE FRAMEWORK SUMMARY

Jan-24

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

Board Assurance Framework 2023/24

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

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

Key Issues that could impact on ability to manage the strategic risk

Lack of learning from incidents, risks,complaints inquests and deaths
Lack of consistent standards of care
Mental capacity act and deprivation of liberty safeguards compliance
Accessible information standard (AIS)
Safeguarding compliance with National Safeguarding accountability and assurance framework

Clinical Negligency Scheme for Trusts (Yr 5) published
Awaiting draft CQC report following inspection
Clinical Governance Review - Gaps inlcuding Clinical Audit

Overseeing Committee

Quality & Effectiveness Committee (QEC)

Date of last Committee review

QEC 1 August & 5 December & Board 31 October 2023

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

Risk Appetite

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

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

Significant gaps in current controls	Areas where further assurance against controls is required
Lack of Quality Dashboard	Risk appetite to be reviewed in line with Trust agreed processes
Divisional Clinical Audit processes	
Clinical Governance review	

Key actions to close gaps

	Lead	Target Date	Progress
Clinical Governance review	EMD and CN	Quarter 4	Plan to have structure approved via Trust processes over Q4
Clinical Audit	EMD	Quarter 4	Plan finalised and on QEC agenda Dec 23
MCA & Dols 360 audit commissioned	CN and EMD	Quarter 3	Audit planned for End of October 2023. complete update to QEC 6/12/23
IT developing Quality Dashboard	CFO	Quarter 3	Still in development, some delays due to metrics/data. Update to QEC on feb 24
CQC Immediate action plan	CN	Dec-23	Immediate actions implemented, plan to finalise before draft report
Accessible information standards gap analysis complete	CN	Quarter 4	Trust Task and Finish group established to progress
Delivery of complete action plan internal Audit on risk	EMD	Quarter 4	On QEC agenda December 2023

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
3291	3	4	12	Behaviour of Concern

3197	4	4	16	Safeguarding Compliance
3246	5	3	15	Mental Capacity Act and Deprivation of Liberty Safeguards
3198	3	4	12	Lack of Quality Dashboard

Board Assurance Framework 2023/24

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

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

Key Issues that could impact on ability to manage the strategic risk

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

Overseeing Committee

People Committee

Date of last Committee review

Committee review
Board - 31 Oct, PC - 7 Nov

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

Risk Appetite

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

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	People Strategy 2023-27 launched May 2023, with detailed delivery plans and regular assurance reporting to People Committee	Chief People Officer Senior Leadership Team (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Annual staff survey results and learner surveys (3)	Assured
		Internal audit on health & wellbeing planned for Q4 (3)	TBC
		Recognised as Employer of the Year at Doncaster Business Awards Dec 23 (3)	Assured
		Recognition and award nominations at national level (3)	Assured
2	Development of strategic Trust-wide workforce plan, including implementation of strategic workforce planning tool and embedding of deep dive/focus workshop approach	Workforce & Education Committee (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Internal audit report - Recruitment (22/23) (3)	Partial Assurance
		Inernal audit report - Return to work interviews (22/23) (3)	Moderate assurance
3	Launch and ongoing embedding of the DBTH Way to set out expectations on behaviours and embed an open and inclusive organisational culture	Reports to Trust Executive Group (1)	Assured
		Reports to People Committee (2)	Assured
		Annual staff survey results and learner surveys (3)	Assured
4	Equality, diversity and inclusion action plan including NHS England high impact actions	EDI Committee (1)	Assured
		Reports to People Committee (2)	Assured
		Annual staff survey results and learner surveys (3)	Assured
		NHS England Dashboard (3)	Assured
5	Provision of quality education, learning and development	Workforce & Education Committee (1)	Assured
		Reports to Trust Executive Group (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Education quality visits (Q 3/4 22/23) (3)	Assured
		Learner surveys (3)	Assured

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

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Delivery of year 1 of People Strategy in line with agreed delivery plan	Zoe Lintin	31/03/2024 for year 1	Delivery plans updated Oct 23 and assurance report to be presented at People Committee on 7 Nov. Plans on track, actions completed.
3	Launch DBTH Way with communications and embedding plan	Zoe Lintin	30/09/2023 for launch - to be completed 31/10/23. Embedding is throughout 2023/24 & future years	Launch started in June/July & continued throughout 2023. Embedding work underway including faciliated sessions with leadership groups. Update to be presented to PC on 9 Jan as part of Engagement & Leadership report.
2	Implementation of strategic workforce planning tool and embedding of deep dive and focus workshops	Zoe Lintin/Anthony Jones	Mar-24	Implementation phase nearing completion and planning for handover of the strategic workforce planning tool from KPMG to the Trust. Use of the tool considered for business as usual activites and incorporated within business planning process for 2024/25. Update & demo of the tool to be presented to PC on 9 Jan in Workforce Supply & Demand report.
4	Refresh of EDI plan to include NHSE High Impact Actions and delivery of 2023/24 actions in the plan	Zoe Lintin/Gavin Portier	Mar-24	EDI action plan refreshed to reflect NHS High Impact Actions with new actions added. Presented to People Committee on 4 July, Committee assured. Summary to Board on 25 July . Board Assured. Update EDI report to be presented to PC on 9 Jan, actions are on track with no escalations needed at this time
1	Delivery of education priorities within People Strategy and Research & Innovation Strategy including new Education Quality Framework	Zoe Lintin/Sam Debbage	31/03/2024 for year 1	Plans on track. Education report to be presented at People Committee on 9 Jan. Education Quality Framework developed, approved and launched in Nov, aligned with the Quality Strategy.

Links to Operational Risks

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

Board Assurance Framework 2023/24

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

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

Key Issues that could impact on ability to manage the strategic risk

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

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

Nov-23

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

Risk Appetite

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

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

4. Theatres Improvement Programme to maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance(2) Monthly report to Transformation Board (2) Monthly Access Standards report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3) Internal audit report (waiting list management) (3)	Partial Assurance - with improvements required

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

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Harm Review Policy in place and implemented	COO	Dec-23	Complete: Harm Review Policy approved by TEG. Next steps: for implementation with Divisional teams
2	Complete capacity and demand modelling (using nationally recognised tools)	COO	Jan-24	In progress as part of 24/25 annual planning process.
3	Implement revised elective governance arrangements, in line with Elective IST recommendations	COO	Dec-23	Off track: Deputy COO (Elective Care) in post 17 Jan 24. Elective Governance structure to be finalised by March 2024.
4	Develop elective care improvement plan	COO	Dec-23	Complete: Elective Care Improvement Plan drafted. Launch event planned for February 2024. Tier 2 meetings continue on a fortnightly basis.
5	Clinical categorisation of patients not currently in line with national guidance	COO	Dec-23	In progress: review of all clincal prioritisation codes complete. Division of Surgery undertaking a review of all P2 code application initially.
6	Bed modelling not yet complete	COO	Dec-23	Complete: Bed modelling and scenario modelling complete (supported by ECIST). Outputs being discussed with Divisonal teams as part of the annual planning process for 2024/25

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
7	4	4	16	Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards
3209	5	4	20	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients

Board Assurance Framework 2023/24

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

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

Key issues

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

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

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

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

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

Lifts - Risk of critical lift failure leading to (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

31/10/23 Board & 27/11/2023 F&P

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

Risk Appetite

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

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Granger Review 2021 & action plan contains a number of actions that are either completed or on track. Includes an action to purchase Top-Up Insurance for DRI site Monitored via F&P. Jan update Top up insurance now in place.	Reports to Audit and Risk Committee (via H&S Report) (2) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
2	Full Asset capture 2022/23 - informing business case to increase Planned Preventative Maintenance schedule to reflect infrastructure risks in line with industry standard SFG 20. Review included all sites. Business case due to November CIG. Jan update, BC being adjusted to include phasing of recruitment for 1,2 & 3 year period. Values are circa £600k pay and £300k revenue specialist contractors (tbc requires tendering)	Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Partial Assurance - with improvements required
3	Report provided to BoD June regarding way forward for DRI site to invest in the current site, and progress the support for the new build bid. Both pieces of work aim to eradicate risk of poor infrastructure of the DRI site. Request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb. Announcement expected Nov 22nd as part of the Autumn Statement, bids for EWB, Theatres, DCC and W&C have been developed in readiness. Update Jan 24, no announcement in Autumn statement, working with DHSC Vicki Cave to identify funding <£25m 24/25 and EWB bid £300m. Meeting took place with Simon Corben NHSE EFM Lead 16th Jan, request for seed funding to develop bids further.	Board Report (1)	Partial Assurance - with improvements required
4	Annual Capital Programme developed using Risk Based methodology - focus on DRI backlog/Critical infrastructure risk reduction. £74m invested in DRI site in last 5 years	Annual Programme to Board of Directors for approval (2) Annual Programme to ICB for information (3) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
5	Key Financial Control Processes in place: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. Reintroduction of financial escalation process with Divisions from June.	POSM & Transformation meetings (1) 360 assurance performance mgt audit Q4 2022/23 (3)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities

6	Comprehensive EFM Risk Register in place, containing actions to mitigate and eradicate risk	Internal Audit 21/22 (3) Reports to Audit and Risk Committee (via H&S Report) Reports to Finance & Performance Committee (2)		Significant Assurance - with minor improvement opportunities

Significant gaps in current controls	Areas where further assurance against controls is required
Insufficient investment to eradicate backlog/infrastructure risk at the DRI site	Further assurance Enhanced planned preventative maintenance
lack of an effective NHS capital regime	
A requirement for additional revenue to support Top Up Insurance of £500k pa and increased estates resource value of circa £900k (£600k pay, £300k revenue)	

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
3	Develop options for investment of the current DRI site, as per request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb	JS	Dec-23	Paper to Board in June, Paper F&P 26th July 2023. updated paper to F&P and BoD in Sept re Autumn statement funding announcement Bid pack completed as required in November, shared with DHSC and NHSE, awaiting further instruction regarding next steps
3	Progress with bid for new DRI site	JS	Mar-25	Paper to Board in June, Paper to F&P 26th July 2023. On hold
3	Discuss National Audit Office findings relating to DRI being removed from the list of 40 new hospitals with DoHSC and NHSE	RP/JS	Aug-23	Paper to Board in June, Paper to F&P 26th July 2023. complete
2	Prepare to submit Short Form Business case for any funding that may become available in the Autumn of 2023	JS	Sep-23	Paper to Board in June, Paper to F&P 26th July 2023.update to action 1. complete
2	Business case to CIG November to support PPM	JS	Aug-23	BC being adjusted to include phasing of recruitment for 1,2 & 3 year period. Values are circa £600k pay and £300k revenue specialist contractors (tbc requires tendering)
1	Business case for Top Up Insurance went to CIG Sept - approved	JS	Nov-23	Purchase Order being raised with Griffiths & Armour Oct, due to time elapsed a new procurement exercise needs to be undertaken. Costs remained the same, insurance now in place - complete

Links to Operational Risks

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

Risk Number	Risk Description
12	Failure to ensure that estates in upgraded in line with current le
1214	Increased Risk to Life and Prope of Fire Compartmentation
1277	Increased Risk of Fire and Smok Compartmentation
1246	Risk of Failure of Critical Ventila and Operating Standard Non-Cc
1782	LV Electrical Distribution DRI- lif

Board Assurance Framework 2023/24

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

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

Key issues

1) The Trust submitted a deficit financial plan of £26.8m with an assumed CIP delivery of £22.1m. The Trust is under scrutiny given its financial position, including a national review of the Trust's financial plan earlier in the financial year, pressure from the ICB and needing a national request for revenue cash support. The Trust is currently forecast to deliver a £25.8m deficit (before industrial action impact on Dec/Jan) which is £1m improvement on plan. However this is short of the £4m stretch requested by the ICB. This position whilst an improvement on plan has been non-recurrently achieved with a starting gap for next financial year currently estimated at c.£65m with an underlying deficit still at c£50m. The SY ICB is currently forecasting a £49.5m deficit at year end against a break even plan, however this includes a number of mitigations at the end of the year to achieve this position.

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

3) Cash - the Trust has had to request central revenue cash support of £26.8m to meet its obligations and c£7m capital. This comes at a cost to the Trust of 3.5% worsening the Trust's financial position but also reduces the ability to invest in services.

4) Productivity - reductions in productivity were seen during COVID, where activity being delivered is below pre-pandemic levels, whilst resource has increased. The challenge in 23/24 has been to deliver above pre-pandemic levels of activity within resources allocated whilst providing safe and sustainable services. However in this year this has been impacted by the ongoing industrial action. The Trust is currently achieving ERF, however this has been supported by additional independent sector spend and the non-recurrent baseline changes to activity targets. The challenge as we enter 24/25 is to deliver the activity lost from industrial action and improve productivity further within the resources the trust has. If activity is not delivered in line with plan the Trust's income position will be at risk. National guidance is awaited on any changes to rules regarding the Elective Recovery Fund for 24/25 but these are not expected to be material.

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

6) Temporary Staffing Spend - agency spend remains above pre-pandemic levels. Further work in this area is required to reduce agency spend where a national target will be set for 24/25 (3.2% or better).

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

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

31/10/2023 & 27/11/2023 F&P

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

Risk Appetite

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

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

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

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Review and progress of national actions on the 23/24 financial plan including independent assessment of the Trust's underlying financial position.	CFO	Completed	Most of the actions from the national review have been implemented or are being progressed. External assessment of underlying position has been commissioned with final report to Board and F&P shortly. Draft presentation at June Finance and Performance Committee. CLOSED
2	Delivery of external and internal audit recommendations	CFO	Mar-24	Internal audit actions implemented on time relating to 22/23. Internal Audit in 23/24 due in Q4. External audit actions progressed significantly since 22/23 per ISA 260 report.
3	Development and delivery of CIP plan	CFO	Ongoing	Delivery of CIP plan in year has seen good progress but further work required on delivery of recurrent savings. Focus now on developing CIP plan for 24/25.
4	Delivery of reduced temporary staffing spend including grip and control in medic areas.	CPO	Ongoing	Nursing temporary staffing spend has reduced in 22/23 due to reduction in agency and bank rates, usage and improved controls. Further assurance now required in medic spend including robust implementation of medic grip and control meetings.
5	Daily cash flow forecast and submission of national request for central cash support	CPO	Ongoing	Daily cash flow in place, with more robust controls in place regarding payment sign off (e.g. sign off by Deputy Dof and Head of Procurement). National request for cash support completed for revenue and capital. Awaiting confirmation from central team on cash for revenue and capital

Links to Operational Risks

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

Board Assurance Framework 2023/24

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

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

Key issues

Lack of a clear partnership strategy for DBTH aligned to its other Trust strategies (to enable their delivery)
Failure to develop effective partnerships and achieve agreed outcomes
DBTH aligned to 2 different ICS's causing complexity and inefficient working for DBTH

Overseeing Committee

Quality & Effectiveness (to be reviewed at a later date)

Date of last Committee review

January 2024

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

Risk Appetite

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

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Duty to collaborate evidence: Partnership working: ICS, Provider Collaboratives ,Place, Neighbourhood - agreements & Memorandums of Understanding	informal feedback to Trust through committees and Board (1) Sign off of Partnership agreements & MOU's at BOD (2) Increased capacity at Exec Director & NED level to support attendance and influence at ICS forums (1) ICB , Provider collaborative minutes, repots and strategies (2)	Partial Assurance - with improvements required Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
2	Duty to collaborate evidence: Supporting the Governor body in achieving its statutory duty	Briefing sessions to governors with leaders from both ICB's (1) Governor annual conference & Workshops around duties to hold to account across ICS and individual Trusts (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
3	Health Inequalities strategy at Trust and Place level led by Directorate of Recovery, Innovation & Transformation to ensure focused in business planning and performance processes.	Monitored via F&P meetings (2)	Partial Assurance - with improvements required
4	Additional Executive capacity created (new DCE post) for partnership working with a particular focus on Nottinghamshire ICS relationships	Cross-reference to Q3 Exec objectives update - visibility and input into Notts and Bassetlaw forums and SY Acute Fed Strategy Directors PPG. Planned discussions with Barnsley & Rotherham to progress collaborative options, building on previous work e.g. MEOC.	Partial Assurance - with improvements required
5	Ensuring our operational risks (Trust Risk Register) are linked to applicable risks relating to partnership / collaboration or system required support.	BAF risks on Datix for mapping to new or existing operational risks to strategic ones. Newly created partnership risk under the same process. Discussed at RMB, requires further development/embedding.	Partial Assurance - with improvements required

Significant gaps in current controls	Areas where further assurance against controls is required
4 Lack of overall partnership strategy linked to other Trust strategies	5 ensuring we are clear where our operational risks required support outside of DBTH to mitigate and ensuring other parties have these risks visible and adequately mitigated on their own risk registers.

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
4	External meetings and engagements mapping to develop clarity of purpose and input for DBTH in partnership forums	ZJ	Dec-23	This is still underway and links to wider work to review our governance and effectiveness.
4	Development of Partnership Strategy linking to our existing DBTH strategies to support delivery and clearer intent and actions for our partnership working	ZJ	Mar-24	This will be linked to refresh of our Trust Strategy and discussions with the Board in February to articulate our objectives and intentions for the year ahead.

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
				This section of the BAF will be populated in Q4 linked to recent work described above to map partnership risks on Datix.

Board Assurance Framework 2023/24

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

BAF 7 Executive Owner	Strategic Risk		Current Risk Score
Jon Sargeant Director of Recovery, Innovation & Transformation	BAF7	**If DBTH does not deliver continual quality improvement, research, transformation & innovation then the Organisation won't be sustainable in long term**	6 - reflect R&I as incorporated

Key issues	Overseeing Committee
There is a risk that DBTH & PLACE/ICB quality improvement methodology and objectives are not aligned	Finance & Performance Committee
New Research & Innovation Strategy to take account of Improvement Innovation in addition to Research Innovation	
DBTH to be recognised as a University Teaching Hospital (requires expansion of R&I)	
Qii Strategy 2022 Out of date - review linked to NHSE Impact published March 23	
Requirement for Board of Directors to receive training in Quality Improvement methods aligned to NHSE Impact Guidance	**Date of last Committee review**
Risk that Innovation ideas are not captured and taken forward due to staff not knowing where to access the right support, Qii or Research Team	31/10/2023 Board

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

Risk Appetite

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

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Head of Qii part of PLACE/ICB network. Self assessment of DBTH Qii methods are aligned to new NHSE Impact guidance	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) Links to Clinical Audit Work with PMO and Monday.com	Significant Assurance - with minor improvement opportunities
2	Collaboration with Director of Education and Director of Innovation & Infrastructure, Head of Research and Head of Qii to inform content of both strategies	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) People Committee (2) Teaching Hospital Board (2)	Significant Assurance - with minor improvement opportunities
3	Outdated Qi Strategy 2022 currently being updated with new NHSE Impact Guidance by October 23. Draft Qii Strategy went to Trust Executive Group on Monday 13th November, and will then go to F&P and Board of Directors for approval.	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) New strategy to TEG November 23	Significant Assurance - with minor Significant Assurance - with minor Significant Assurance - with minor
4	Proposal for BoD Qii Training developed and submitted to Exec Team for 2nd August meeting for discussion. Update BoD workshop taking place 31st October. Workshop complete and a second will be held to ensure NED's achieve level 1 equivalent Qii training, Executive team will have further sessions in order to achieve level 2 training	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2)	Significant Assurance - with minor improvement opportunities
5	Collaboration with Director of Education and Director of Innovation & Infrastructure, Head of Research and Head of Qii to develop joint Innovation Form via Hive for streaming and selection	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2)	Significant Assurance - with minor Significant Assurance - with minor Significant Assurance - with minor
6	Research and Innovation strategy (2023-2028) approved at Board (January 2023)	Reports to TEG (1) Reports to THB (1) and PC (2) Reports to People Committee (2)	Assured
7	R&I Delivery plan developed (2023: Year 0 & 1)	Reports to THB (1) and PC (2)	Assured
8	5 year business case to be developed and submitted from April 2024 (Year 1-5	Work with PMO and Monday.com	Assured

Significant gaps in current controls	Areas where further assurance against controls is required
Estate to support a Clinical Research Facility	Strategic issue. Locally mitigated by use of clinic space.
Capability and Capacity of current workforce	Collaborative planning with local Higher Education Institutes

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Delivery of year 0 of the Research and Innovation Strategy in line with agreed delivery plan	Sam Debbage/ Jane Fearnside	31/3/24 for year 0	Delivery plans updated Dec 2023 and assurance report to be presented at People Committee on 9 Jan 2024. Plans on track, actions completed.
2	Research and Innovation Strategy publicly launch	Sam Debbage/ Jane Fearnside	31/6/23	Formal launch in June 2023 with all significant partners.
3	Develop a 5 year detailed business case from April 2024	Sam Debbage/ Jane	31/4/24	Outline draft in progress for 28/2/24
4	Update Qii Strategy and reflect NHS Impact	Kirsty Edmondson-Jones/Rob Mason	Feb-24	Draft went to Nov TEG, feedback being incorporated and due to F&P Feb 24
5	Board Training programme to be developed	Kirsty Edmondson-Jones/Rob Mason	Oct-23	First session commenced October - ongoing
6	meetings with Director of Education and Director of Innovation & Infrastructure, Head of Research and Head of Qii to ensure process for capturing Innovation ideas with correct streaming process	Kirsty Edmondson-Jones/Sam Debbage	Sep-23	meetings have taken place and process been agreed.

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

Trust Risk Register

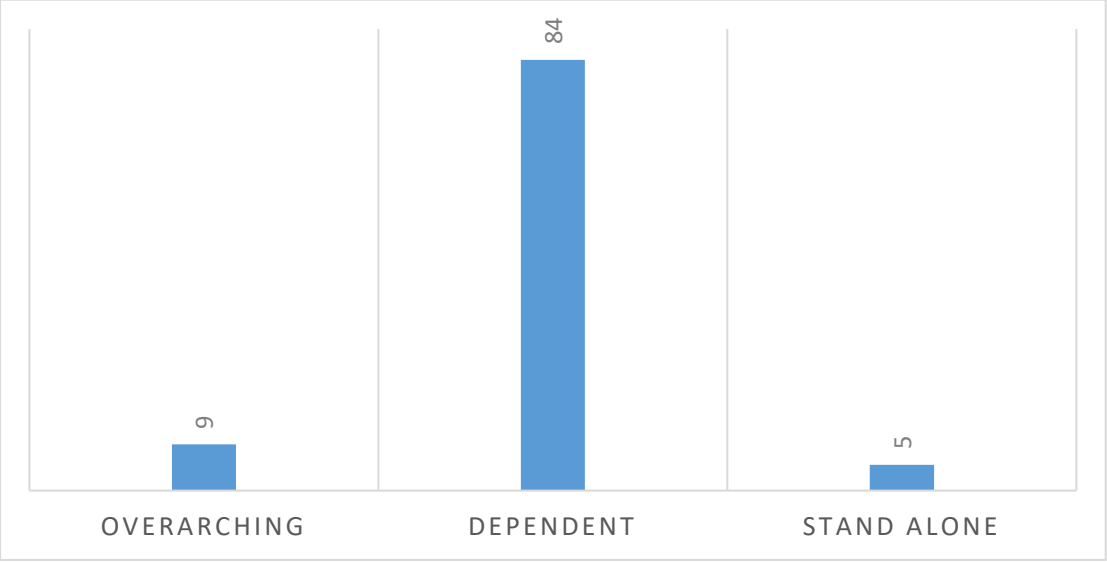
The Trust Risk Register is compiled of all Risks with a grade of 15 or more. It contains the overarching and stand-alone risks and notates the dependent risks. Dependent risks can be seen on linked records field of the Overarching risk. See **Appendix 1** for the Trust Risk Register details. Detailed mitigating control and actions can be found by accessing the risk record within the DATIX risk management system.

Top 3 Risks

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

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

Risks by Risk Authority



All 15+ risks have been reviewed and where appropriate, linked to an overarching risk, which has resulted in a streamlined Trust Risk Register.

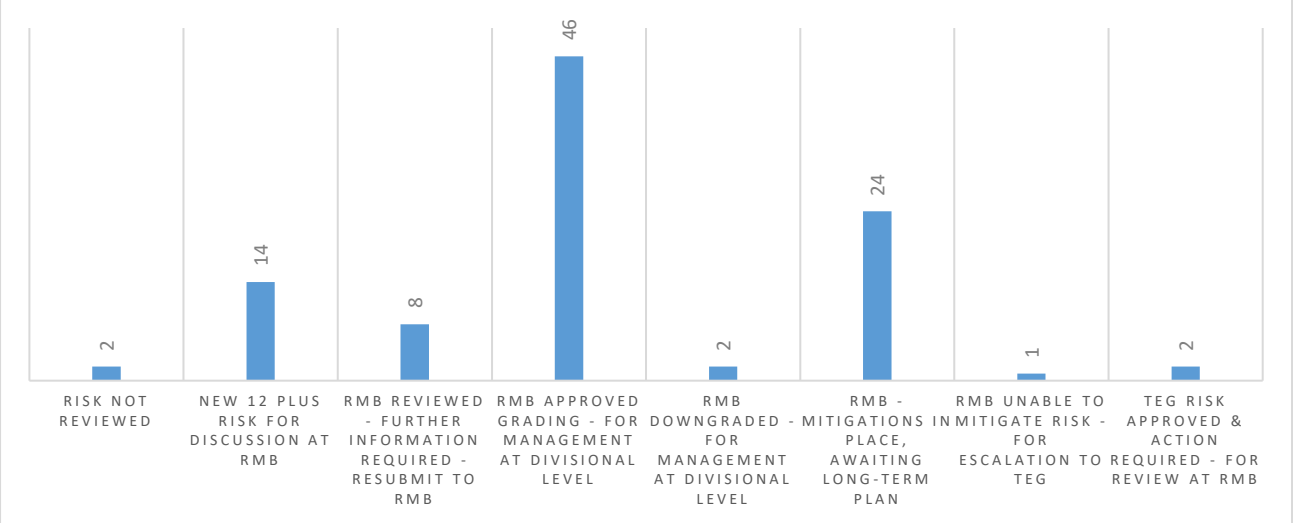
There are 9 overarching risks* with 84 dependent risks (up 17 since December) and 5 standalone (down from 12 in December).

*The agreed in principle proposal to have a defined list of Overarching themes for the Operational Risks, this is not yet live.

Trust Risk Report – January 2024

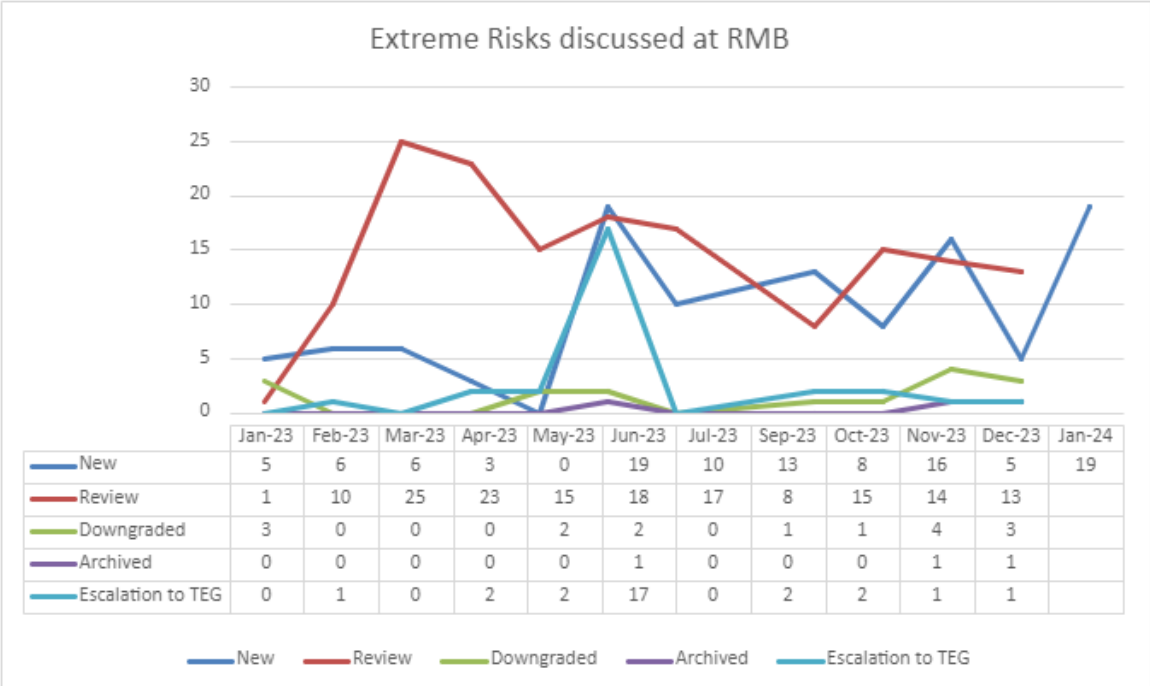
Summary of data pulled from Datix Risk Management System 11th January 2024.

Risks by RMB Status



There are 99 Risks in the Extreme level, an increase of 10 since last month due to addition of Emergency Department Risks. All risks have now either been discussed at RMB, with the Risk Manager or are scheduled for discussion at the next RMB.

Cumulative RMB Status



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
New	5	6	6	3	0	19	10	13	8	16	5	19
Review	1	10	25	23	15	18	17	8	15	14	13	
Downgraded	3	0	0	0	2	2	0	1	1	4	3	
Archived	0	0	0	0	0	1	0	0	0	1	1	
Escalation to TEG	0	1	0	2	2	17	0	2	2	1	1	

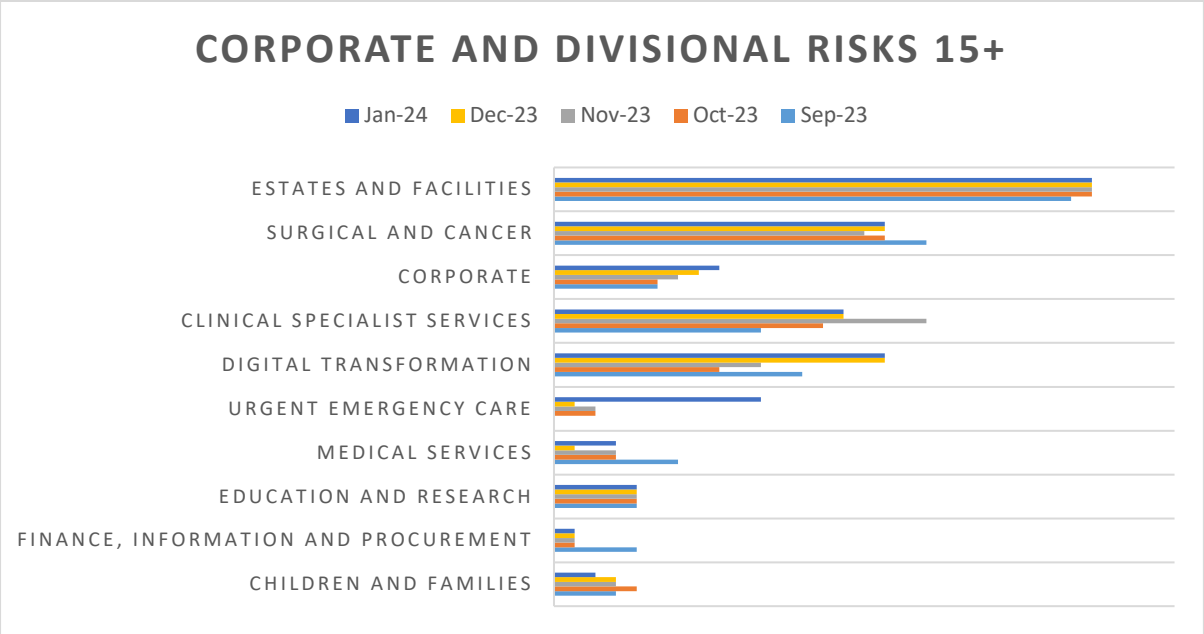
The data is downloaded prior to the RMB meeting, therefore the outcome of RMB will be one month behind the new data on Datix.

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

Since the writing of the December report there has been 13 Risks Archived, and 23 new risks added to Datix

15+ Risks per Division over time



Overdue Risks on Trust Risk Register

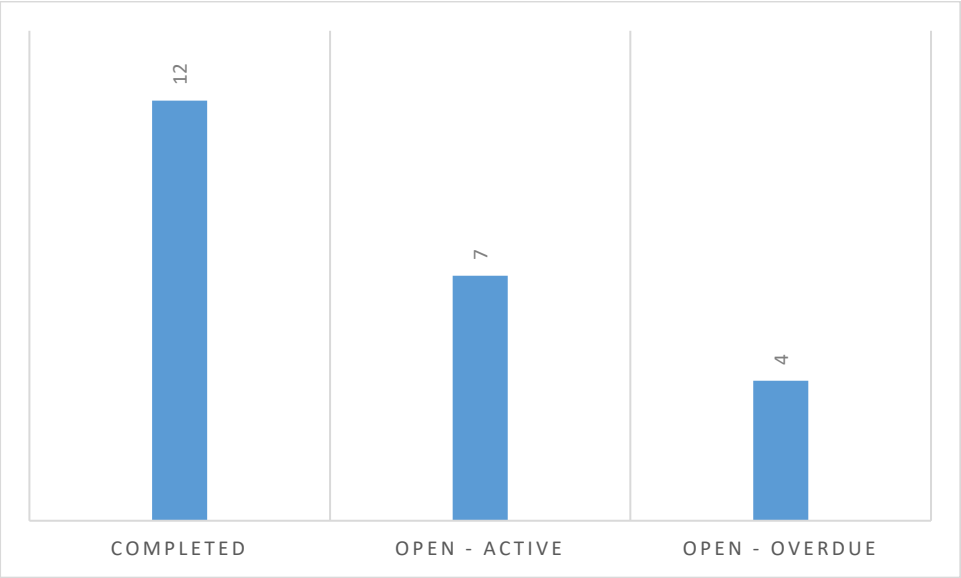
There is 1 risk overdue, which equates to 1.01% of risks.

Action Plan Status on Trust Risk Register

There are 14 Risks on the Trust Risk Register; of the risks, 10 have actions (71.4%). The 10 risks have a total of 23 actions between them, the status of these actions can be seen in the chart below:

Trust Risk Report – January 2024

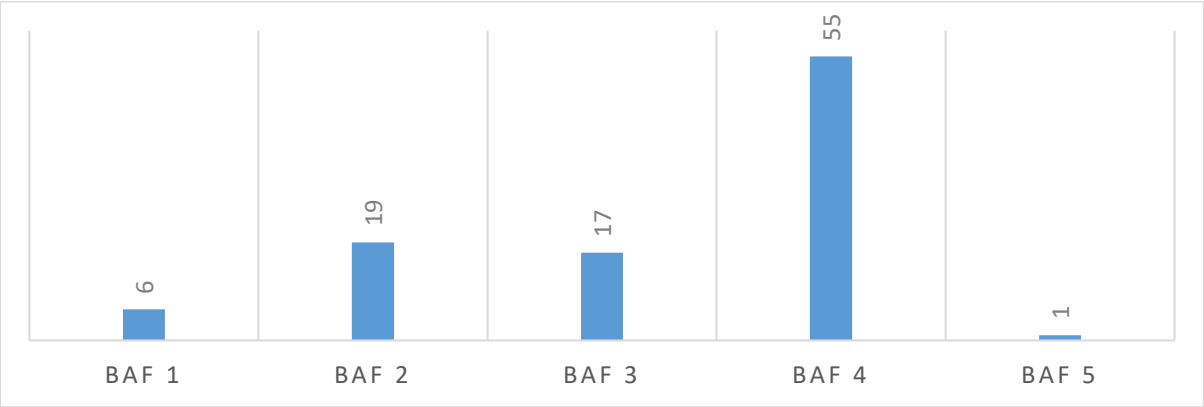
Summary of data pulled from Datix Risk Management System 11th January 2024.



Of the four risks with no actions; one risk is awaiting a Divisional downgrade following discussion at the November RMB, one risk is waiting for approval from their SMT meeting scheduled later this month, and one requires discussion with the Risk Owner. The final risk without actions is newly added and will be discussed at January RMB.

Trust Risk Register relationship with BAF Risks

Work has been completed to align each of the 15+ Risks to one of the Strategic Risks within the Board Assurance Framework.

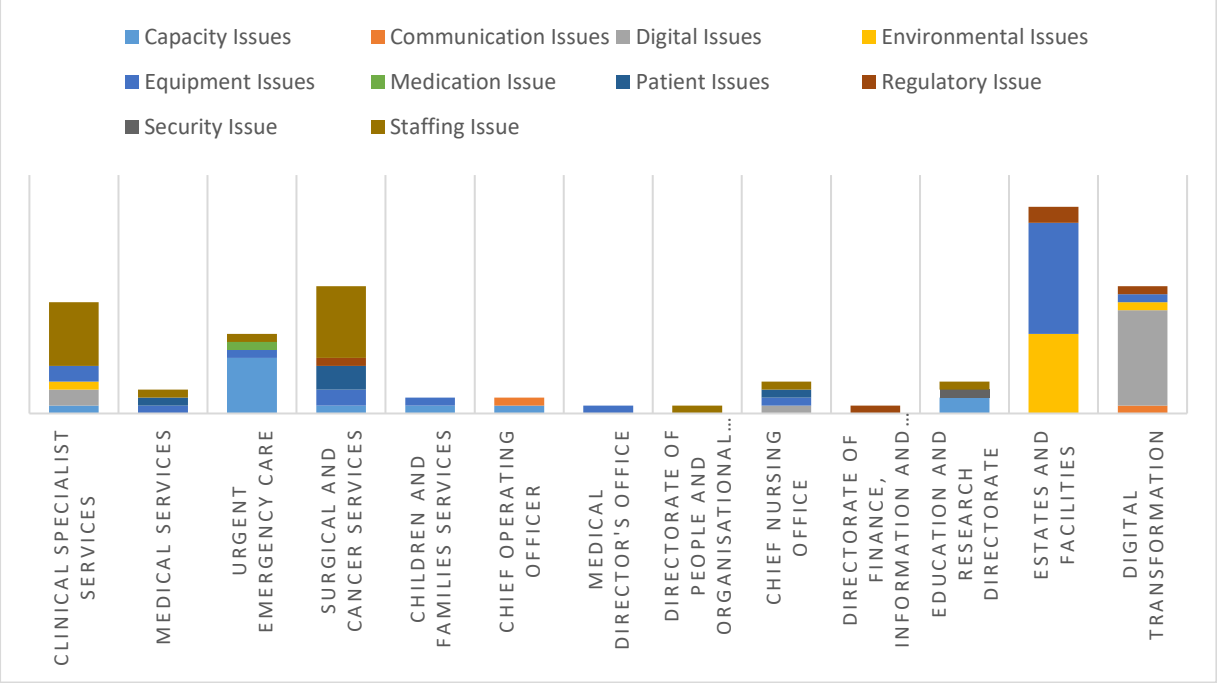


Over half of the 15+ risks (56%) are directly related to BAF 4, the DBTH Estate which includes Estate Infrastructure, Digital Infrastructure and Equipment, 19% pertaining to BAF 2, workforce and 17% to BAF 3, Capacity.

Trust Risk Report – January 2024

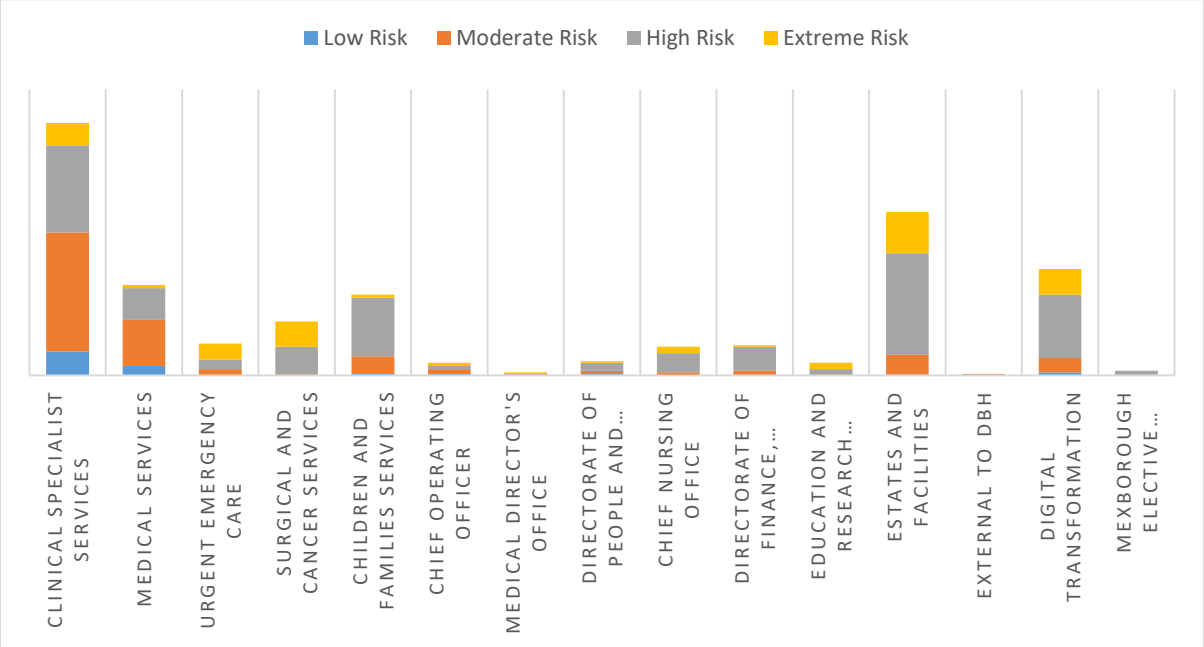
Summary of data pulled from Datix Risk Management System 11th January 2024.

Risk Themes



The largest Risk issues are linked to equipment, with 24% of the risk profile. Staffing issues represent 22% of the risk profile and Digital issues 15% (due to systems becoming end of life and out of support) Capacity Issues have increased to 13% of the risks and Environmental issues falling to 12%.

Complete Trust Risk Profile



Overall, there are 559 risks on Datix, of which there are 26 low risks, 153 Moderate risks. 281 High Risks and 99 Extreme Risks. Clinical Specialist Services has the greatest number of risks and cover the greatest number of individual specialties

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	BAF number	Action ID	Due date	Done date
11	Sargeant, Jonathan	Failure to achieve compliance with financial performance and achieve financial plan	[12/10/2023 11:27:00 Fiona Dunn] reviewed. kept on TRR but strategic risk on BAF. [16/05/2023 10:02:21 Fiona Dunn] 22/23 achieved financial plan. 23/24 - trust has a significant CIP target which will have a decreasing effect on the organisational run rate. This sets a significant risk to operational & financial position.	31/01 2024	16	Extreme Risk	8	Overarching	RMB approved grading - for management at Divisional level	Yes	High 3017, 3170, 3179 Moderate 3174, 3175	BAF 5	15992 15993 16844	20/10/2023 30/06/2023 30/06/2023	03/01/2024 03/01/2024 05/01/2024
12	Timms, Howard	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation	[11/10/2023 08:15:08 Howard Timms] Asset Capture Complete Estates Business Case being finalised to support additional staffing requirements and compliance with SFG20	29/03 2024	20	Extreme Risk	10	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1078, 1082, 1083, 1095, 1096, 1097, 1208, 1209, 1246, 1264, 1274, 1277, 1782, 2335, 2863, 2868, High 1781, 2867, 3190 Moderate 2878,	BAF 4	1914 6207 16159	13/12/2023 31/03/2020 31/03/2017	10/10/2016 12/08/2017 12/12/2023
16	Lintin, Zoe	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	[07/11/2023 09:18:18 Anthony Jones] Deep Dive Workforce Planning Workshop Update - Nov 23. A schedule of Deep Dive workshops arranged throughout 2023/24 and will continue into 2024/25.	29/03 2024	16	Extreme Risk	12	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 26, 2465, 2768, 2781, 2865, 2948, 3006, 3010, 3043, 3120, 3127, 3159, 3197, 3200, 3212, 3213, 3219, 3244, 3250, 3259,	BAF 2	1920 15995 15996	31/05/2016 31/03/2024 31/08/2023	13/09/2018

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

											3265, 3266, 3267, 3311, 3257, 3342, 3345, 2335 High 441, 1047, 1228, 2427, 2715, 2745, 2749, 2872, 3001, 3023, 3067, 3143, 3152, 3183, 3187, 3192, 3211, 3240, 3245 Moderate 1448, 1855, 2535, 2537, 2850, 2963, 3003, 3026, 3035, 3130 Low 3218				

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	BAF number	Action ID	Due date	Done date
1412	Timms, Howard	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	[07/09/2023 15:24:45 Howard Timms] Works in progress as part of 23/24 Capital Programme [14/04/2023 10:23:49 Howard Timms] Further fire improvement works programmed for FY23/24 as part of the Capital programme.	29/03 2024	15	Extreme Risk	10	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1077, 1214, 1216, 1225, 2941, Moderate 147,	BAF 4	16703 16704 16705	19/02/2024 20/05/2024 13/05/2024	
1807	Hutchinson , James	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	[21/02/2023 14:10:51 Sean Alistair Tyler] Work commenced on South block and Women's and children's hospital lifts DRI. MMH pain management lift included within the MEOC project FY23/24.	29/03 2024	15	Extreme Risk	8	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1224, 1239, 2682, High 885, 1240, 2798, 3154 Moderate 2608, 2681, 3360,	BAF 4	10218 10219 16158	13/06/2024 31/03/2020 31/03/2017	10/10/2016 12/08/2017
2977	Wattoo, Ghulam	HER2 Test Result Delays resulting in delayed diagnosis and discussion of treatment	[30/10/2023 17:11:37 Clare Rogers] Situation unchanged for HER2 IHC testing at STH. Situation worsening for indeterminate tests needing FISH testing. Recent update from STH is that the delay for FISH testing is 2 weeks (on top of current time for IHC testing).	22/01 2024	15	Extreme Risk	3	Stand alone	RMB downgraded - for management at Divisional Level	Yes		BAF 1			

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	BAF number	Action ID	Due date	Done date
3114	Debbage, Sam	Door access rights to areas for resus team - system process	[02/11/2023 09:19:29 Lisette Caygill] A project manager has been assigned via PMO to oversee this work. Provisional timelines are b agreed for separate phases of implementation and the risk will be reviewed and amended accordingly on completion of each phase.	19/04 2024	15	Extreme Risk	10	Stand alone	RMB - Mitigations in place, awaiting Long-term Plan	Yes		BAF 4	16347	15/03/2024	
3157	Rajasundaram, Ramanan	One Stop BDGH Prostate Clinic not running and patients seen at separate appointments - inequitable service across Trust	[20/03/2023 12:29:16 Nicki Sherburn] 1, Patients are seen at DRI or general urology clinics with extra work being undertaken by various clinical members of staff. 1, Patients are seen at DRI or general urology clinics with extra work being undertaken by various clinical members of staff.	18/01 2024	16	Extreme Risk	4	Stand alone	RMB approved grading - for management at Divisional level	Yes		BAF 1	16223 16800 16873	18/10/2023 28/06/2023 29/12/2023	20/09/2023
3209	Smith, Denise	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	[26/09/2023 12:22:41 Wayne Chapman] 1) Current SOPs to be reviewed by services, and identify current anomalies 2) Staff should be released to participate in user acceptance training, and general training for the upcoming patient tracker to be implemented 24/25.	20/03 2024	20	Extreme Risk	6	Overarching	RMB - Mitigations in place, awaiting Long-term Plan	Yes	Extreme 3051, High 3094 Moderate 2568	BAF 1	15703 15704 15705 15706 15707	20/03/2023 20/03/2023 20/03/2023 19/06/2023 17/04/2023	09/03/2023

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	BAF number	Action ID	Due date	Done date
3246	Brown, Simon	Mental Capacity Assessment and Deprivation of Liberty Safeguards	[22/11/2023 16:10:56 Simon Brown] risk reamins.QI project ongoing. External audit review and recommendations awaited. MCA / DOLS audit proforma created and audit about to commence MCA assessment on nerve centre MCA / DOLs training as part of safeguarding training	29/01 2024	15	Extreme Risk	9	Stand alone	RMB approved grading - for management at Divisional level	Yes		BAF 1	16329	31/07/2023	20/07/2023
3348	Mallaband, Nicholas	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	Business cases for replacement or updates are discussed at MEG. Goodwill gestures from the companies or our internal team to maintain the machines as best they can	20/03 2024	20	Extreme Risk	10	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 2819, 3147, 3184, 3237, 3238, 3251, 3320, 3346 High 53, 2398, 2534, 2581, 2935, 3036, 3060, 3142, 3146, 3288, 3298, 3308 Moderate 795, 971, 2372 Low 1012, 2378, 2623, 2755,	BAF 4			

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	BAF number	Action ID	Due date	Done date
3364	Smith, Denise	Risk of demand for services beyond capacity resulting in services not meeting requirements and poorer outcomes for patients	Additional sessions, prioritisation of patients, monitoring of activity and waiting lists, discussions with Finance	15/12 2023	20	Extreme Risk	10	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 2750, 3119, 3296, 3354, High 2775, 3032, 3101, 3109, 3124, 3269, 3292, Moderate 3359	BAF 3			
3384	POPE, ANDREW	Failure to update software/hardware may lead to increased cyber attack exposure and general failure of digital services	Request for capital investment Procurement of extended contracts and sourcing of third-party companies providing support where manufacturers are unable Purchase via second hand market of parts for repair and replacement South Yorkshire Federation wide procurement where possible Sharing of services across the SY Federation / support as necessary	12/01 2024	16	Extreme Risk	8	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1410, 1670, 2685, 2717 ,2727, 3184, 3224, 3280, 3282 ,3283, 3284, 3285, 3287, 3375 High 1663, 1664, 1674, 1675, 1676, 1677, 1678, 2116, 2135, 2686, 2691, 2695, 2703, 2720, 2721, 2722, 2726. 2732, 2734, 2735, 2736, 2747, 3056, 3078, 3111, 3186, 3215, 3225, 3226, 3281, 3286, 3295 Moderate Risk 1665, 1667, 1671, 2733, 2848, 3160 Low Risk 2624, 2740	BAF 4	17439 17440	29/03/2024 28/03/2025	

Trust Risk Report – January 2024

Summary of data pulled from Datix Risk Management System 11th January 2024.

ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	BAF number	Action ID	Due date	Done date
3399	Brown, Simon	LC- ward 24 - eating disorder - complex care needs not being met	small number of staff trained in therapeutic hold nutrition nurse supporting feeding named practitioner for safety in care support Mental health sporadic agency support Bed watch cahms post feeding support for de-escalation support from other wards safety pod in use	15/01 2024	15	Extreme Risk	8	Stand alone	NEW 12 plus Risk for discussion at RMB	Yes		BAF 1			

2401 - G3 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 12:35

5 minutes

REFERENCES

Only PDFs are attached

G3 - Chair's Assurance Log - Audit & Risk Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Audit & Risk Committee Meeting	**Board Date: January 2024**
Prepared By:	Audit & Risk Committee Chair: Kath Smart	
Approved By:	Audit & Risk Committee Members	
Presented By:	Audit & Risk Committee Chair: Kath Smart	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 16 January 2024	

Matters of Concern (with Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Internal Audit Reports issued:- • Policy Management Framework Audit - Limited Assurance outcome. This audit reviewed the systems in place for ensuring effective Policy Management and agreed a number of recommendations to improve the approach. 3 x medium recommendations relating to updating the overarching framework; utilising Monday.com and ensuring consistency and standardisation were agreed by management. Work aimed to be complete by March 2024. Lead Director: Deputy CEO. • Mental Capacity Act Compliance – Limited Assurance outcome. This audit evaluated the application of the MCA within the Trust. There is 1 high, 2 medium recommendations and 1 low recommendation, all agreed by management. This report was also referred into QEC for oversight. Lead Director: Chief Nurse Stage 2 Head of Internal Audit Opinion • Although no assurance level has yet been assigned (due in April) the Committee wished to appraise the Board of the current Audit Recommendations closure rate of 69% for timely closure and 81% overall closure rate. The target aim for this is 75% for timely closure. ARC have asked for an increased focus on closing high risks and mitigations in place whilst high risks are being closed going forward, however, for those high and medium risks which need closure during 23/24, then management will receive reports via TEG.	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery via 360 Assurance follow-up of audit recommendations b) Board Assurance Framework – This was reviewed by ARC alongside the Stage 2 HOIA feedback from Internal Audit which showed there are areas for improvement which are currently being addressed. This will be reviewed by IA in Q4. c) Risk Management Board & Trust Risk register– ARC received two reports evidencing the work of RMB in continuing to improve the Trusts Risk Management process & progress and plans for the future. Progress has been made in reviewing 15+ risks (and now 12+ risks); linking to actions on Datix & reducing the number of extreme risks by ensuring consistency of scoring. This will be reviewed by IA in Q4. d) Committee Effectiveness – The Committee and attendees carried out an effectiveness review, based on the HFMA standards/ questions. The results of this were largely positive, and a full report with an assigned assurance level will be brought back to Board once considered alongside the other Committees effectiveness. e) Audit Recommendations – ARC have requested more information within the papers from management to focus on those overdue high/ medium recommendations. Including narrative of why they are overdue and mitigations whilst being implemented. f) Fair Pay Comparison – ARC considered good progress has been made on understanding the drivers for high activity areas. People Committee will monitor the delivery of the action plan going forward.

	g) Health & Safety - Additional assurance were requested on understanding any reasons/ causes for increases in Sharps, Manual Handling and Falls incidents, plus the links into H&WB work of the People Committee; and QEC safety work. h) Staff Accommodation – A visit was undertaken by Board members ion Dec 2023 to view the staff accommodation to support on-call arrangements. A number of areas for improvement have been identified:- • Action plan to focus on decency standards and compliance with health & safety requirements. • Establishment of an Accommodation Steering group to oversee future refurbishment – reporting into TEG and People Committee • Cessation of utilisation of unrefurbished areas • Review of control measures for access and utilisation of staff accommodation
Significant or Full Assurances to Provide	**Decisions Made**
a) Counterfraud Progress 23/24 – Significant assurance on the update on work for 23/24, and cases being progressed. b) Internal Audit Progress & delivery – 23/24 – Significant assurance on the delivery of the IA plan. A further item (Partnership Working) has been deferred to 24/25 and replaced with a Corporate Governance Review c) Internal Audit Review of Business Planning – Significant Assurance on the processes to support effective business planning and plans to deliver agreed strategic objectives. This work was viewed very positively by ARC, with 2 x low recommendations for implementation in Q1 2024. d) Single Tender Waivers – Significant assurance for compliance with the Trust process e) Losses & Compensations – Significant Assurance for compliance with the Trust financial process. However, some concern of the number and volume of hearing aids/dental /patient property losses which may impact patient experience. f) Health & Safety Management - The report demonstrated that overall system for H&S Management is in place and working to mitigate health & safety risks with significant assurance. Additional assurance was requested on understanding any reasons/ causes for increases in Sharps, Manual Handling and Falls (see work commissioned above)	a) ARC approved the Fraud, Bribery & Corruption Policy which has been amended slightly.

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

2401 - G4 ACUTE FEDERATION ? COMMITTEES IN COMMON AGREEMENT

Decision Item | Fiona Dunn, Director Corporate Affairs / Company Secretary | 12:40

10 minutes

REFERENCES

Only PDFs are attached

- G4 - DBTH Committee in Common Update.pdf
- G4 - Appendices - Committee In Common ToR - Dec 23.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	30 January 2024	**Agenda Reference:**	**G4**
Report Title:	**Updated Committees in Common (CiC) Terms of Reference and Joint Working Agreement to reflect new provisions under the Health and Care Act 2022**		
Sponsor:	Richard Parker OBE, Chief Executive		
Author:	Fiona Dunn, Director Corporate Affairs		
Appendices:	CiC Terms of Reference & Joint Working Agreement for each Trust		

Report Summary

Executive Summary

Background

In 2017 Working Together partnership members agreed to put in place a governance structure to enable them to make decisions and work together to implement change. Each Trust agreed to establish a Board Committee and adopt terms of reference in substantially the same form, except the membership of each Committee in Common (CIC) being different. Each committee comprises the respective Chair and Chief Executive of that Trust and has a scheme of matters delegated by the Board, consequently each committee may only make decisions in respect of the Trust of which it is part.

The Acute Federation Board noted in June 2023, that whilst some Acute Federation organisations were still formally reporting their Acute Federation Committee in Common as part of its Board Committee structure, that was not the case consistently across all partners.

Therefore the South Yorkshire and Bassetlaw Company Secretaries Professional Partnership Group (PPG) was requested to review decision-making arrangements in place across the South Yorkshire and Bassetlaw (SYB) Acute Federation (AF) Provider Collaborative.

Progress

Company Secretaries coordinated an expert master class session to enable collective consideration of potential models available, and consider new provisions under the Health and Care Act 2022.

Following this consideration, it was noted that there was merit in asking the Board of Directors of each individual partner Trust to formally re-adopt its Committee in Common terms of reference and associated documentation. To support this, documentation has been reviewed and updated to reflect nomenclature and other non-material changes.

In developing this current paper, documentation was reviewed and updated, this work has included updates to reflect nomenclature changes and other non-material changes.

The decision making process for the Board of each Trust is clearly highlighted in Annex 1 of the attached appendices and confirms that the sovereign entity of each Trust remains and will be sighted on any proposals for service change and all proposals with strategic impact coming from the Acute Federation partnership.

If it is intended that the CICs are to discuss a proposal or matter which is outside the decisions delegated to each Trust CIC, then where at all practical, each proposal will be discussed by the Board of each Trust prior to the individual Trust CIC meeting with a view to the Trust CIC requesting individual delegated authority to take action and make decisions. These decisions would be within a set of parameters agreed by the Trust Board of Directors. Any proposals discussed at the Individual Tust CIC meeting outside of these parameters would come back before Each of the Trust Board of Directors.

Next step

The next step is for the Board of each Acute Federation partner to formally re-adopt its Committee in Common to enable upcoming decisions on the workplan of the Acute Federation Board to be enacted under this governance structure.

Full details of the CIC terms of reference and joint working agreemt are included in the attached appendices.

Recommendation:	The Board is asked to **RECOMMEND** approval of the Committee in Common Terms of Reference and Joint Working Agreement in preparation of final sign of January 2024 by the Acute Federation.			
Action Required:	**Approval**	Discussion	Take assurance	Information only
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**NA**	

Implications	
Board assurance framework:	N/A
Risk register:	*NA*
Regulation:	new provisions under the Health and Care Act 2022 for CiCs
Legal:	Health and Care Act 2022
Resources:	*N/A*

Assurance Route	
Previously considered by:	Board 2017 & 2021 on initial signing
Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	Previous CiC agreement – working together AFEd prior to ICB

MODEL
TERMS OF REFERENCE

FOR A [NAME OF PARTNER TRUST]
COMMITTEE OF THE BOARD OF DIRECTORS TO MEET
IN COMMON WITH COMMITTEES OF OTHER TRUSTS

1. INTRODUCTION

1.1 [Trust name] has put in place a governance structure which will enable it to work together with the other Trusts to implement change.

1.2 Each Trust has agreed to establish a committee which shall work in common with the other Acute Federation Partnership Committees in Common (CiC), but which will each take its decisions independently on behalf of its own Trust.

1.3 Each Trust has decided to adopt Terms of Reference in substantially the same form to the other Trusts, except that the membership of each CiC will be different.

1.4 Each Trust has entered into the Joint Working Agreement on [**date to be inserted**] and agrees to operate its CiC in accordance with the Joint Working Agreement.

1.5 [Trust name] Board of Directors has agreed to establish and constitute a committee with these Terms of Reference, to be known as the [Trust name] Committee in Common (CiC). These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the [Trust name] CiC.

1.6 The [Trust name] CiC shall work co-operatively with the other CiCs and in accordance with the terms of the Joint Working Agreement.

2 DUTIES / RESPONSIBILITIES

2.1 The duties and responsibilities of the [Trust name] CiC are to work with the other CiCs to:

- provide strategic leadership, oversight and delivery of new models of care through the development of the Acute Federation and its workstreams;
- set the strategic goals for the Acute Federation, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

- consider different employment models for service line specialities including contractual outcomes and governance arrangements;
- review the key deliverables and hold the Trusts to account for progress against agreed decisions;
- ensure the System Delivery Group (SDG) and professional partnership groups (PPGs) have clarity of responsibility and accountability and drive progress;
- establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;
- receive and seek advice from the professional partnership groups (PPGs);
- receive and seek advice from the South Yorkshire Integrated Care Board;
- ensure compliance and due process with regulating authorities regarding service changes;
- oversee the creation of joint ventures or new corporate vehicles where appropriate;
- review and approve the Terms of Reference for the Acute Federation Board;
- improve the quality of care, safety and the patient experience delivered by the Trusts;
- deliver equality of access to the Trusts' service users; and
- ensure the Trusts deliver services which are clinically and financially sustainable.

3 FUNCTIONS OF THE COMMITTEE

3.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. [This power is enshrined in paragraph [4.3] of [Trust name] constitution].

3.2 The [Trust name] CiC shall have the following function: decision making in accordance with Annex 1 to these Terms of Reference.

4 FUNCTIONS RESERVED TO THE BOARD OF THE FOUNDATION TRUST

Any functions not delegated to [Trust name] CiC in paragraph 3 of these Terms of Reference shall be retained by [Trust name] Board of Directors. For the avoidance of doubt, nothing in this paragraph shall fetter the ability of [Trust name] to delegate functions to another committee or person.

5 REPORTING REQUIREMENTS

5.1 On receipt of the papers detailed in paragraph 9.1.2, the [Trust name] CiC Members and [Trust Executive Group] members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to [Trust name] Board of Directors for inclusion on the agenda of [Trust name] next Board meeting in order that the Board of Directors may consider any additional delegations necessary in accordance with Annex 1.

5.2 The [Trust name] CiC shall send the minutes of its meetings to the [Trust name] Board of Directors, on a monthly basis, for inclusion on the agenda of the Board meeting.

5.3 [Trust name] CiC shall provide such reports and communications briefings as requested by [Trust name] Board of Directors for inclusion on the agenda of its Board meeting.

6. MEMBERSHIP

Members

DESIGNATION	CHAIR/DEPUTY
Chair	Chair
Chief Executive	

Serviced by:

Acute Federation Programme Office

6.1 Each [Trust name] CiC Member shall nominate a deputy to attend [Trust name] CiC meetings on their behalf when necessary (“Nominated Deputy”).

6.2 The Nominated Deputy for the Chair shall be a Non-Executive Director of [Trust name] and the Nominated Deputy for the Chief Executive shall be an Executive Director of [Trust name].

6.3 In the absence of the [Trust name]s' CiC Chair Member and/or the [Trust name]s' CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

- attend [Trust name] CiC's meetings;
- be counted towards the quorum of a meeting of [Trust name] CiC's; and
- exercise Member voting rights,

and when a Nominated Deputy is attending a [Trust name] CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

Non-voting Attendees

6.4 The members of the other CiCs shall have the right to attend the meetings of the [Trust name] CiC.

6.5 A nominated Trust Corporate Secretary shall have the right to attend the meeting of [Trust name] CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CiCs.

6.6 The Acute Federation Partnership Managing Director shall have the right to attend the meetings of [Trust name] CiC.

6.7 Without prejudice to paragraphs 6.4 to 6.6 inclusive, the Meeting Lead (as defined in section 14) may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CiCs shall not count towards the quorum or have the right to vote at such meetings.

6.8 The attendees detailed in paragraphs 6.4 to 6.7 inclusive above, may take contributions, through the Meeting Lead, but shall not have any voting rights nor shall they be counted towards the quorum of the meetings of the [Trust name] CiC.

Conflicts of Interest

6.9 Members of the [Trust name] CiC shall comply with the provisions on conflicts of interest contained in the [Trust name] Constitution / Standing Orders. For the avoidance of doubt, reference to conflicts of interest in the [Trust name] Constitution / Standing Orders also apply to conflicts which may arise in their position as a member of the [Trust name] CiC.

6.10 All members of the [Trust name] CiC shall declare any new interest at the beginning of any [Trust name] CiC meeting and at any point during the meeting if relevant.

7. QUORUM AND VOTING

7.1 Members of the [Trust name] CiC have a responsibility for the operation of the [Trust name] CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.2 Each member of the [Trust name] CiC shall have one vote. The [Trust name] CiC shall reach decisions by consensus of the members present.

7.3 The quorum shall be two (2) members; one (1) Executive Director and one (1) Non-Executive Director.

7.4 If any member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

7.5 At the discretion of the Chair, business may be transacted through a teleconference or videoconference provided that all Board members present are able to hear all other parties and where an Agenda has been issued in advance. Participation in a meeting via electronic means shall constitute presence in person at the meeting.

8. MEETING FREQUENCY AND PROCEDURES

8.1 [Trust name] CiC meeting to take place on a regular basis.

8.2 Any Trust CiC Chair may request an extraordinary meeting of the CiC (working in common) on the basis of urgency etc, by informing the Meeting Lead and Managing Director. In the event it is identified that an extraordinary meeting is required the Acute Federation Programme Office shall give five (5) working days' notice to the Trusts.

8.3 Meetings of the [Trust name] CiC shall be held in private.

8.4 Matters to be dealt with at the meetings of the [Trust name] CiC shall be confidential to the [Trust name] CiC members and their nominated deputies, others in attendance at the meeting and the members of the [Trust name] Board.

8.5 [Trust name] shall ensure that, except for urgent or unavoidable reasons, [Trust name] CiC members (or their nominated deputy) shall attend [Trust name] CiC meetings and fully participate in all [Trust name] CiC meetings.

9. ADMINISTRATIVE

9.1 Administrative support for the [Trust name] CiC will be provided by the Acute Federation Programme Management Office (or such other person as the Trusts may agree). The Acute Federation Programme Management Office will:

9.1.1 draw up an annual schedule of CiC meeting dates and circulate it to the CiCs.

9.1.2 circulate the agenda and papers three (3) working days prior to CiC meetings; and

9.1.3 take minutes of each [Trust name] CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all members within ten (10) working dates of the relevant [Trust name] CiC meeting.

9.2 The agenda for the [Trust name] CiC meetings shall be determined by the Acute Federation Programme Management Office and agreed by the Meeting Lead prior to circulation.

9.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the Acute Federation Programme Management Office to agree such within five (5) working days of receipt.

10. DATE TERMS OF REFERENCE WERE APPROVED

[insert date]

11. REVIEW DATE

Annually

12. PROCESS FOR REVIEWING EFFECTIVENESS

Review of progress against duties/responsibilities set out above and Annual Report to be submitted to the [Trust name] Board of Directors.

13. REPORTING STRUCTURE

No other groups report to this Committee.

14. GLOSSARY

In this Terms of Reference, the following words bear the following meanings:

Acute Federation	The federation formed by the Trusts to provide strategic leadership and oversight of the delivery of the Partnership;
Acute Federation Board	The South Yorkshire and Bassetlaw Acute Federation Board is constituted as the principal body of the South Yorkshire and Bassetlaw Acute Federation of Providers.
Acute Federation Programme Management Office	Administrative infrastructure supporting the Acute Federation Partnership;
CiCs	The committees established by each of the Trusts to work alongside the committees established by the other Trusts and "CiC" shall be interpreted accordingly;
"Joint Working Agreement" or "JWA"	The agreement signed by each of the Trusts in relation to their joint working and the operation of the [Trust name] CiC together with the CiCs;
Meeting Lead	The CiC Member nominated (from time to time) to preside over and run the CiC meetings when they meet in common;
Member	A person nominated as a member of a CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;

[Trust name]/acronym]	[Trust name in full]
[Trust name] **(CiC)**	The committee established by [Trust name], pursuant to these Terms of Reference, to work alongside the other CiCs in accordance with these Terms of Reference;
[Trust name] **CiC Chair**	The [Trust name] CiC Member nominated to chair the [Trust name] CiC meetings;
Trusts	Barnsley NHS Foundation Trust Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Sheffield Children's NHS Foundation Trust Sheffield Teaching Hospitals NHS Foundation Trust The Rotherham NHS Foundation Trust "**Trust**" shall be interpreted accordingly;
Working Day	A day other than a Saturday, Sunday or public holiday in England;

Annex 1

Decisions of [Trust name] CIC

The Board of each Trust within the Acute Federation partnership remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [Trust name] CIC's Scheme of Delegation, the matters or type of matters, that are fully delegated to the [Trust name] CIC to decide are set out in the table below.

If it is intended that the CICs are to discuss a proposal or matter which is outside the decisions delegated to the [Trust name] CIC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [Trust name] CIC meeting with a view to [Trust name] CIC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [Trust name] Board of Directors). Any proposals discussed at the [Trust name] CIC meeting outside of these parameters would come back before the [Trust name] Board of Directors.

References in the table below to the **"Services"** refer to the services that form part of the joint working between the Trusts and may include both back office and clinical services.

	Decisions delegated to [Trust name] **CIC**
1.	Providing overall strategic oversight and direction to the development of the Acute Federation programme ensuring alignment of all Trusts to the vision and strategy.
2.	Promoting and encouraging commitment to the key principles.
3.	Seeking to determine or resolve any matters referred to it by the Acute Federation Programme Office or any individual Trust.
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the risks associated in terms of the impact to the Acute Federation Programme and recommending remedial and mitigating actions across the system.
5.	Formulating, agreeing and implementing strategies for delivery of the Acute Federation Programme.
6.	In relation to the Services preparing business cases;
7.	Provision of staffing and support and sharing of staffing information in relation to the Services.

8.	Decisions to support service reconfiguration (pre-consultation, consultation and implementation), including but not limited to: a. Provision of financial information; b. Communications with staff and the public and other wider engagement with stakeholders; c. Support in relation to capital and financial cases to be prepared and submitted to national bodies; including NHS England; d. Provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. Support in relation to any competition assessment; f. Provision of staffing support; and g. Provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. Redesign of clinical rotas; b. Provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. Developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services including but not limited to: a. Preparing joint venture documentation and ancillary agreements for final signature; b. Evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. Carrying out an analysis of the implications of TUPE on the joint arrangements; d. Engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. Undergoing soft market testing and managing procurement exercises; f. Aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. Amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority.
12.	Reviewing and agreeing the Terms of Reference and Joint Working Agreement of the CiC on an annual basis for recommendation to the [Trust name] Board of Directors for approval.
13.	Reviewing and approving the Terms of Reference for the Acute Federation Board.

DATED: [Date to be added]

(1) BARNSLEY HOSPITAL NHS FOUNDATION TRUST

(2) DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

(3) THE ROTHERHAM NHS FOUNDATION TRUST

(4) SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

(5) SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

JOINT WORKING AGREEMENT

1. Introduction

1.1 In this joint working agreement, the following words bear the following meanings:

Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this JWA;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Joint Working Agreement or their respective rights and obligations under it;
Meeting Lead	the Acute Federation CiC Member nominated (from time to time) in accordance with paragraph 6.4 of the Terms of Reference, to preside over and run the Acute Federation CiC meetings when they meet in common;
Member	a person nominated as a member of a Acute Federation CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
"Joint Working Agreement" or "JWA"	this agreement signed by each of the Trusts in relation to their joint working and the operation of the Acute Federation CiCs;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices to this Joint Working Agreement;

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, Sheffield Teaching Hospitals NHS Foundation Trust and "**Trust**" shall be interpreted accordingly;
Acute Federation **CiCs**	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**Acute Federation CiC**" shall be interpreted accordingly.
Acute Federation Board	The South Yorkshire and Bassetlaw Acute Federation Board is constituted as the principal body of the South Yorkshire and Bassetlaw Acute Federation of Providers.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other Acute Federation CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each Acute Federation CiC will be different.

2. Background

2.1 Since 2013, the Trusts have been working together as an innovative partnership (the **Working Together Partnership**) and the Working Together Partnership became an Acute Care Collaboration Vanguard in 2015, and then South Yorkshire and Bassetlaw (SYB) Acute Federation in 2018.

2.2 The Acute Federation's stated strategic aims are:

2.2.1 Working together to drive the quality of care to be amongst the best in the country;

2.2.2 Taking a proactive approach to reduce health inequalities for the populations we serve;

2.2.3 Collaboratively developing our colleagues and teams so that we have happy staff;

2.2.4 Being a great partner to the rest of the health and care system in SYB;

2.2.5 Supporting each other to achieve all the NHS waiting time standards for local people; and

2.2.6 Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system.

2.3 In July 2016 the Boards of the Trusts, as part of the Working Together Partnership, confirmed the creation of the Acute Federation. It was agreed that further phases for changes to the governance structure would develop to enhance the delivery of the new models of care as the service change options became clearer.

2.4 In light of the above, the Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the existing legislation, enables "group" and common decision making structures; the Acute Federation CiCs.

2.5 The Trusts will remain as five separate legal entities with their own accountabilities and responsibilities. For avoidance of doubt there is no intention that the governance structure outlined in this Joint Working Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3. Principles of working

3.1 The Trusts have agreed to adopt this Joint Working Agreement dated [Date to be added] and agree to operate the Acute Federation CiCs in line with the terms of this JWA, including the following principles (the "**Principles of Working**"):

3.1.1 through collaboration with each other aspiring, for the benefit of our patients, to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems;

3.1.2 making the starting point for everything the Trusts do "can this be done better, safer, more economically for our patients if we work with our partners in a different way?";

3.1.3 move at pace in examining all activities on a "bottom up" basis, across the Trusts, engaging clinical and non-clinical teams to adopt innovative approaches and best practice;

3.1.4 challenge themselves and embrace change where it benefits its patients or the health care system as a whole. Status quo is not an option if we are to do the right thing for patients on a sustainable basis;

3.1.5 establish a governance model which facilitates this approach. Structure will not be a barrier to innovative change while recognising the statutory responsibilities of all five individual Trust Board of Directors;

3.1.6 models of cost/benefit equalisation will be a key ingredient of the partnership activity to ensure financial loss or gain for any individual Trust is not a barrier to beneficial system change/progress;

3.1.7 seek support from commissioners to ensure changes are achieved at pace in order to gain maximum benefits for patients and system stability;

3.1.8 collaborate and co-operate. Establish and adhere to the governance structure set out in the Terms of Reference to ensure that activities are delivered and actions taken as required;

3.1.9 be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference;

3.1.10 be open. Communicate openly about major concerns, issues or opportunities relating to the joint working subject always to appropriate treatment of commercially sensitive information and competition law compliance;

3.1.11 adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation;

3.1.12 act in a timely manner. Recognise the time-critical nature of the joint working and respond accordingly to requests for support;

3.1.13 manage stakeholders effectively; and

3.1.14 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the requirements and responsibilities set out in this Joint Working Agreement and the Terms of Reference.

4. Process of working together

4.1 The Acute Federation CiCs shall meet together in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-6).

4.2 The Acute Federation CiCs shall work collaboratively with each other in relation to the committees in common model.

4.3 Each Acute Federation CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of References, and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any Acute Federation CiC or its duty to act in the best interests of its Trust, each Acute Federation CiC shall seek to reach agreement with the other Acute Federation CiCs and take decisions in consensus, in light of its aims and Principles of Working set out in clauses 2 and 3 above.

4.4 When the Acute Federation CiCs meet in common, the Meeting Lead shall preside over and run the meeting on a rotational basis for a period of two years, rotating at the January meeting each year.

5. Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Joint Working Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Joint Working Agreement.

6. Exit Plan

6.1 Within three (3) months of the date of this JWA the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this JWA;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the Acute Federation CiC Chairs varying the JWA under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this JWA at Appendix 6 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this JWA.

7. Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant committee and exit this JWA ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the Acute Federation Managing Director of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exiting the JWA,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 6) exit this JWA.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its Acute Federation CiC and exits this JWA then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this JWA; or

7.3.2 Amend and replace this JWA with a revised joint working agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8. Information Sharing and Competition Law

8.1 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the provision of the JWA in an honest, open and timely manner.

8.2 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law.

9. Conflicts of Interest

Members of each of the Acute Federation CiCs shall ensure that Members of the other Acute Federation CiCs are aware of any conflict of interest applicable to them, which has any relevance to the work of the Acute Federation CiCs.

10. Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Principles of Working set out in clause 3 above.

10.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to any matter in this JWA, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the Acute Federation CiC Chairs the appropriate course of action to take.

10.4 If the Meeting Lead and the Acute Federation CiC Chairs reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of

the decision by written notice. Any decision of the Meeting Lead and the Acute Federation CiC Chairs will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the Acute Federation CiC Chairs, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the Acute Federation CiC Chairs, may determine whatever action they believes is necessary including the following:

10.5.1 If the Meeting Lead and the Acute Federation CiC Chairs cannot resolve a Dispute, the Meeting Lead may select an independent facilitator to assist with resolving the Dispute; and

10.5.1.1 the independent facilitator shall:

a) be provided with any information he or she requests about the Dispute;

b) assist the Meeting Lead and Acute Federation CiC Chairs to work towards a consensus decision in respect of the Dispute;

c) regulate his or her own procedure and, subject to the terms of this JWA, the procedure of the Meeting Lead and Acute Federation CiC Chairs at such discussions;

d) determine the number of facilitated discussions, provided that there will be not less than three and not more than five facilitated discussions, which must take place within 20 Working Days of the independent facilitator being appointed; and

e) have its costs and disbursements met by the Trusts equally.

10.6 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only after such further consideration again fails to resolve the Dispute, the Meeting Lead and Acute Federation CiC Chairs may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the JWA;

10.6.2 vary the JWA (which may include a re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11. Variation

No variation of this JWA shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

Counterparts

11.1 This JWA may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this JWA, but all the counterparts shall together constitute the same agreement.

11.2 The expression “counterpart” shall include any executed copy of this JWA transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

11.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

12. Governing law and jurisdiction

This JWA shall be governed by and construed in accordance with English law.

THIS JOINT WORKING AGREEMENT is executed on the date stated above by

……

For and on behalf of Barnsley Hospital NHS Foundation Trust

……

For and on behalf of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

……

For and on behalf of The Rotherham NHS Foundation Trust

……

For and on behalf of Sheffield Children's NHS Foundation Trust

……

For and on behalf of Sheffield Teaching Hospitals NHS Foundation Trust

APPENDIX 1

[Insert Terms of Reference for the Barnsley Hospital NHS Foundation Trust CiC]

APPENDIX 2

[Insert Terms of Reference for the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 3

[Insert Terms of Reference for The Rotherham NHS Foundation Trust CiC]

APPENDIX 4

[Insert Terms of Reference for the Sheffield Children's NHS Foundation Trust CiC]

APPENDIX 5

[Insert Terms of Reference for the Sheffield Teaching Hospitals NHS Foundation Trust CiC]

Appendix 6

Exit Plan

1. In the event of termination of this Joint Working Agreement (JWA) by all parties, the Trusts agree that:
   a. each Trust will be responsible for its own costs and expenses incurred as a consequence of the termination of this JWA up to the date of termination *unless* it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;
   b. upon reasonable written notice, each Trust will be liable for one fifth of any professional adviser's fees incurred by and on behalf of the Acute Federation in relation to the termination of this JWA (if any) up to and including the date of termination of this JWA;
   c. each Trust will revoke its delegation to its Working Together Partnership Acute Federation Committee in Common (CiC) on termination of this JWA;
   d. termination of this JWA shall not affect any rights, obligation or liabilities that the Trusts have accrued under this JWA prior to this termination of this JWA;
   e. there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this JWA how any joint assets or resources will need to be dealt with on termination of the JWA.
2. In the event of an exiting Trust exiting this JWA in accordance with clause 7, the Trusts agree that:
   a. a minimum of six months' notice will be given by the exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the exiting Trust's exiting from the Acute Federation and this JWA up to and including the exiting Trust's date of exit from this JWA. Notwithstanding this, the exiting Trust's total aggregate liability, in respect of such reasonable costs and expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the Committee in Common;
   b. upon reasonable written notice from the other Trusts, the exiting Trust shall be liable to pay one fifth of any professional adviser's fees incurred by and on behalf of the Acute Federation as a consequence of the exiting Trust's exit from the Acute Federation and this JWA up to and including the date of exit of the exiting Trust from this JWA;
   c. the exiting Trust will revoke its delegation to its Acute Federation on its exit from this JWA;
   d. the remaining Trusts shall use reasonable endeavours to procure that the JWA is amended or replaced as appropriate in accordance with clause 7.3.2.
   e. subject to any variation to or replacement of this JWA in accordance with paragraph d above and clause 7.3.2 this JWA shall remain in full force and effect following the exit of the exiting Trust from the JWA.

2401 - H INFORMATION ITEMS

12:50

2401 - H1 CHAIR AND NEDS REPORT

Information Item

Suzy Brain England OBE, Chair of the Board

REFERENCES

Only PDFs are attached

H1 - Chair & Non-executive Directors Board Report.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page				
Meeting Title:	**Board of Directors**			
Meeting Date:	30 January 2024	**Agenda Reference:**	**H1**	
Report Title:	**Chair and Non-executive Directors' Board Report**			
Sponsor:	Suzy Brain England OBE, Chair of the Board			
Author:	Suzy Brain England OBE, Chair of the Board			
Appendices:	N/A			

Report Summary				
This report is for information only and provides an update on the Chair and Non-executive Directors' activities since November 2023's board meeting.				
Recommendation:	The Board is asked to **note** the contents of this report.			
Action Required:	~~Approval~~	~~Review and discussion/ give guidance~~	~~Take assurance~~	**Information only**
Link to True North Objectives:	**TN SA1:** *To provide outstanding care and improve patient experience*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from colleagues and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**Nottingham & Nottinghamshire ICS**	
	NA		**NA**	

Implications	
Board assurance framework:	
Risk register:	
Regulation:	
Legal:	
Resources:	

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

Chair's Report

Official Openings

Just before Christmas I joined Ed Miliband MP to cut the ribbon on the Endoscopy Unit at Montagu Hospital. This marked the completion of phase two of the three-phase Community Diagnostic Centre project, representing a significant investment to enhance health services within the Dearne Valley area of South Yorkshire. The Endoscopy Unit officially opened to patients on 20 November 2023 and features two fully functioning procedure rooms, in addition to training facilities and multifunctional clinic rooms.

Just a few days later, Richard Parker and I were joined by the Chief Executive and Chairs of The Rotherham Foundation Trust and Barnsley Hospital NHS Foundation Trust at a ribbon cutting ceremony at the Mexborough Elective Orthopaedic Centre. The Centre of Excellence welcomed its first patients earlier this month. The dedicated orthopaedic hub features two state-of-the-art theatre units, anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds within a dedicated ward area. Working in collaboration with Rotherham and Barnsley Hospitals, the Trust will provide services across the region, in an environment that is protected from typical disruptions experienced by general hospitals, especially during periods of increased activity in the winter months.

Celebratory Events

During December I was delighted to join colleagues to recognise and celebrate their loyal service to the NHS of 10, 20, 30, 40 and even 50 years at a number of afternoon tea celebrations. The gatherings were part of a relaunch of the Trust's Long Service Programme which included marking long service with a certificate, pin badge and for those serving 40 and 50 years a gift voucher, via the Vivup Highfive app. The events were very well attended and provided a great opportunity for the Board of Directors to meet colleagues and share its appreciation, which I know from feedback was much appreciated.

The Trust also took the opportunity to recognise the contribution of our volunteers and governors at coffee mornings and along with other members of the Board I attended the Bassetlaw League of Friends Carol Service.

Doncaster Business Awards 2023

December was certainly a month of significant achievements and at the Doncaster Business Awards I was delighted to hear the Trust named as Employer of the Year, in addition to being awarded Campaign of the Year for the Serenity Appeal.

In recent years the Trust has achieved improved results in colleague engagement, demonstrated by its high response rates in the annual NHS Staff Survey, implemented the RACE Equality Code Quality Mark and a comprehensive action plan on equality, diversity and inclusion, as well as the

redevelopment of a comprehensive programme of reward and recognition. The Trust's People Strategy, launched in early 2023, further outlines its commitment to improving the working lives of its colleagues.

Governors

Following the recent election of governors in September 2023 and as part of an ongoing training and development programme, governors were invited to a bespoke, face to face training session this month. The session was engaging, interactive and focused on the development of the collective Council of Governors. Facilitated by Carl Smith, a long-term faculty member of NHS Leadership Academy, the session explored effective ways of working, strengthened existing relationships and developed new ones.

1:1s & Introductory Meetings

In addition to my regular meetings with the Chief Executive, I have taken part in one-to-one discussions with the Deputy Chief Executive, Non-executive Directors and met with the Lead Governor, Deputy Lead Governor and Company Secretary. I have met with both the interim and recently appointed substantive Chief Information Officer and the Divisional Director of Surgery.

Other Meetings/Events

Since my last report I have chaired December's Board meeting and attended a non-executive development session on the Patient Safety Incident Response Framework.

I have chaired a meeting of the Council of Governors Nomination & Remuneration Committee and attended a meeting of the Charitable Funds Committee.

I continue to be actively engaged at Place and across both systems, representing the Trust at South Yorkshire Acute Federation, South Yorkshire Integrated Care Board Chair & Chief Executive Planning Meetings, Doncaster Place Partnership Forum and Nottingham & Nottinghamshire Chairs & Elected Members meeting.

I supported the latest DBTH People Path session which highlighted the career journeys of Professor Sam Debbage, Director of Education & Research and Lucy Nickson, Non-executive Director; if you were unable to join the call you can catch up on the discussion here.

Following an unsuccessful bid for the New Hospital Programme the Trust continues to take all opportunities to raise awareness of the need for refurbishment of the Doncaster Royal Infirmary site, including engagement with local MPs, the South Yorkshire Mayor, NHSE and the Department of Health & Social Care.

Finally, in another exciting development for the Trust, I was pleased to see a demonstration of the da Vinci robotic surgical platform, supported by charitable funds, took place this week.

Non-executive Director's (NEDs) Report

Kath Smart

Since the last report, Kath has attended her corporate meetings of the Finance & Performance Committee, Charitable Funds Committee and Board of Directors, and along with NED colleagues she attended the non-executive development session on the Patient Safety Incident Response Framework

In preparation for January's Audit & Risk Committee, Kath worked with the corporate team to develop the agenda and also met with internal auditors, 360 Assurance. January's Audit & Risk Committee took place on 16 January and the outcome is reported separately on this Board agenda. Two new Governors have joined as observers and Kath has met with both to assist with their new role. As Chair of Audit and Risk, she attended the

Trust's November Health & Safety Committee meeting to keep abreast of how the Committee is providing assurances to the Audit and Risk Committee.

Kath attended the Qii Team report out in November and heard from the Finance team and their improvement projects, including Financial Forecasting, Workforce Establishment Review and Patient Level Information and Costing Systems (PLICS), and also the January report out which had presentations on Falls Prevention and use of Huddle Boards in the Neonatal Unit.

There were opportunities for a number of engagement events in December, and Kath attended two of the Long Service Awards presentations with the opportunity to engage with many of those staff receiving such awards. She attended the Governor Christmas engagement session, and the Volunteers thank you session, providing an opportunity to talk with governors and volunteers about their roles.

Emyr Jones

Since his last report Emyr Jones has participated in his designated Board and Committee meetings. In addition, he has attended bi-monthly catch-up meetings with the Chair of the Quality & Effectiveness Committee and the Chief Nurse. He has also met with the recently appointed South Yorkshire Integrated Care Board Maternity and Neonatal Independent Senior Advocate.

Together with Richard Parker, Chief Executive and others, Emyr has visited the accommodation for medical and other clinical staff at Doncaster Royal Infirmary and has been involved in discussions about how future improvements in standards of accommodation can be planned and monitored.

With Non-executive director colleague, Mark Day, Emyr was a member of the panel hearing a grievance, conducted in accordance with the Trust's Grievance Procedure.

In respect of additional learning, Emyr has attended the two-day on-line training event delivered by NHS Providers for Non-executive directors: 'Board development: Non-executive Director Induction'. He has also attended an event on 'Excellence in Healthcare'.

Along with fellow non-executive directors Emyr has participated in a non-executive development session where, together with follow Non-executive director Jo Gander, he led the presentation and discussion on the introduction the Patient Safety Incident Response Framework (PSIRF).

Emyr attended the Governors' Christmas Coffee morning, the Volunteers Festive Brunch and the Bassetlaw League of Friends Carol Service.

Jo Gander

Since the last Board report, Jo has chaired December's Quality and Effectiveness Committee, attended the Charitable Funds and Audit & Risk Committees, as well as attending the Quality & People Committee at Nottingham & Nottinghamshire ICB.

Jo held a bi-monthly meeting with the Chief Nurse and along with Emyr Jones met with South Yorkshire Integrated Care Board's Maternity and Neonatal Independent Senior Advocate.

She attended an NHS Providers roundtable event with the Chair of NHS England's Maternity & Neonatal Board, met with international midwives and nurses and attended the Bassetlaw League of Friends Carol Service.

Jo chaired an interview panel for a Consultant Endoscopist.

Lucy Nickson

Since the last Board meeting, Lucy has been on site at Doncaster Royal Infirmary for meetings and non-executive director development time. She attended a long service afternoon tea in December and has spent time meeting staff at Bassetlaw Hospital, accompanying the Health and Well Being team on their wellbeing drinks and chat trolley round.

Lucy has chaired the Teaching Hospital Board and attended her regular corporate meetings, including the Quality & Effectiveness, People and Charitable Funds Committees. She has also attended the Council of Governors.

In addition, Lucy has attended two days of NHS Providers training 'Effective Chairing of NHS Organisations'.

Mark Bailey

Since the last Board report, Mark has chaired the Board Committee for People and attended his designated corporate meetings; Finance and Performance Committee, including a follow-on session examining progress on cost improvements, Audit & Risk and Board of Director and Board and Non-Executive development sessions.

Mark has met with the Chief People Officer to continue assurance work on the implementation of our People Strategy and planning for 2024/5. Executive and Non-Executive colleague assurance and strategic development discussions have continued including time with the Deputy Chief Executive, Chief Nurse, Chief Financial Officer, Director of Education & Research, and the Managing Director of the Doncaster & Bassetlaw HealthCare Services subsidiary business. Most recently, Mark was pleased to have the opportunity to meet with and have an introductory buddy conversation with the recently appointed Chief Information Officer.

Other activities have included chairing of the recruitment panel for the appointment of a consultant in trauma and orthopaedics and participation in the non-executive panel for a grievance hearing relating to employment.

Finally, site visits have included time with the Estates and Facilities team based at Bassetlaw and the opportunity to thank our team of volunteers at DRI just before Christmas.

2401 - H2 CHIEF EXECUTIVE'S REPORT

Information Item

Richard Parker OBE, Chief Executive

REFERENCES

Only PDFs are attached

H2 - Chief Executive's Report.pdf

Chief Executive Report
January 2024

Orthopaedic Centre at Mexborough welcomes its first patients

The Mexborough Elective Orthopaedic Centre of Excellence (MEOC) welcomed its first patients to the service on Monday 15 January 2024.

The MEOC is part of a national initiative to reduce waiting lists and is one of two orthopaedic surgical hubs sponsored by the South Yorkshire Integrated Care System (ICS). The project was delivered following investment of just under £15 million, with construction beginning in July 2023 and completing in December 2023.

The service will operate 50 weeks a year, starting as a five day a week service, increasing to six days once running to full capacity, expected by mid-2024. It is anticipated that knee and hip replacement patients will be able to go home the same day as their surgery, in line with national best practices.
The centre, which is a collaboration between three hospital trusts, Doncaster and Bassetlaw Teaching Hospitals (DBTH), Barnsley Hospital NHS Foundation Trust (BH), and The Rotherham Foundation Trust (TRFT), will focus exclusively on procedures such as hand and wrist surgeries, foot and ankle treatments, arm and shoulder procedures, carpals, and knee and hip replacement.

Its location at Montagu Hospital in Mexborough, ensures that it will remain protected from the typical disruptions experienced by general hospitals, particularly emergency treatment pressures and heightened activity during the colder months.

On Friday 5 January, a number of visitors, including governors and non-executive directors from all three trusts, toured the new department. Surgeons from each Trust visited the service as have clinicians from Sheffield Children's Hospital.

Those wishing to find out more about the MEOC, including a walkthrough video of the department, can head over to the dedicated section on the DBTH website here: www.dbth.nhs.uk/meoc

Community Diagnostic Centre (CDC) Ribbon-cutting Ceremony

In December 2023, Ed Miliband MP, officially opened The Endoscopy Unit at The Montagu Community Diagnostic Centre (CDC).

Phase two of a three-phase project opened in November introducing a fully functional endoscopy suite to Montagu Hospital with training facilities, and multifunctional clinic rooms, including ultrasound.

The CDC has received funding of just under £25m in total, of which £9m has been spent in the phase two development.

Topping Out event at Bassetlaw Emergency Village

On Friday 19 January, a ‘topping out’ event took place to mark the completion of the structure of the building works for the Bassetlaw Emergency Care Village project.

Brendan Clarke-Smith MP, building partners and colleagues from the trust attended the event to mark the milestone. The project is on track to deliver the new enhanced and expanded Emergency Department in Bassetlaw in early 2025.

Da Vinci Xi Robotic surgical platform engagement event

On Monday 29 January, the Education Centre will host an exclusive hands-on experience with the da Vinci robotic platform including Advanced Instrumentation and Simulator.

In the new financial year, , thanks to funding from Doncaster and Bassetlaw Teaching Hospitals Charity, Doncaster Royal Infirmary will receive the da Vinci Xi Robotic surgical platform. The investment in the state-of-the-art surgical robot will transform the way DBTH performs some cancer surgery, commencing with colorectal cancer patients before extending into other types of cancer surgery.

Colleagues and partners will be invited to hear about the difference it would make to patients, get up close to the surgical robot, and have a go on the surgeon's console.

Doncaster Cancer Detection Trust Donate Life-saving Liver Scanner

Patients at DBTH will now benefit from enhanced liver health assessments thanks to a donated Fibroscanner, or transient elastography machine, by Doncaster Cancer Detection Trust (DCDT).

The £92,000 Fibroscanner enables clinicians to diagnose liver disease by measuring inflammation, stiffness and fatty changes in a patient's liver, in a non-invasive, painless scan which takes less than ten minutes.

The scanner will play a crucial role in helping to diagnose liver disease at an earlier stage. With early diagnosis, patients can make different life-style choices, and we can offer more effective treatments to help reverse the damage, allowing patients to fully recover.

The funding for the mobile scanner also includes a comprehensive training package for four dedicated DBTH colleagues. This investment in expertise ensures that the technology will be used to its full potential, providing the best possible care to the patients of Doncaster.

Trust hosts Special Celebration Event for Recent Learner Graduates

A special celebration and graduation event for the Trust's latest cohort of learners took place in December. This ranged from graduating apprentices to those who completed specific caring qualifications, as well as individuals achieving functional skills in English and maths.

In 2022/23 DBTH hosted over 1,180 students, including nurses, and allied health professionals (physios and therapists). Acknowledging the hard work and dedication of the organisation's learners, their mentors, peers and managers, the celebratory event took place in Doncaster Royal Infirmary's (DRI) Lecture Theatre in December.

Each of the successful learners were presented with a certificate detailing their achievement and a special pin badge. Graduates were then able to interact and share experiences with colleagues and leaders who supported them whilst on their learning journey.

DBTH receive Employer of the Year and Campaign of the Year awards at the Doncaster Business Awards 2023

DBTH collected two awards at the Doncaster Business Awards 2023. DBTH were shortlisted for nine awards at the ceremony, held on Thursday 7 December at the Doncaster Racecourse, which marks the achievements and contributions of businesses in the borough.

DBTH were named Employer of the Year, an award which acknowledged the significant steps the Trust has made to celebrate and nurture its diverse workforce, placing a high value on wellbeing and engagement.

DBTH Charity also picked up the award for 'Campaign of the Year' following its hugely successful baby loss campaign, 'The Serenity Appeal'. The appeal, which surpassed its £150,000 target by thousands of pounds, saw the funding of a specialist maternity bereavement suite at DRI.

NHS England Chief Nursing and Midwifery Officer Awards

Katrina Hall-Evans and Kelly Roberts, both Midwifery Support Workers at the Trust, received the prestigious Chief Midwifery Officer Awards to mark their incredible achievements and dedication to their practice.

Katrina and Kelly were both nominated by their colleagues for their work to improve the infant feeding provision at DBTH for women who were having feeding difficulties. They worked with the infant feeding lead midwives to develop a dedicated infant feeding team. Women who give birth at DBTH now have better education about the process and benefits of breastfeeding and have access to appropriate support. As a result, women are more likely to breastfeed.

Pauline McNeil was the recipient of the Chief Nursing Officer Award. With over 30 years of service in the NHS, and nearly a decade of experience with in DBTH's Children's Outpatients Department, Pauline was recognised for her exceptional dedication to compassionate patient care and mentoring her colleagues to support them in their professional development.

Residents urged to attend scheduled hospital appointments

In an effort to enhance the overall healthcare experience for the local community, the Trust is calling on all patients to let the hospital know if they cannot attend their appointment.

Missed appointments occur when patients do not attend an appointment and don't let the Trust know in advance, this means the appointment slot cannot be used for another patient. In August alone, over 3,800 appointments were missed, this equates to around 10% of all scheduled appointments.

The Trust provides an appointment reminder service via text message and via the DrDoctor app. It is essential that the trust have up to date contact information for patients so that they can receive these reminders. Most appointments can be rescheduled by contacting the booking team using the contact details on your appointment letter, or by downloading the DrDoctor app and requesting an alternative appointment.

The need to reduce the number of missed appointments has never been more important as we strive to reduce waiting times following the Covid-19 pandemic.

Police and Crime Commissioner Consultation

The Government's Levelling Up White Paper published in 2022 outlined a commitment to enable Mayors (such as South Yorkshire's Mayor) to take on public safety functions, including Police and Crime Commissioners, reiterating the key leadership role that combined authority Mayors have in public safety and improving public health.

In response to this South Yorkshire's Mayoral Combined Authority (MCA) and the Police and Crime Commissioner agreed to write to the Government to express their ambition for the Mayor to take on these functions.

The transfer of these responsibilities to the Mayor presents opportunities to align police and crime priorities with other MCA work around health, public transport, regeneration, skills and employment, and to improve outcomes for people and communities across South Yorkshire.

If the order passes through Parliament, the role of Police and Crime Commissioner for South Yorkshire would be abolished in May 2024. As there would then be a Mayoral election taking place on the 2 May 2024 people across South Yorkshire would have the opportunity to vote for the candidate they would like to elect for the integrated role of Mayor and Police Crime Commissioner.

A public consultation on the proposed changes has been taking place and we have shared the consultation with our colleagues.

2401 - H3 INTEGRATED QUALITY & PERFORMANCE REPORT

Information Item

Executive Directors

REFERENCES

Only PDFs are attached

H3 - Integrated Quality & Performance Report.pdf

DBTH Digital Transformation

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Integrated Quality & Performance Report

Reporting Period - December 2023

Report Purpose	Data Source(s)	Report Created	Report Layout Modified	Report Owner	Contact Details	Training
To understand the Trust's current position with respect to the services they deliver.	Mega Cube Data Warehouse MS Forms	15/01/2024	19/01/2024	Executive Director of Restoration, Innovation and Transformation	dbth.informationservicesrequests@nhs.net	Regular training sessions are held, please email for more information.

DBTH Performance - Trust Level View

Aug 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

DBTH Health

6.5%

(Last Month 7.5%)

(9+17 / 400 = 6.5 %)

Finance

NOT AVAILABLE

Coming Soon

People

Unvalidated

0 %

0 out of 6 KPI's

SET Training	86.06%
Completed Appraisals	83.29%
Employee Turnover	1.93%
Sickness Absence	5.94%
Workforce Vacancies	7.43%
Consultants with Signed Off Job Plans in EJP	44.00%
Time to Fill Vacancies	74 Days

Health Inequalities

0 %

0 out of 1 KPI's

Health Inequalities	0/1

Patients

31 %

9 out of 29 KPI's

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

Performance

27 %

17 out of 62 KPI's

Urgent and Emergency Care	0/11
Waiting List	0/8
Cancer	3/8
Activity Against Plan	4/9
Elective Recovery Fund	N/A
Stroke	3/6
Elective Outpatients	1/9
Elective Theatres	2/7

Index

Finance

Coming Soon

People

- People
- People Forms Data
- People Forms Data 2

Health Inequalities

- Ethnicity Recorded

Patients

- IPC
- HSMR
- Patient Safety
- Skin Integrity
- Falls
- Patient Experience
- Claims
- Friends and Family Test
- Audit and Effectiveness
- VTE
- Reducing Length Stay
- Medical Examiner

Performance

Urgent & Emergency Care	Urgent & Emergency Care Trends
Waiting List	Waiting List Trends
Cancer	Cancer Trends
Activity Against Plan	Activity Against Plan Outpatients Trends
	Activity Against Plan Inpatients Trends
Elective Recovery Fund	Elective Recovery Fund Trends
Stroke	Stroke Trends
Elective Outpatients	Elective Outpatients Trends
Elective Theatres	Elective Theatres Trends

All Performance KPIS Trends

Urgent & Emergency Care Dec 23

ED Attendances
16333

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Ambulance Handovers

Ambulance Handovers Within 15 Mins
36.15 % !
Goal: 65.00 %

Ambulance Handovers Within 30 Mins
64.81 % !
Goal: 95.00 %

Ambulance Handovers More Than 60 Mins
16.82 % !
Goal: 0.00 %

EM Wait Times

A&E: Max wait 4 hours from arrival/admission/transfer/discharge
62.45 % !
Goal: 95.00 %

% Patients with Total Length of Stay in Emergency Department More Than 12 hours
7.08 % !
Goal: 2.00 %

Self Arrivals - Initial Assessment Within 15 Mins
53.72 % !
Goal: 95.00 %

Critical Time Standards

STEMI Heart Attack - to be seen within 1 hour
Not Available

Early Stroke Intervention - to be seen within 1 hour
Not Available

Acute Physiological (RAPID) Asthma - to be seen within 1 hour
Not Available

Admission Wait Times

TOTAL - % patients leaving A&E from clinically ready to proceed to admission within 60 Mins
7.02 % !
Goal: 95.00 %

Specialty Item Category	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to admission within 60 Mins
PAEDIATRICS	142	65.52 %
GYNAECOLOGY	123	37.04 %
OTHER	408	13.18 %
GENERAL SURGERY	246	4.24 %
GENERAL MEDICINE	1258	2.73 %
TRAUMA AND ORTHO SURGERY	119	0.00 %
Total	**2296**	**7.02 %**

Non Admission Wait Times

(For Monitoring Only)

TOTAL - % patients leaving A&E from clinically ready to proceed to Departure within 60 Mins
49.34 % !
Goal: 95.00 %

Attendance Disposal Item	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to departure within 60Mins
ANP Discharge	9	33.33 %
Brought in Dead	1	
Dead on Arrival	1	
Died in department	17	0.00 %
Discharged	10057	50.37 %
Discharged home with COVID-19 advice to self-isolate	7	66.67 %
ESA - Direct to Orthopaedics	11	
ESA - Direct to Urology	2	100.00 %
ESA - Referred to Ambulatory Care	149	53.85 %
Total	**14037**	**49.34 %**

Hospital

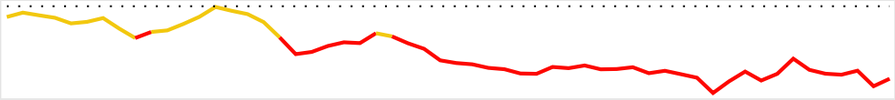
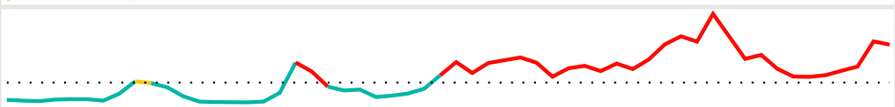
Doncaster Royal Infirmary | Bassetlaw District General Hos... | Mon...

Click here for EM Trends

Urgent & Emergency Care

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
A&E: Max wait four hours from arrival/admission/transfer/discharge	66.23 %	95.00 %	!	
Ambulance Handovers Within 15 Minutes	40.86 %	65.00 %	!	
Ambulance Handovers Within 30 Minutes	70.06 %	95.00 %	!	
Ambulance Handovers More Than 60 Minutes	12.83 %	0%	!	
% Patients with Total Length of Stay in Emergency Department >12 hours	5.74 %	2.00 %	!	
TOTAL -% patients leaving ED from clinically ready to proceed to admission within 60 mins	7.95 %	95.00 %	!	
Self Arrivals - Initial Assessment Within 15 Mins	54.25 %	95.00 %	!	

Waiting List

Dec 23

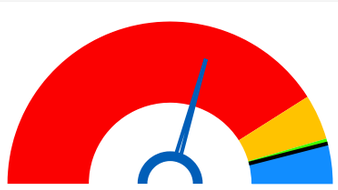
Active RTT waiters (Total Incomplete Pathways)
53897

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

RTT Waiters

% of patients waiting less than 18 weeks from referral to treatment
58.86 % !
Goal: 92.00 %



RTT Number of 52 Weeks Waiters
1330

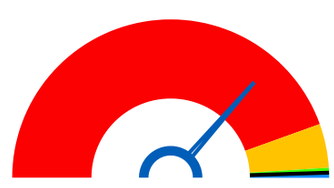
RTT Number of 78 Weeks Waiters
16
Target 0

RTT Number of 65 Weeks Waiters
303
Target 0

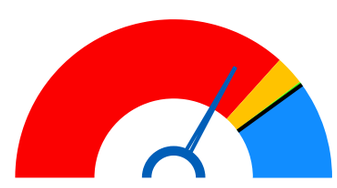
RTT Number of 104 Weeks Waiters
2
Target 0

Waiters - Diagnostic Activity

% of patients waiting less than 6 weeks from referral for a diagnosti...
72.86 % !
Goal: 99.00 %

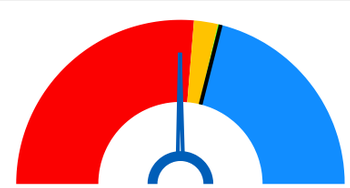


Trust - % DM01 Diagnostic Activity vs 19/20 levels
99.30 % !
Goal: 120.00 %

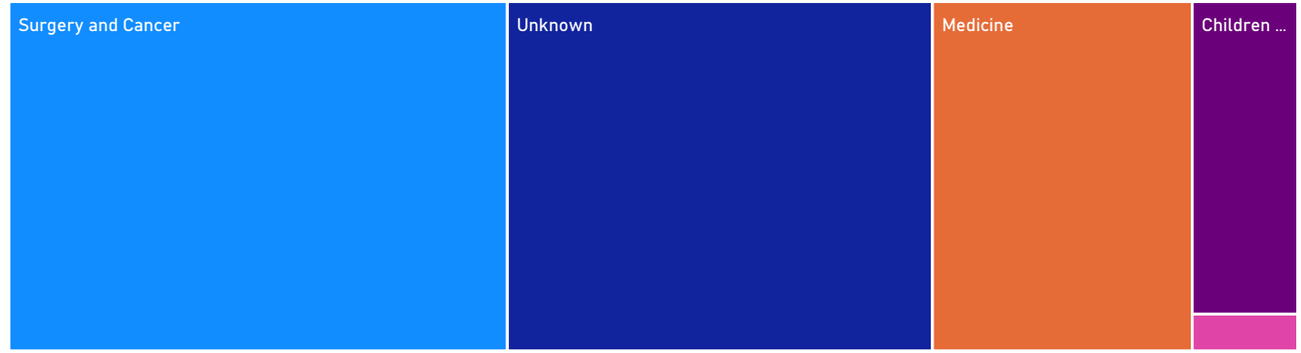


RTT Clock Stop Activity

Clock Stop Activity (% against 19/20)
94.76 % !
Goal: 110.00 %



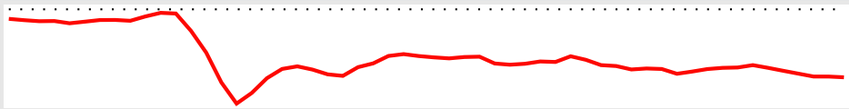
Division (Drill Down For Speciality)



Click here for RTT Waiters Trends

Waiting List

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
% of patients waiting less than 18 weeks from referral to treatment	61.12 %	92.00 %	!	
RTT Number of 52 Weeks Waiters	1335			
RTT Number of 78 Weeks Waiters	16	0		
RTT Number of 104 Weeks Waiters	2	0	▲	
% of patients waiting less than 6 weeks from referral for a diagnostics test (DM01)	76.13 %	99.00 %		
Clock Stop Activity (% against 19/20)				

Cancer

Nov 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	M All KPIs on this page are refreshed on monthly basis.

Day 28 Faster Diagnosis Standard (patients received diagnosis or exclusion of cancer within 28 da...

85.20 %✓

Goal: 75.00 %

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

95.60 % !

Goal: 96.00 %

Maximum 31 day wait for subsequent treatment - Surgery

100.00 %✓

Goal: 94.00 %

Maximum 31 day wait for subsequent treatment - Drugs

100.00 %✓

Goal: 98.00 %

Maximum 62 day wait for patients on 2ww pathway to first definitive treatment

64.50 % !

Goal: 85.00 %

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

66.60 % !

Goal: 90.00 %

Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days

37.00 !

Goal: 22.00

Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +

16.00 !

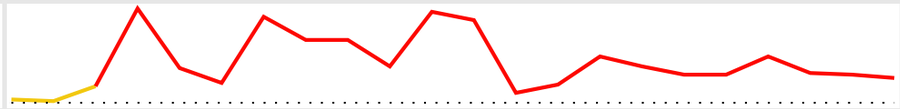
Goal: 0.00

Click here for Cancer Trends →

Cancer

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Maximum 31 day wait for subsequent treatment - Drugs	100.00 %	98.00 %	✓	
Day 28 Faster Diagnosis Standard (patients received diagnosis or exclusion of cancer within 28 days)	85.20 %	75.00 %	✓	
Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	95.60 %	96.00 %	▲	
Maximum 31 day wait for subsequent treatment - Surgery	100.00 %	94.00 %	✓	
Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	66.60 %	90.00 %	!	
Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	64.50 %	85.00 %	!	
Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days	37.00	22.00	!	
Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	16.00	0.00	!	

Activity Against Plan

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Inpatients

TOTAL Activity against plan

40617!

Plan: 43589(-2972) (M)

Non Elective Activity - Discharges (for monitoring)

5411 (D)

Endoscopy Activity against plan

1231!

Plan: 1663(-432) (M)

Day Case Theatre Activity against plan

796!

Plan: 858 (-62) (D)

Non-Theatre Elective Activity - excluding Endoscopy against plan

247✓

Plan: 180 (+67) (M)

In Patient Elective Theatre Activity against plan

394!

Plan: 406 (-12) (D)

Outpatients

Outpatient Procedures (For Monitoring Only)

7,018 (D)

Outpatient New Activity - face to face Including Procedures against plan

10,532!

Plan: 11,816 (-1,284) (D)

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

19,636!

Plan: 22,290 (-2,654) (D)

Outpatient New Activity - Virtual against plan

1,682✓

Plan: 1,620 (+62) (D)

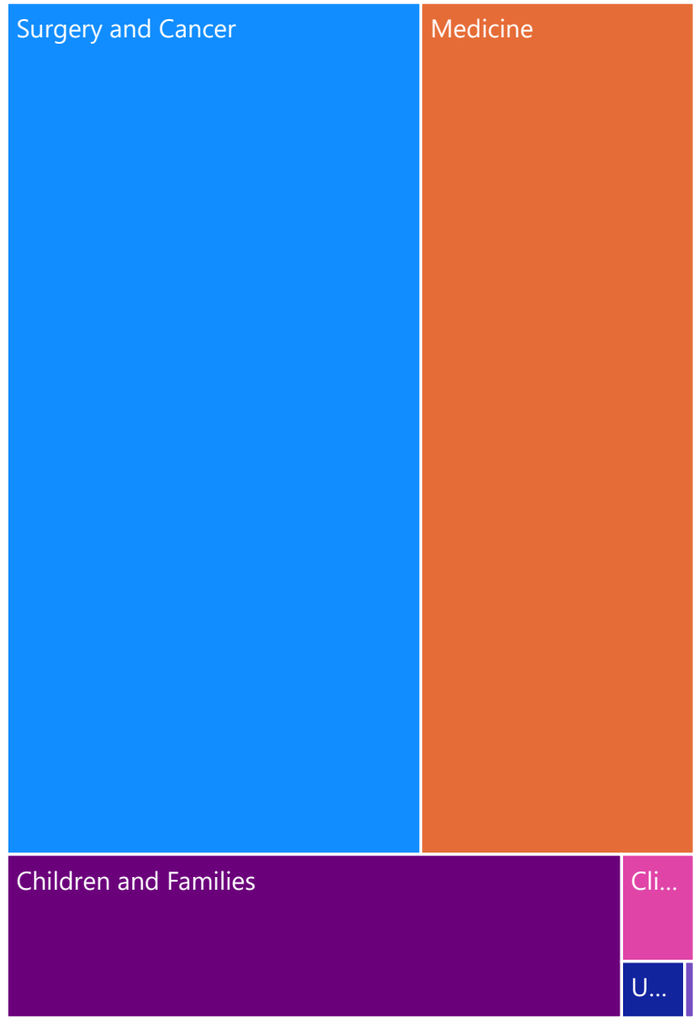
Outpatient Follow Up Activity - Virtual against plan

3,635✓

Plan: 2,744 (+891) (D)

Click here for Activity Against Plan Trends →

Division (Drill Down Currently Not Available for Inpatients Section)

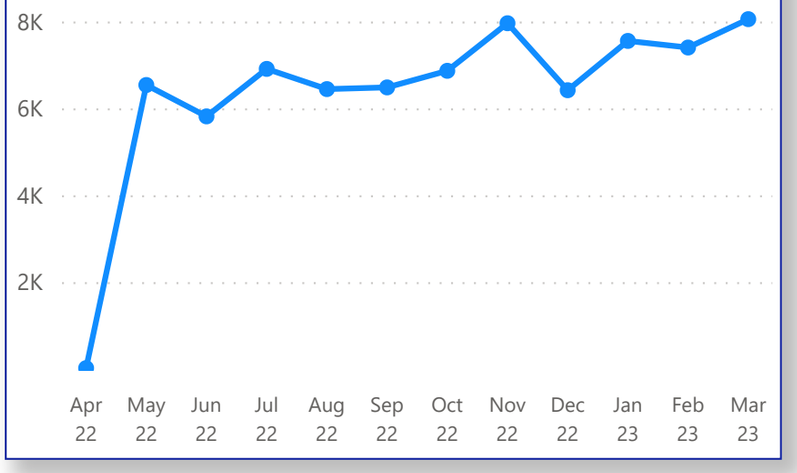


Activity Against Plan Trends - Outpatients

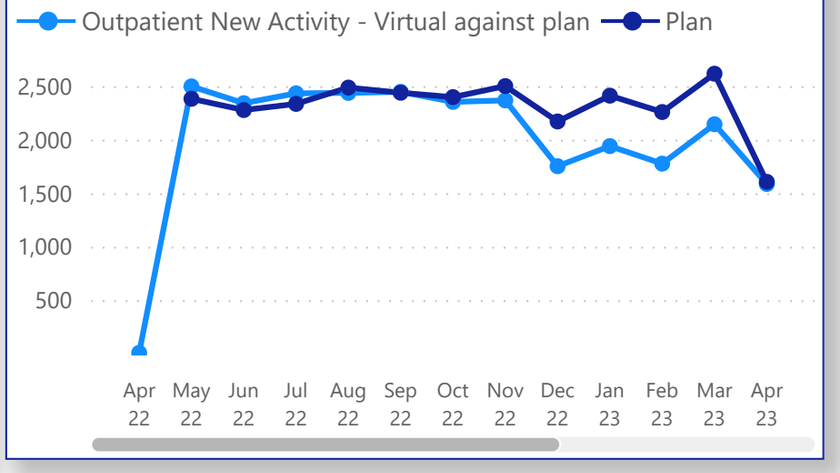
Data refresh	D All KPIs on this page are refreshed on daily basis.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

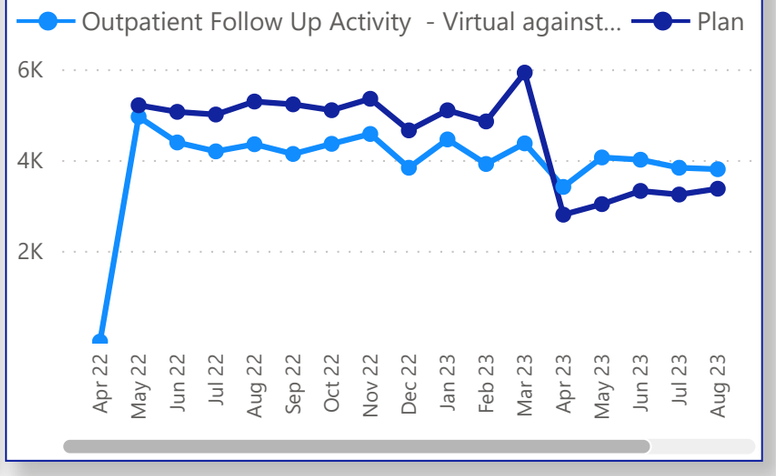
Outpatient Procedures (For Monitoring Only)



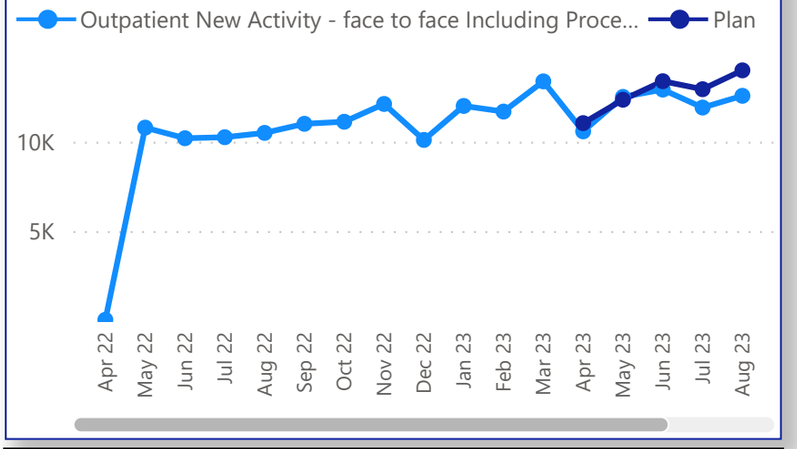
Outpatient New Activity - Virtual against plan



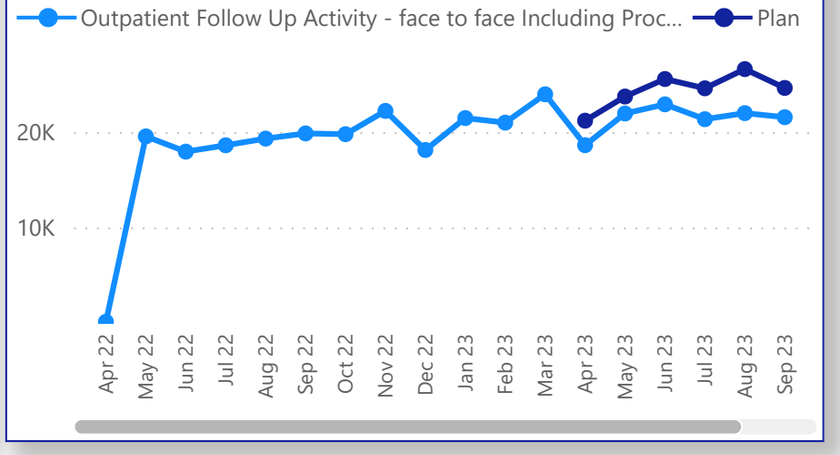
Outpatient Follow Up Activity - Virtual against plan



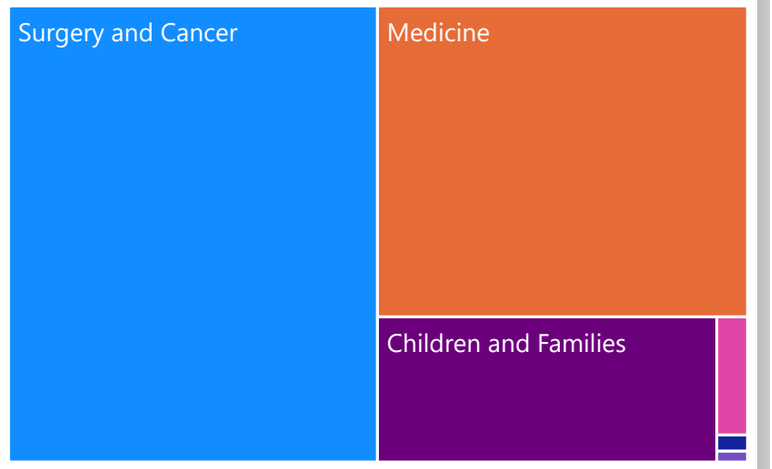
Outpatient New Activity - face to face Including Procedures against plan



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



Division (Drill Down For Speciality)



30/04/2022 31/12/2099

Click here for Intpatients Trends

Activity Against Plan Trends - Inpatients

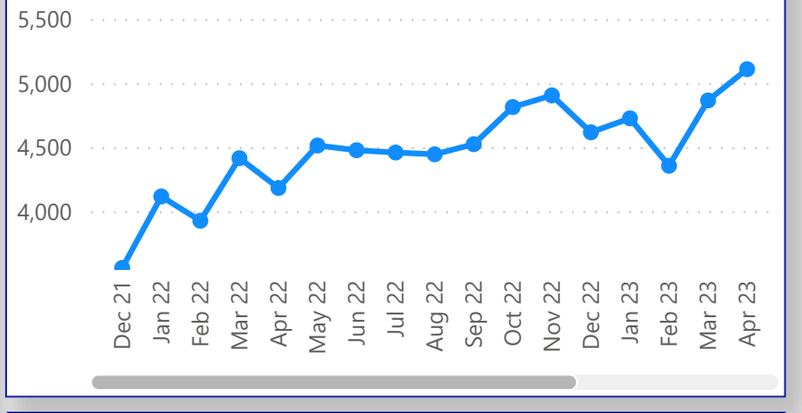
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

TOTAL Activity against plan

Not Available

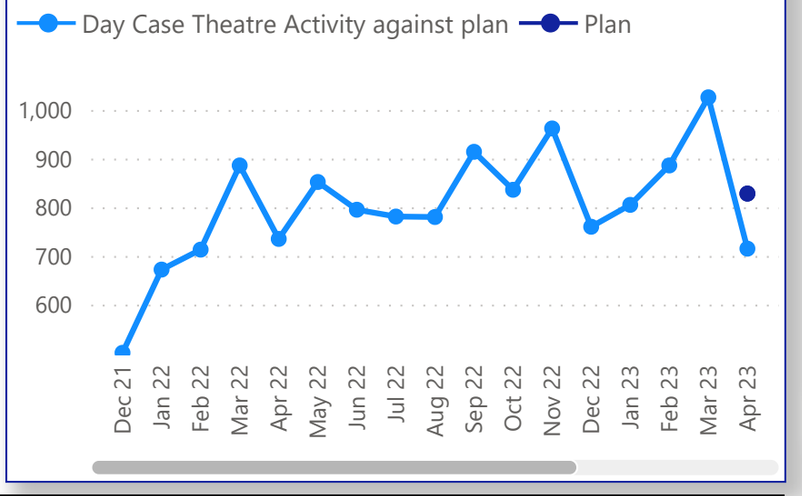
Non Elective Activity - Discharges (for monitoring)



Endoscopy Activity against plan

Not Available

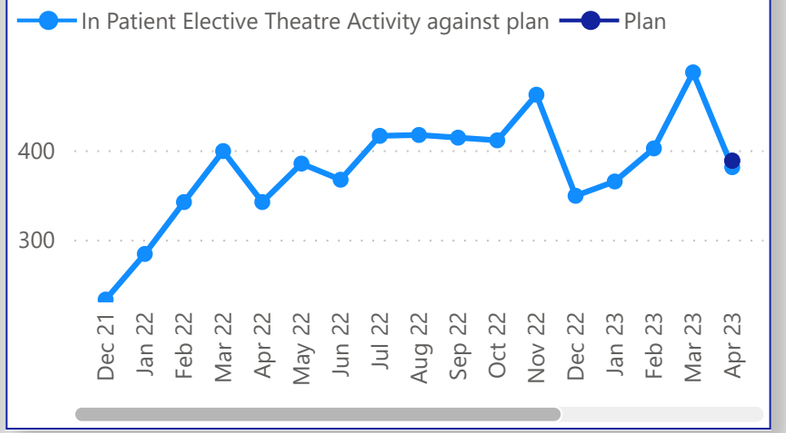
Day Case Theatre Activity against plan



Non-Theatre Elective Activity - excluding Endoscopy against plan

Not Available

In Patient Elective Theatre Activity against plan



07/12/2021 31/12/2099

Division (Drill Down For Speciality)

Elective Recovery Fund

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Core Activity

TOTAL Activity Value (% against 19/20)

Not Available

TOTAL Core Activity Value (% against 19/20)

104.05 %✓

Goal: (Blank)

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

106.67 %✓

Goal: (Blank)

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

111.31 %✓

Goal: (Blank)

Outpatient Procedures Core Value (% against 19/20)

99.38 %✓

Goal: (Blank)

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

96.54 %✓

Goal: (Blank)

TOTAL Independent Sector Activity Value (Sum of Price Actual)

£396,000.60

TOTAL Independent Sector Activity Value (Sum of Total Income)

£388,607.49

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

£226,825.73

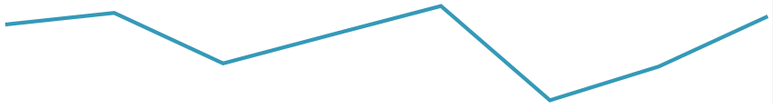
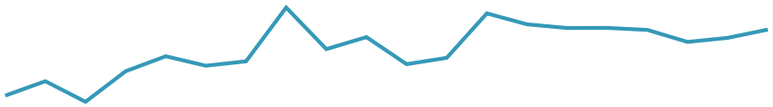
Division (Drill Down For Speciality)

Click here for Elective Recovery Fund Trends →

Elective Recovery Fund Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	M	All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	Sparklines	Year To Date Value
Trust ERF Core Income Value Against 19/20	106.71 %			92.96 %
Outpatient New ERF Core Income Value Against 19/20	106.68 %			93.46 %
Outpatient Procedures ERF Core Income Value Against 19/20	110.77 %			107.60 %
Elective ERF Core Income Value Against 19/20	94.15 %			85.04 %
Daycase ERF Core Income Value Against 19/20	115.74 %			94.17 %

Stroke

Oct 23

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Percentage treated by a stroke skilled Early Supported Discharge team

70.37 %✓

Goal: 24.00 %

Overall SSNAP Rating

Query

Goal: B

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

33.33 % !

Goal: 75.00 %

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

50.00 %✓

Goal: 48.00 %

Percentage discharged given a named person to contact after discharge

51.85 % !

Goal: 80.00 %

Percentage of eligible patients given thrombolysis

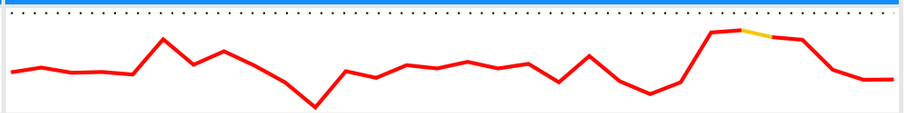
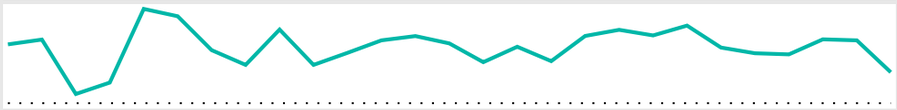
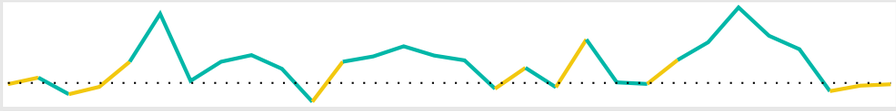
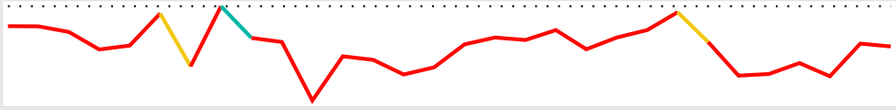
100.00 %✓

Goal: 90.00 %

Click here for Stroke Discharges Trends →

Stroke Trends

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Proportion directly admitted to a stroke unit within 4 hours of clock start	35.00 %	75.00 %	!	
Percentage treated by a stroke skilled Early Supported Discharge team	45.00 %	24.00 %	✓	
Percentage of eligible patients given thrombolysis	100.00 %	90.00 %	✓	
Proportion of patients scanned within 1 hour of clock start (Trust)	47.50 %	48.00 %	▲	
Percentage discharged given a named person to contact after discharge	57.50 %	80.00 %	!	

Elective Outpatients

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Utilisation

Central - Out Patient Booking % Appointments Booked 2 weeks Prior
72.50 % !
Goal: 95.00 % (D)
Unvalidated

Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior
64.99 % !
Goal: 95.00 % (D)
Unvalidated

Utilisation - % Booked Out Patient Clinic Slots Attended
85.51 % !
Goal: 90.00 % (D)
Unvalidated

Number of Registered Referrals not Appointed
34,286 (M)

Attended Appointments

New to Follow Up Ratio 19/20 Comparison
-0.01 !
Goal: -25.00 % (D)

TRUST - % of OP appointments delivered virtually (video or telephone)
14.98 % !
Goal: 25.00 % (D)

% of First Out Patient Appointment via ERS Advice & Guidance Activity
6.44 % !
Goal: 16.00 % (M)
Unvalidated

Not Attended Appointments

Out Patients: % Provider Cancellation Rate (less than 6 weeks notice)
64.01 % !
Goal: 5.00 % (D)

Out Patients DNA Rate 19/20 Comparison
-1.47 % ! (D)

Out Patients: DNA Rate (First Appointment)
11.22 %
(for monitoring only) (D)

Out Patients: DNA Rate (Follow Up Appointment)
10.42 %
(for monitoring only) (D)

Typing Turnaround

Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD
In Development

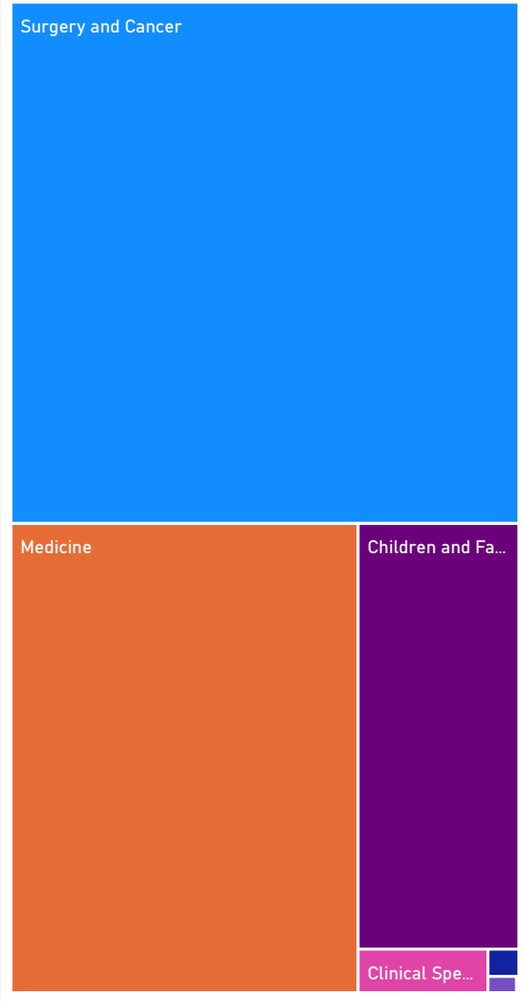
Patient Initiated Follow Up Pathway

TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month
2.67 % !
Goal: 5.00 % (D)

Data Quality

Number of Unreconciled Appointments 14 days +
1973 !
Goal: 0 (D)
Unvalidated

Division (Drill Down For Speciality)

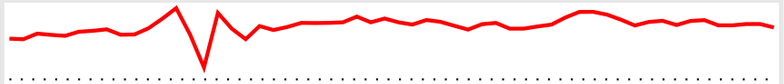
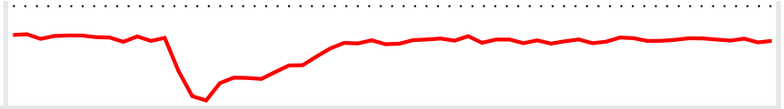
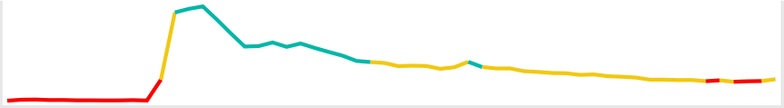
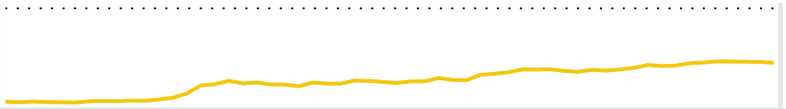
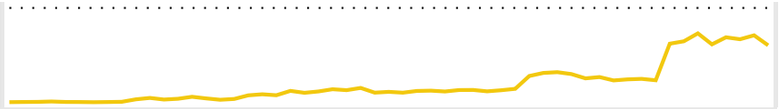
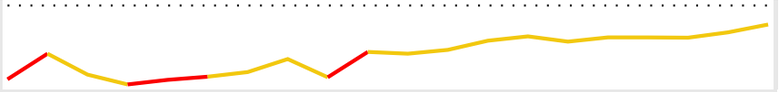


Click here for Elective Outpatients Trends →

Elective Outpatients Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Out Patients: % Provider Cancellation Rate (less than 6 weeks notice) (D)	60.78 %	5.00 %	!	
Central - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	73.99 %	95.00 %	!	
Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	68.60 %	95.00 %	!	
TRUST - % of OP appointments delivered virtually (video or telephone) (D)	15.08 %	25.00 %	▲	
% of First Out Patient Appointment via ERS Advice & Guidance Activity (M)	6.98 %	16.00 %	▲	
Number of Registered Referrals not Appointed (M)	33,751	0		
Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD (D)	In Development			
Number of Unreconciled Appointments 14 days + (D)	1972	0	!	
TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month (D)	3.02 %	5.00 %	▲	
Utilisation - % Booked Out Patient Clinic Slots Attended (D)	87.33 %	90.00 %	▲	

Elective Theatres | Dec 23

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Trust: Operating Theatre Booking - % of available time booked 1 week prior

91.96 % !
Goal: 95.00 %
(D)

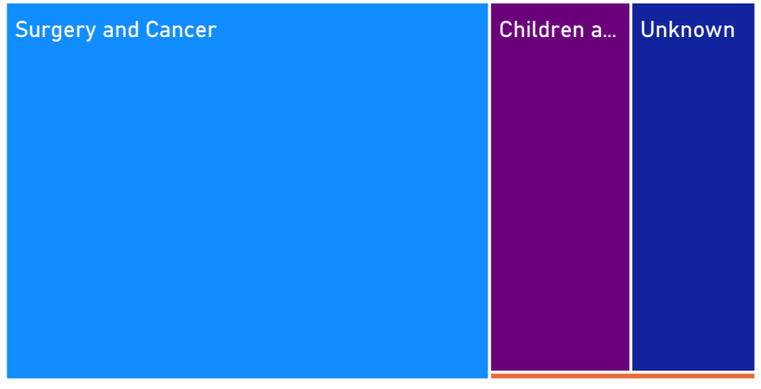
Trust: Operating Theatre Booking - % of available time booked 2 weeks prior

79.27 % ✓
Goal: 75.00 %
(D)

Trust: Operating Theatre Booking - % of available time booked 4 weeks prior

51.29 % ✓
Goal: 50.00 %
(D)

Division (Drill Down For Speciality)



% Cancelled Operations on the day (non-clinical reasons) (M)

Trust View	0.90 % ✓ Goal: 1.00 %
Surgery & Cancer	1.30 % ! Goal: 1.00 %
Children & Families	3.60 % ! Goal: 1.00 %
Medicine	0.20 % ✓ Goal: 1.00 %

Cancelled Operations Not Rebooked within 28 Days (M)

Trust View	5 ! Goal: 0
Surgery & Cancer	5 ! Goal: 0
Children & Families	0 ✓ Goal: 0
Medicine	0 ✓ Goal: 0

Number of Priority 2 Patients waiting 28 days + for surgery from date of listing or P2 Categorisation (M)

Trust View	895 ! Goal: 0
Surgery & Cancer	884 ! Goal: 0
Children & Families	11 ! Goal: 0
Medicine	0 ✓ Goal: 0

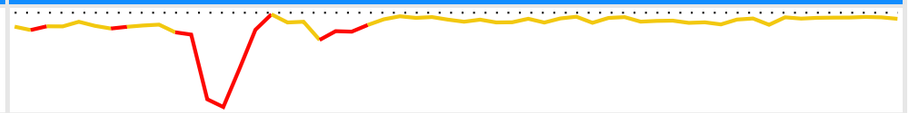
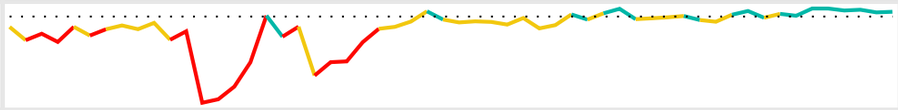
% of available Operating Theatre Time Utilised

81.40 % !
Goal: 85.00 %
(D)

Click here for Elective Theatres Trends

Elective Theatres Trends

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

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Operating Theatre Booking - % of available time booked 1 week prior	90.46 %	95.00 %	▲	
Operating Theatre Booking - % of available time booked 2 weeks prior	78.67 %	75.00 %	✓	
Operating Theatre Booking - % of available time booked 4 weeks prior	48.98 %	50.00 %	▲	
% of available Operating Theatre Time Utilised	84.00 %	85.00 %	▲	

Patients: IPC

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Hospital Acquired MRSA (Colonisation) Cases Reported in Month

Trust View

2 !

Goal: 0

Medicine Division

1 !

Goal: 0

Surgery & Cancer Division

1 !

Goal: 0

Children & Families Division

0 ✓

Goal: 0

Clinical Specialities Division

0 ✓

Goal: 0

Hospital Acquired MRSA (Bacteraemia) Cases Reported in month

Trust View

0 ✓

Goal: 0

Medicine Division

0 ✓

Goal: 0

Surgery & Cancer Division

0 ✓

Goal: 0

Children & Families Division

0 ✓

Goal: 0

Clinical Specialities Division

0 ✓

Goal: 0

Patients: IPC

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month and YTD

Trust View

In Month	YTD
7 !	44 !
Goal: 2	Goal: 18

Medicine Division

In Month	YTD
4 !	33 !
Goal: 2	Goal: 18

Surgery & Cancer Division

In Month	YTD
3 !	9 ✓
Goal: 2	Goal: 18

Children & Families Division

In Month	YTD
0 ✓	0 ✓
Goal: 2	Goal: 18

Clinical Specialities Division

In Month	YTD
0 ✓	2 ✓
Goal: 2	Goal: 18

Number of Community Onset Healthcare associated (COHA) C.Diff cases in month and YTD

Trust View

In Month	YTD
0 ✓	3 ✓
Goal: 2	Goal: 18

Medicine Division

In Month	YTD
0 ✓	0 ✓
Goal: 2	Goal: 18

Surgery & Cancer Division

In Month	YTD
0 ✓	3 ✓
Goal: 2	Goal: 18

Children & Families Division

In Month	YTD
0 ✓	0 ✓
Goal: 2	Goal: 18

Clinical Specialities Division

In Month	YTD
0 ✓	0 ✓
Goal: 2	Goal: 18

Patients: HSMR

Oct 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Hospital Services Mortality Rate (HSMR): (rolling 12 Months - Combined)

103.31 !

Goal: 100.00

Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months)

65.88 ✓

Goal: 100.00

Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months)

103.73 !

Goal: 100.00

Patients: Patient Safety | Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Number of SI actions more than 1 month overdue

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
26 !	13 !	6 !	0 ✓	7 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0

Number of SI actions overdue

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
71 !	31 !	20 !	2 !	18 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0

Patients: Patient Safety

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Serious Incidents Reported in Month (For Monitoring Only)

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
2	1	0	1	0

Number of open overdue incidents greater than 3 months in Datrix (Excluding patient experience, SI, Inquests and HSIB)

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
565 !	385 !	41 !	31 !	108 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0





Patients: Patient Safety

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Never Events - Reported in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
0✓	0✓	0✓	0✓	0✓
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0





Patients: Skin Integrity | Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

YTD Hospital Acquired Pressure Ulcers (HAPU) Category 2 and above - 20% reduction on 20/21 by March 2023

Trust View

In Month	YTD
50✓	351✓
Goal: 56	Goal: 504

Medicine Division

In Month	YTD
28✓	204✓
Goal: 56	Goal: 504

Clinical Specialities Division

In Month	YTD
4✓	28✓
Goal: 56	Goal: 504

Surgery & Cancer Division

In Month	YTD
11✓	71✓
Goal: 56	Goal: 504

Children & Families Division

In Month	YTD
3✓	5✓
Goal: 56	Goal: 504

Non Inpatient Areas

In Month	YTD
4✓	46✓
Goal: 56	Goal: 504

Patients: Falls

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Inpatient Falls resulting in low Moderate or Severe Harm reported in month

Trust

-20.00 %✓

Goal: -10.00 %

Current Year	Last Year
28	35

Medicine

0.00 %!

Current Year	Last Year
25	25

Surgery & Cancer

-66.67 %✓

Current Year	Last Year
3	9

Children Families

-100.00 %✓

Current Year	Last Year
0	1

Clinical Specialities

NaN✓

Current Year	Last Year
0	0

Patients: Patient Experience | Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Complaints - New in month

Trust	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
-27.27 % ✓	-50.00 % ✓	-50.00 % ✓	200.00 % !	100.00 % !
Goal: -10.00 %				
Current Year: 32	Current Year: 8	Current Year: 11	Current Year: 3	Current Year: 10
Last Year: 44	Last Year: 16	Last Year: 22	Last Year: 1	Last Year: 5

Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)

Trust	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
12.00 % !	29.00 % !	0.00 % !	0.00 % !	0.00 % !
Goal: 95.00 %	Goal: 95.00 %	Goal: 95.00 %	Goal: 95.00 %	Goal: 95.00 %





Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
24 !	7 !	10 !	1 ✓	6 !
Goal: 4	Goal: 4	Goal: 4	Goal: 4	Goal: 4





Patients: Claims

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Claims CNST (patients) - new in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
3	1	1	0	1

Claims LTPS - (staff) new in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
0	0	0	0	0

Patients: Friends and Family Test

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Friends & Family Response Rates (ED) Increase response by year end

0.19 % !

Goal: 10.00 %

Friends & Family Response Rates (Inpatients) Increase response by year end

5.80 % !

Goal: 15.00 %

Patients: Audit and Effectiveness

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Mixed Sex Accommodation - reported breaches in month

Trust View | Medicine Division | Surgery & Cancer Division | Clinical Specialities Division | Children & Families Division





NICE Guidance Response Rate Compliance

Trust View | Medicine Division | Surgery & Cancer Division | Clinical Specialities Division | Children & Families Division





NICE Guidance % Non & Partial Compliance (For Monitoring Only)

Trust View | Medicine Division | Surgery & Cancer Division | Clinical Specialities Division | Children & Families Division

Patients: Medical Examiner

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

% Over 18 in-hospital deaths scrutinised by Medical Examiner Team

100.00 %✓

Goal: 100.00 %

Patients: VTE

Oct 23

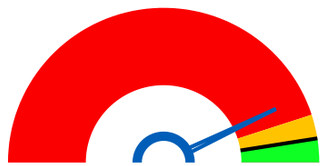
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

VTE - % of patients having a VTE Risk Assessment

85.74 % !

Goal: 95.00 %



Patients: Reducing Length Stay | Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

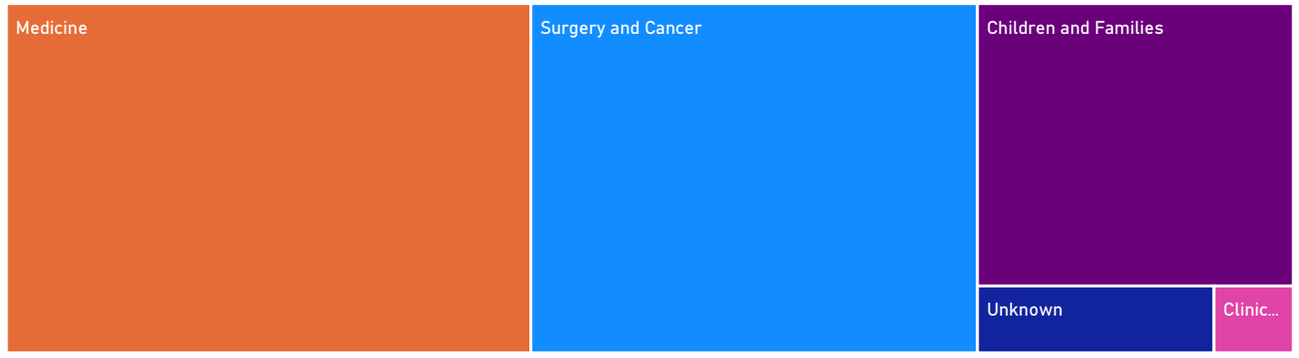
Days - Reducing length of stay for patients in hospital for 21 days +

-15.42 %

Discharges - Reducing length of stay for patients in hospital for 21 days +

-15.24 %

Division (Drill Down For Speciality)



People

Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Employee Turnover

1.46 % !

Goal: 0.83 %

Completed SET Training

86.65 % !

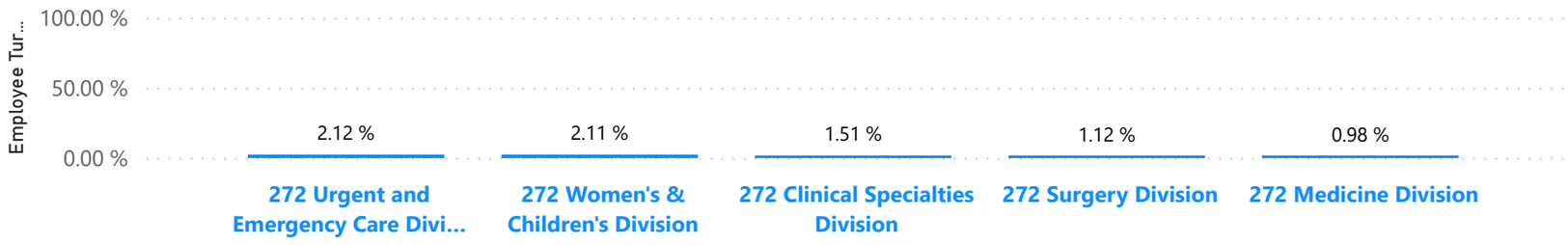
Goal: 90.00 %

Completed Appraisals

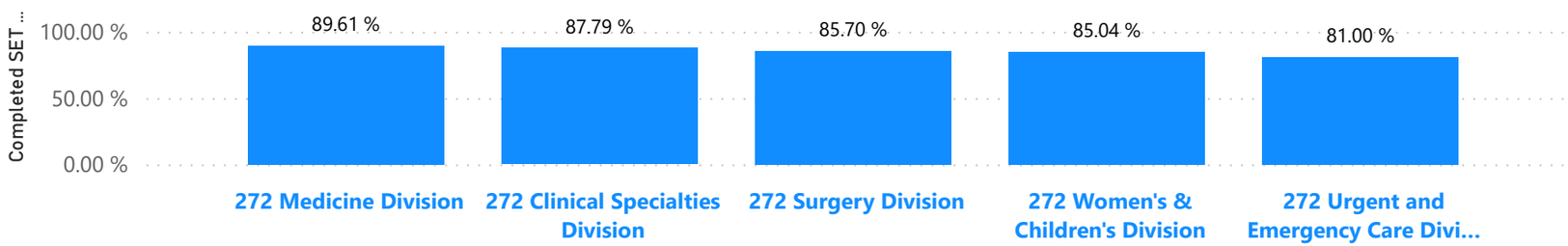
82.29 % !

Goal: 90.00 %

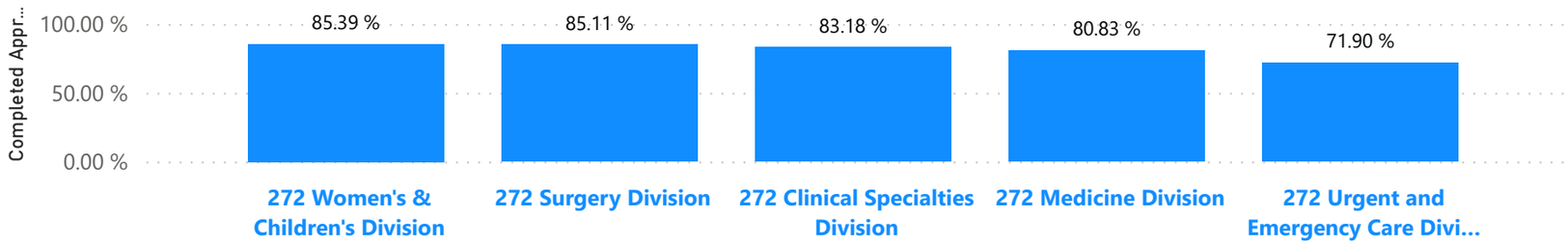
Division - Employee Turnover



Division - Completed SET Training



Division - Completed Appraisals



People Forms Data | Dec 23

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Overall Staff Sickness Absence
5.83 % !
Goal: 5.00 %

Overall Staff Vacancies
7.59 % !
Goal: 5.00 %

Consultants with Signed Off Job Plans in EJP
50.00 % !
Goal: 90.00 %

Medicine Division Sickness Absence
6.68 % !
Goal: 5.00 %

Children & Families Sickness Absence
6.69 % !
Goal: 5.00 %

Medicine Division Workforce Vacancies
9.21 % !
Goal: 5.00 %

Children & Families Workforce Vacancies
4.59 % ✓
Goal: 5.00 %

Medicine Division Consultants with Signed Off Job Plans in EJP
60.00 % !
Goal: 90.00 %

Children & Families Consultants with Signed Off Job Plans in EJP
58.00 % !
Goal: 90.00 %

Surgery & Cancer Sickness Absence
6.38 % !
Goal: 5.00 %

Clinical Specialties Sickness Absence
5.05 % !
Goal: 5.00 %

Surgery & Cancer Workforce Vacancies
4.55 % ✓
Goal: 5.00 %

Clinical Specialties Workforce Vacancies
8.90 % !
Goal: 5.00 %

Surgery & Cancer Consultants with Signed Off Job Plans in EJP
30.00 % !
Goal: 90.00 %

Clinical Specialties Consultants with Signed Off Job Plans in EJP
58.00 % !
Goal: 90.00 %

People Forms Data | Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Time to Fill Vacancies (from TRAC authorisation - unconditional offer) A4C posts only

102 !
Goal: 47 Days

Medicine Division - Time to Fill Vacancies (Days)

72 !
Goal: 47 Days

Children & Families - Time to Fill Vacancies (Days)

77 !
Goal: 47 Days

Surgery & Cancer - Time to Fill Vacancies (Days)

57 !
Goal: 47 Days

Clinical Specialties - Time to Fill Vacancies (Days)

56 !
Goal: 47 Days

People Forms Data | Dec 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Theme	DBTH 2021 Score	National Sector Average 2021	DBTH 2022 Score	National Sector Average 2022
We are compassionate & inclusive	7.2	7.2	7.3	7.2
We each have a voice that counts	6.7	6.7	6.7	6.6
We are always learning	5.2	5.2	5.6	5.4
We are a team	6.4	6.6	6.6	6.6
Staff Engagement	6.7	6.8	6.8	6.8

Health Inequalities

Apr 23

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

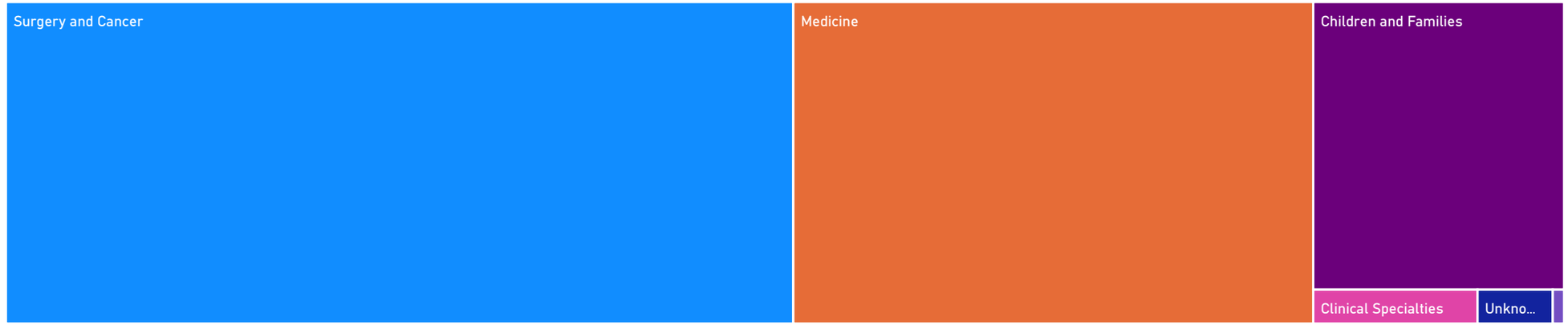
Data refresh (D) All KPIs on this page are refreshed on daily basis.

% Patients on CAMIS with Ethnicity Recorded

95.24 % !

Goal: 100.00 %

Division (Drill Down For Speciality)



KPI Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Self Arrivals - Initial Assessment Within 15 Mins (Unvalidated)

Ambulance Handovers within 15 Minutes

Ambulance Handovers within 30 Minutes

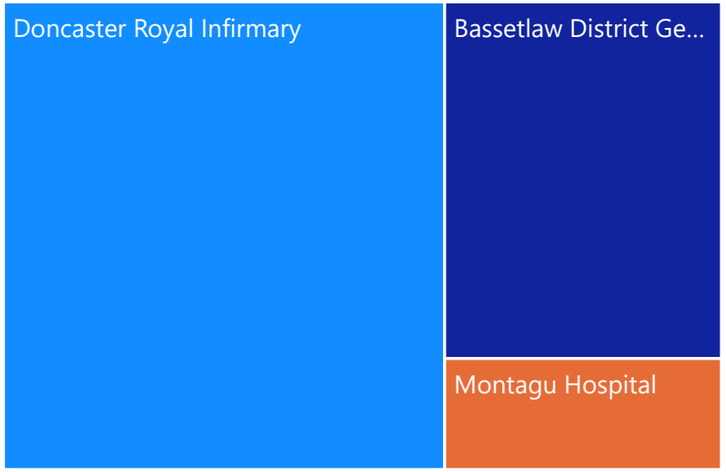
Ambulance Handovers More Than 60 Minutes

TOTAL -% patients leaving Emergency Department from clinically ready to proceed to admission within 60 mins

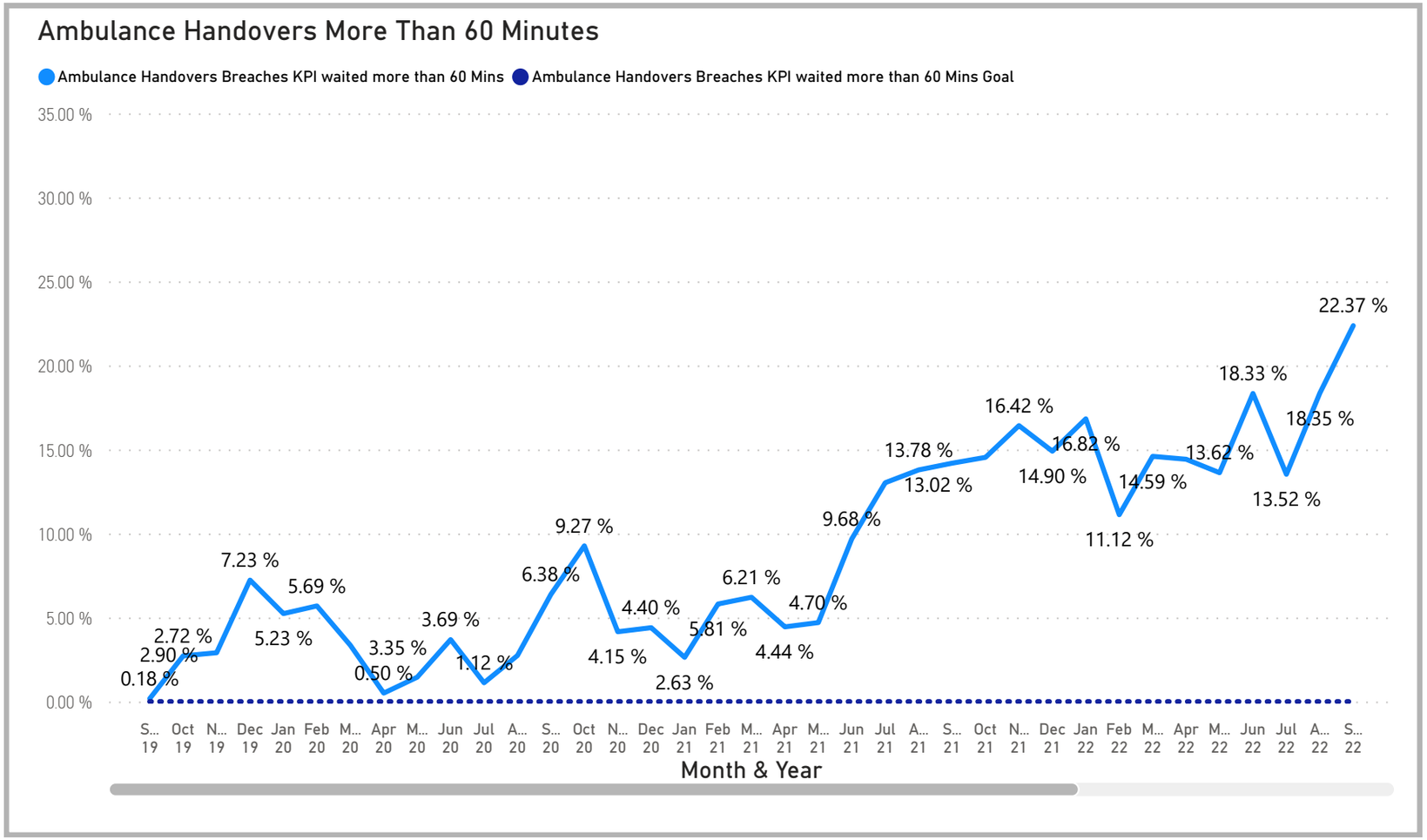
A&E: Max wait four hours from arrival/admission/transfer/discharge

% Patients with Total Length of Stay in Emergency Department >12 hours

EM Hospital



Urgent & Emergency Care | Waiting List | Cancer | Elective Outpatients - Not Available | Elective Recovery Fund | Activity Against Plan - Outpatients | Activity Against Plan - Intpatients | Elective Theatres



2401 - H4 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE ? 30 OCTOBER 2023

Information Item

Mark Day, Non-executive Director

REFERENCES

Only PDFs are attached

H4 - Finance & Performance Committee Minutes - 30 October 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee held on Monday 30 October 2023 at 09:00 via Microsoft Teams

Present:	Mark Day - Non-Executive Director (Chair) Emyr Jones - Non-Executive Director Jon Sargeant - Chief Financial Officer Kath Smart - Non-Executive Director Denise Smith - Chief Operating Officer	
In attendance:	Paula Bailey - SYB Pathology Operations Director (agenda item E2) Alex Crickmar - Deputy Director of Finance Kirsty Edmondson Jones – Director of Infrastructure and Innovation (agenda item C1, C2 & D5) Mathew Gleadall – Acting Deputy Director of Estates & Facilities (agenda item D5) Kelly McKenzie - Public Health Consultant (agenda item C2) Angela O'Mara - Deputy Company Secretary (minutes) Jamie Stone - Head of Finance for SYB Pathology (agenda item E2) Andrew Turner - SYB Pathology Transformation Programme Director (agenda item E2)	
To Observe:	Zara Jones, Deputy Chief Executive Andrew Middleton - Public Governor – Bassetlaw	
Apologies	Mark Bailey - Non-Executive Director Fiona Dunn - Director Corporate Affairs /Company Secretary Joseph John - Medical Director for Operational Stability and Optimisation Lynne Schuller - Governor Observer - Bassetlaw	
		ACTION
FP23/10/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members of the Committee and those in attendance to the meeting. The above apologies for absence were noted and no declarations of interest were received.	
FP23/10/A2	**Requests for any other business (Verbal)**	
	No items of other business were received.	
FP23/10/A3	**Action Notes from Previous Meeting (Enclosure A3)** **Action 3 – FP23/07/B1 – Diagnostic Reporting Time –** deferred to November 2023	

	<u>Action 4 - FP23/07/B2 – UEC Improvement Programme</u> – a potential sum of money from Doncaster Place had been identified from a vacant post, to be discussed @ November's UEC Board **<u>Action 5 - FP23/07/B3 – Elective Activity Report</u>** – updated report provided – **action to be closed** **<u>Action 6 - FP23/07/C3 – Health Inequalities Strategy</u>** – included @ agenda item C2 – **action to be closed** **<u>Action 8 - FP23/07/E1 – Getting It Right First Time</u>** - draft GIRFT report to be taken to November's Trust Executive Group for review/agreement. **Committee to agree frequency of reporting to F&P** **<u>Action 10 - FP23/09/A3 – CT & Obstetric Ultrasound Demand</u>** - questions had been submitted by Kath Smart & Mark Bailey for response outside of the meeting**. Action to be closed** **<u>Action 12 - FP23/09/B1 – Board Assurance Framework 3</u>** – Updated BAF received, **action to be closed** **<u>Action 13 - FP23/09/B1 – Board Assurance Framework 4-7</u>** – Updated BAF received, **action to be closed** **<u>Action 14 - FP23/09/B5 – Trust Access Policy -</u>** a revised Access Policy was in development, due for completion November 2023 **<u>Action 15 – FP23/09/B6 – Operational Winter Plans -</u>** to be provided at November's Committee **<u>Action 16 - FP23/09/B6 – Virtual Wards</u>** - the report was received in the absence of the Medical Director for Operational Stability and Optimisation and questions submitted for response outside of the meeting - **action to be closed**	
	The Committee: - ***Noted the above updates***	
FP23/10/B1	**<u>Access Standards Report (Enclosure B1)</u>**	
	The Committee received the Access Standards Report, which provided August's data for emergency, elective and diagnostics performance and July's for cancer standards. The Chief Operating Officer confirmed the Divisional Director and Divisional Nurse for Urgent & Emergency Care had commenced in post and the Divisional General Manager would start mid-January 2024. A forecast to the end of March 2024 had been requested for all diagnostic tests, there continued to be high demand for CT and MRI, with work ongoing to manage CT demand. Staffing challenges in dual-energy x-ray absorptiometry (DEXA) were expected to be resolved within the next quarter, mutual aid had been agreed but the offer had not been taken up by patients. Modelling for the 65 week elective trajectory had been completed and would be made available to Committee members. Trauma and Orthopaedics and ENT would face the greatest	

	challenge due to the volume in T&O and the reliance on a single consultant for a specific ENT procedure. Mutual aid had been sought at a regional and national level in respect of the ENT procedure, without success and consideration would be given to the reallocation of internal capacity. Non-executive Director, Emyr Jones sought clarification on what appeared to be a deteriorating ambulance handover position within the report, as compared to the verbal narrative. The Chief Operating Officer confirmed the improvement related to the number of hour lost, which had reduced by 50% over the last 12 months. Annual leave and junior doctor rotation had impacted upon emergency care access during August. Non-executive Director, Kath Smart echoed Emyr's concerns with regards to ambulance handover delays and in view of the fast approaching winter months sought confirmation of future actions to manage the position. The Chief Operating Officer confirmed available space and flow out of the department impacted upon ambulance handover delays, currently all available beds were open at DRI, however a change to the opening hours of the Same Day Emergency Care Centre (SDEC), as part of winter plans, would relieve some pressures and through work with partners opportunities were being explored for patient to be taken straight to SDEC where clinically appropriate. There was also the potential to open further beds at Bassetlaw, at a cost. Work with the Chief Nurse and Acting Executive Medical Director around appropriate and consistent use of the discharge lounge would also support improved flow. Kath Smart enquired of any opportunities to improve work between SDEC and the Emergency Department, including the in reach of clinicians, the Chief Operating Officer confirmed work remained in progress, with opportunities to develop the model of care and staffing model within surgical SDEC. In respect of cancer 62 day waits, further work was required at tumour site level before the improvement could be confirmed sustainable. The impact of industrial action on activity was captured for cancellations, however, the number of patients not booked in due to planned action was not easy to identify, the Trusts approach in reporting was consistent with other organisations.	
	The Committee: - ***Noted and took partial assurance from the Access Standards Report***	
FP23/10/B2	**<u>Urgent & Emergency Care (UEC) Improvement Plan Update (Enclosure B2)</u>**	
	The Chief Operating Officer provided an overview of the various workstreams. In respect of workstream one and with the support of the Trust's Qi team a number of sessions had taken place with the Emergency Department and FCMS to consider a redesign of the front door offer. The same day emergency care model was being explored to strengthen the current service and some initial mapping work had taken place in frailty. Overall, the pace across the UEC Programme was slower than required and the Executive Place Director would attend November's meeting to provide a Place overview. The expected support from ECIST on length of stay had not commenced and a decision would be taken by the senior responsible officers as to how best to progress this with the involvement of all partners.	

	Deputy Chief Executive, Zara Jones, enquired if the impact of each initiative had been determined, in order that efforts could be focused and if this would be in time for winter. The Chief Operating Officer confirmed there had been a reprioritisation of efforts through winter, with a focus on effective discharge to support flow. Non-executive Director, Kath Smart welcomed the support of the Qi Team and individual coaching offered by ECIST. In respect of the workstream highlight reports, not all included a self-assessment which was difficult for the Committee to take assurance from and the Chief Operating Officer agreed to share this feedback with the SROs.	
	The Committee: - ***Noted the Urgent & Emergency Care Improvement Plan Update and took partial assurance on the pace and progress of the Improvement Programme***	
FP23/10/B3	**<u>Elective Activity Plan (Enclosure B3)</u>**	
	The Chief Operating Officer confirmed that speciality level detail had been included within this report and the narrative would continue to be developed over time. An overperformance could be seen in diagnostics, whilst outpatient first, outpatient follow up and day case elective were behind plan, a significant impact had been seen from the ongoing industrial action and utilisation rates were being addressed through the relevant improvement programmes. Non-executive Director, Kath Smart, welcomed the additional detail. Where delivery was identified to be sub-optimal the Chief Operating Officer was asked how improvements would be progressed to ensure consistency. Following her attendance at a recent theatre improvement programme the Chief Operating Officer confirmed she had committed to observe the theatre utilisation and planning meetings to determine that the level of scrutiny and engagement and accountability was appropriate. In respect of day case activity, Kath Smart reflected on the Trust's positive historical performance and enquired what had driven the change. The Chief Financial Officer supported the discussion in terms of organisational memory which he felt had seen a shift this year, potentially linked to industrial action. In addition, the Chief Operating Officer recognised the focus of the theatre improvement programme was weighted towards elective work, particularly trauma and orthopaedics, in view of the high volume and agreed to look at the trend over time. Considering the broad span of business received by the Committee and reflecting on recent preparatory discussions ahead of the CQC inspection, the Chair encouraged members to consider the frequency and reporting to future meetings.	
	The Committee: - ***Noted and took assurance from the Elective Activity Plan***	
FP23/10/B4	**<u>Diagnostic Imaging Demand Management (Enclosure B4)</u>**	
	The report was received and noted. Whilst the paper described the position well, further clarity was required with regards to proposed solutions; questions had been shared with the report author for response outside of the meeting.	

	The Committee: - ***Noted the Diagnostic Imaging Demand Management***	
FP23/10/B5	**<u>Virtual Wards – Trust Plans & Progress Update (Enclosure B5)</u>**	
	The report was received and noted. Whilst the paper described the position well, further clarity was required with regards to proposed solutions; questions had been shared with the report author for response outside of the meeting.	
	The Committee: - ***Noted the Virtual Wards – Trust Plans and Progress Update***	
FP23/10/C1	**<u>Recovery, Innovation & Transformation Directorate Update (Enclosure C1)</u>**	
	The Director of Infrastructure and Innovation brought the key highlights of the Report to the Committee's attention. - a draft Quality Improvement & Innovation Strategy had been prepared, to reflect the introduction of NHS Impact, this would progress through the appropriate governance route for review/comment - a range of bids to address the challenged DRI estate would be finalised next week, in response to potential funding opportunities - the Bassetlaw Emergency Village programme of work was on track, SDEC requirements had been discussed with the Chief Operating Officer (Phase 2) - Mexborough Elective Orthopaedic Centre was due for completion on 18 December 2023. Recruitment was underway but in view of delays a Plan B solution was being considered In response to a question from the Deputy Chief Executive, the Chief Financial Officer confirmed the intention for the Mexborough Elective Orthopaedic Centre (MEOC) to be utilised from January, either with a variation on usage or with the support of an alternative workforce solution. In response to a question from Non-executive Director, Emyr Jones with regards to clinical engagement in transformational projects, the Chief Financial Officer confirmed there had been good clinical engagement across the trusts involved in the MEOC programme, however, the impact of a potential delay, or change in usage on winter plans was recognised and was understandably difficult at this point in the year. Varying levels of clinical engagement were acknowledged by the Chief Financial Officer and Chief Operating Officer, some pockets of good engagement were seen, whilst others faced capacity, capability and operational pressures, further work should be undertaken to support and develop this and was worthy of consideration by the Board. Whilst a little disappointed with a potential delayed start in the planned elective work, Kath Smart recognised and remained positive about the Trust's long term strategic intent to provide additional capacity on a non-emergency site. Kath Smart confirmed she had approached the Head of Procurement with regards to a procurement strategy/policy, the terms of reference for the Audit & Risk and Finance &	

	Performance Committees would be considered by the Committee Chairs to determine appropriate Committee oversight. A temporary cessation on new referrals to pain management services was noted in the Performance Overview and Scrutiny Meeting update and the Chief Operating Officer confirmed that following a pause of six months this would be considered at the November meeting of the Trust Executive Group, an increase in referrals had been evidenced across the system and was likely to be a topic of discussion with commissioners.	**MD/KS**
	The Committee: - ***Noted and took assurance from the Recovery, Innovation & Transformation Directorate Update***	
FP23/10/C2	**<u>Health Inequalities Strategy (Enclosure C2)</u>**	
	The Chair welcomed the Director of Infrastructure and Innovation and the Consultant in Public Health to the meeting. Since the review of the initial draft strategy in July 2023, additions had been made to incorporate the Committee's feedback and reflect input from the extensive internal and partner engagement. The Committee's attention was drawn to the changes, which included key performance indicators relating to training and education, a reference to improving access within the children and young people's priority for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD), an overview of the potential return on investment and a supporting action plan. The strategy had been aligned with the Trust's True North objectives and the suite of enabling strategies, a three tier framework would support delivery of the strategy. In terms of next steps, and subject to approval by the Board of Directors, the strategy would be formally branded and launched, with a celebration event planned to raise awareness. In response to a question from the Deputy Chief Executive, the Public Health Consultant confirmed the strategy was aligned with Place and System strategies, with key strategic pillars and partnership working at its core. In respect of ensuring that actions taken were not negatively impacting upon health inequalities, strong connections across Place were highlighted, with the Public Health Consultant role being a joint post across the Trust, Rotherham, Doncaster & South Humber NHS Foundation Trust and City of Doncaster Council. The need for a standalone strategy had been considered in view of health inequalities being an integral part of the work of the Trust, however, at this stage it was felt to be helpful in raising awareness and supporting education. A toolkit had been developed for use and was currently being piloted to help identify and then provide an options appraisal to address health inequalities. The addition of a simple question as part of the Quality Performance Impact Assessment ensured a focus on health inequalities as part of major decision/change processes. Non-executive Director, Emyr Jones enquired of links with the University of Sheffield and Sheffield Hallam University who had recently launched a digital healthcare hub; the Public Health Consultant held an honorary contract at the University of Sheffield in the Division of Population Health and would ensure those connections were used to maximum effect.	

	Non-executive Director, Kath Smart welcomed the inclusion of did not attends, the use of NHSE's Emergency Care Intensive Support Team data to identify and target specific population groups and the SMART action plan. As no financials or resource had been included in the action plan clarification was provided that this would be delivered within the existing resource/budget. The Chair confirmed the Committee's support and commended the strategy for Board approval, the identification of notable actions to drive an improvement in health inequalities was recommended.	
	The Committee: - ***Approved the Health Inequalities Strategy***	
FP23/10/D1	**Financial Performance – Month 6 – (Enclosure D1)**	
	The Chief Financial Officer reported a month six deficit of £4.1m, £1.4m adverse to plan, £23.9m deficit year to date and £1.4m, adverse to plan, driven by Elective Recovery Fund under performance and the cost of industrial action. Capital spend in month six was £2.9m, against a plan of £4.6m, the year to date position was £10.3m, against a plan of £20.7m. The cash balance at the end of September was £21.6m, an increase of £6.7m, due to revenue and capital cash support, £6.3m of cash support was expected in October. In month, the Trust had delivered £1.4m of savings, £0.4m adverse to plan, £7.8m of savings year to date, £1.1m favourable to plan. Following NHSE's Chief Financial Officer meeting with the Treasury a decision was awaited on funding to meet the cost of industrial action. In response to a question from Non-executive Director, Kath Smart, the Chief Financial Officer confirmed the effectiveness of medical staff grip and control meetings was being considered by the Chief People Officer, Acting Executive Medical Director and the Associate Chief Nurse for Safe Staffing. A review of the standard operating procedure against NHSE guidance had taken place and further work was in train to understand the position. In respect of the confirmed financial cost of industrial action at £1.5m, the Chief Financial Officer confirmed this related to additional spend only and did not take into account lost income . In response to a question from Non-executive Director, Emyr Jones and to clarify the reference in the paper of spend against a zero medical equipment budget, the Chief Financial Officer confirmed that the Trust had a significant capital budget for medical equipment, managed via the Medical Equipment Group and supported by a robust governance process.	
	The Committee: - ***Noted the Financial Performance – Month 6***	

FP23/10/D2	**<u>Year end and Long Term Forecast (Enclosure D2)</u>**	
	A five year, medium term financial plan had been prepared by the Integrated Care Board based upon an agreed set of assumptions. The forecast identified the need for significant system change to deliver a balanced financial plan. The Trust had also modelled a longer term, ten year financial plan which confirmed a significant financial challenge to deliver a break even position over the medium to long term. The paper identified a number of modelled options and outputs; considering this and the recommendations of the Deloitte's drivers of deficit review an outline financial strategy would be prepared. Kath Smart sought clarification of next steps, the Chief Financial Officer confirmed opportunities would be explored including feedback from NHSE's visit earlier this year, the Deloitte review and participation in a system workshop. The Chair recognised the plans and suggested it may be appropriate for the Board to review the opportunities, the Chief Financial Officer proposed this be included as the Board development session in December. In respect of the in-year forecast, since writing the paper a review had taken place by the Executive Team which identified a reasonable case variance to plan of £5.3m, due to a potential need to backdate the Band 2-3 work. This was being considered by the Chief People Office on her return from leave and represented a £1.3m risk. The updated paper was circulated to the Committee post meeting. The assumptions of the forecast were highlighted in the paper. Key areas of focus and actions included the need to strengthen grip and control, implementing a review of discretionary expenditure, a vacancy freeze, with the vacancy control panel now being completed by the Executive Team, analysis of misaligned costs vs activity and ensuring all opportunities were taken to maximise elective recovery funding (ERF). The Chief Nurse and Deputy Chief Executive were considering the request for a £600k prior year pay back, related to the Clinical Negligence Scheme for Trusts. Organisation wide communications were planned from the Chief Executive and the Chief Financial Officer would host a briefing session with members of the senior leadership team. To close the financial gap of £5.3m several actions had been agreed by the Executive Team to deliver the year end plan, summarised by the Chief Financial Officer and included within the updated paper. Non-executive Director, Kath Smart sought clarity on the extent of the vacancy freeze, which was confirmed to be across all staff groups, subject to Executive Team scrutiny. The Chief Financial Officer confirmed a vacancy freeze of varying forms had been in force at Place throughout the year, and despite the Trust having the largest deficit at Place level this action had not been taken earlier as delivery was in line with the financial plan. Non-executive Director, Emyr Jones recognised that some actions had the potential to adversely impact Trust's activities and enquired of any impact on the associated risk profile. The Chief Financial Officer confirmed discussions regarding the delay of national cleaning standards were ongoing between NHSE and the Chief Nurse and did not represent a change in year. In respect of ERF and independent sector work, there was a need to fully understand the impact, the Trust would continue to spend up to the agreed independent sector budget but not beyond. Any	**JS**

	significant change to provision would require sign off as part of the Quality Performance Impact Assessment by the Executive Medical Director and Chief Nurse. The Committee was assured by the suggested actions but were mindful of associated risks.	
	The Committee: - ***Noted the Year end & Long Term Forecast***	
FP23/10/D3	**ICB and National Financial Update (Enclosure D3)**	
	The Committee received and noted the paper and supporting slide deck, the Chief Financial Officer highlighted the greater efficiency opportunities available to neighbouring Trusts within the South Yorkshire Integrated Care System.	
	The Committee: - ***Noted the ICB and Year end Financial Update***	
FP23/10/D4	**CIP Plan 2023/24 (Enclosure D4).**	
	The Committee received and noted the CIP Plan and following the recent focused CIP deep dive noted the need for additional schemes to deliver the annual plan.	
	The Committee: - ***Noted the CIP Plan 2023/24***	
FP23/10/D5	**Granger Report Quarterly Update (Enclosure D5)**	
	The Chair welcomed the Acting Deputy Director of Estates & Facilities to the meeting. The Director of Infrastructure and Innovation introduced the paper and provided progress updates against the open Granger Report actions. Non-executive Director, Kath Smart reflected on the significant work undertaken since the commissioning of the report and the monitoring of actions via this Committee over an extended period. As the Health & Safety Strategy would be presented to the next Health & Safety Committee Kath enquired if it was appropriate for this work to be considered as business as usual, with such action being monitored as part of delivery of the strategy via the Health & Safety Committee. The Director of Infrastructure & Innovation and Acting Deputy Director of Estates & Facilities welcomed this suggestion and the Committee confirmed its support. The Committee's work plan would be updated.	
	The Committee: - ***Noted and took assurance from the Granger Report Quarterly Update***	

FP23/10/E1	**<u>Board Assurance Framework (BAF) & Trust Risk Register 15+ (Enclosure E1)</u>**	
	The Chair reflected on the extended discussion at last month's meeting and the suggested areas of improvement, whilst some of those changes had been incorporated, Non-executive Director, Kath Smart suggested it would be helpful for the ongoing review of the content to focus on any gaps, with the strengthening of actions within BAF risks 5-7. There was a need to determine which Committee would have oversight of BAF risk 6 (partnership/prevention) outside of the meeting. The summary sheet for BAF risk 4 (estates) should be updated to reflect agreement that the current risk score of 20 and this was updated post meeting.	**JS** **FD**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework and Trust Risk Register 15+***	
FP23/10/E2	**<u>South Yorkshire & Bassetlaw Pathology Target Operating Model Full Business Case (Enclosure E2)</u>**	
	Colleagues from the SYB Pathology Team were welcomed to the meeting to present the Full Business Case for the Target Operating Model. Following presentation of the case to the SYB Pathology Partnership Board in September 2023, the case had been received by all organisations' Trust Executive Groups and was subject to ongoing discussions with the ICB and Provider Chief Financial Officers. The case would be received by the Acute Federation Board at the beginning of November. The case for change for a consolidated and sustainable pathology service and benefits to patients was noted. The Full Business Case (FBC) progressed the decision of the Outline Business Case (OBC) for a locally agreed Target Operating Model which provided resilience without losing efficiencies. The SYB Pathology Operations Director brought the Committees attention to changes since the OBC and provided an overview of the future blood sciences, microbiology, histopathology and paediatric operating models. In order to provide some background information and in response to feedback, the Head of Finance for SYB Pathology provided a summary of baseline financials by partner organisation for income, pay and non-pay. The change in savings from OBC to FBC was provided and the key areas highlighted. The 12 year economic case highlighted the fully consolidated model provided the greatest benefit to cost ratio of 2.47, with the model of choice resulting in a benefit to cost ratio of 2.42. Non-executive Director, Kath Smart asked the Chief Financial Officer what the impact of the change of costs was to the Trust. There was a need to run this through the forecast but some of the costs would be addressed by the block contract. The estates costs were not yet known but the SYB Pathology Head of Finance confirmed a small amount of funding had recently been approved to progress this work.	

	In response to a question from Non-executive Director, Emyr Jones with regards to whether there was a working model elsewhere to ensure functionality and costs were realistic, the SYB Pathology Transformation Manager confirmed the case was based on a realistic assessment, links with other networks had been formed and national benchmarking used to prepare a balanced, proportionate case with a sensible level of optimum bias and risk. Non-executive Director, Emyr Jones enquired of the level of dependence on income from work outside of the NHS and if the business environment would be a threat to the continuing success of the operation. The SYB Pathology Operations Director confirmed the formation of networks had put certain elements of commercial income at risk, Sheffield Teaching Hospitals had operated a large scale laboratory over the last ten years which had brought in significant commercial income, however, as network formed delivery at scale was possible elsewhere and there was the potential for volume work to drift to local networks. There remained a demand for highly specialised work and across the region tenders had been successful, the introduction of paediatric pathology provided the potential for growth for SYB as many networks had focused purely on consolidation rather than growth. In terms of the ask of the Committee, an agreement in principle was sought recognising that work continued to progress the FBC, with planned discussions at SY Acute Federation Board and Pathology Partnership Board. The direction of travel had received the support of all Provider Trust Chief Executives as part of the OBC and Partnership Agreement. A Q&A log was being compiled to provide assurance across the network.	
	The Committee: - ***Provided agreement in principle support of the South Yorkshire & Bassetlaw Pathology Target Operating Model Full Business Case***	
FP23/10/E3	**<u>Management of Committee Meetings</u>**	
	Following the earlier reflection and due to the prioritisation of other agenda items the Chair agreed to pick up this conversation outside of the meeting.	**MD**
FP23/10/F1	**<u>Governor Observations</u>**	
	In the interest of time the governor observer did not offer verbal observations on this occasion, a written report would be shared post meeting and the Chair extended an opportunity to speak on a one to one basis.	
FP23/10/G1	**<u>Any Other Business</u>**	
	There were no items of any other business received.	
FP23/10/G2	**<u>Protecting & Expanding Elective Capacity – Self Certification (Enclosure G2)</u>**	
	The Committee: - ***Received and noted the Protecting & Expanding Elective Capacity – Self Certification***	

FP23/10/G3	**Minutes of the Sub – Committee Meetings (Enclosure G3)**	
	The Committee: - ***Noted the Cash Committee Minutes from 27 July 2023*** - ***Noted the Capital Monitoring from 27 July 2023***	
FP23/10/G4	**Minutes of the meeting held on 21 September 2023**	
	The minutes of the meeting were approved post meeting.	
FP23/10/G5	**Assurance Summary (Verbal)**	
	The Committee was assured, on behalf of the Board of Directors on the following matters: • Matters of Concern/Key Risks to Escalate • Major Actions Commissioned/Work Underway • Positive Assurance to Provide • Decisions Made • Progress against committee associated Executive's objectives. The Chair would circulate a draft assurance log post meeting prior to presentation at the Board of Directors.	
FP23/10/G6	Date: Monday 27 November 2023 Time: 11:00 Venue: Microsoft Teams	
FP23/10/H	Meeting closed at: 12:18	

2401 - H5 MINUTES OF THE PEOPLE COMMITTEE ? 7 NOVEMBER 2023

Information Item

Mark Bailey, Non-Executive Director

REFERENCES

Only PDFs are attached

H5 - People Committee Minutes - 7 November 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee held on Tuesday 7 November 2023 at 09:00am via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director (Chair) Hazel Brand, Non-Executive Director Mark Day, Non-Executive Director Karen Jessop, Chief Nurse Zara Jones, Deputy Chief Executive Zoe Lintin, Chief People Officer Nick Mallaband, Acting Medical Director Lucy Nickson, Non-Executive Director	
In attendance:	Sam Debbage, Director of Education and Research Sudipto Ghosh, Associate Medical Director for Professional Standards Paula Hill, Freedom to Speak Up Guardian Anthony Jones, Deputy Director of People and Organisational Development Shaina O'Hara, PA for Director of Finance (Minutes) Angela O'Mara, Deputy Company Secretary Gavin Portier, Head of Organisational Development, EDI, and Wellbeing Anne-marie Steele, Deputy Director of Education and Research Adam Tingle, Deputy Director of Communications and Engagement Sean Tyler, Head of Compliance Kerry Williams, LSMS/Contract Manager	
To Observe:	Kim Anderson, Paediatric Nurse & Project Manager (Neonatal Critical Care ODN for Y&H) Board Development Programme Delegate Mark Bright, Public Governor - Doncaster	
Apologies:	Fiona Dunn, Director Corporate Affairs/Company Secretary Alexis Johnson, Public Governor – Doncaster	
		ACTION
PC05/11/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed members, those in attendance, observers including Kim Anderson who joins as part of the Board Development Delegate Programme. Mark Bright Governor had recently been re-elected, and Anne-marie Steel the Deputy Director of Education and Research. No apologies for absence were noted and no conflicts of interest were declared.	
PC05/11/A2	**Requests for Any Other Business (Verbal)**	
	No items of other business had been received.	
PC05/11/A3	**Actions from previous meeting (Enclosure A3)**	
	PC05/09/B1 Board Assurance Framework (Verbal) – Action closed.	

	PC05/09/B2 People Strategy Assurance Report & IQPR – More details included in People Strategy Assurance Report as part of the agenda. Action closed. **PC05/11/C2 Education Report** – January 2024 **PC05/09/D1 Widening Participation Report** - The outcomes from discussions will be reported back to the PC for assurance within the Q1 (24/25) WP report. Action closed. **PC05/11/D2 Overview of Improvement Projects (Occupational Health)** – May 2024 **PC05/09/D5 Job Planning** - Agreed that the report would come to PC each March. Action closed.	
PC05/11/B1	**Board Assurance Framework (Verbal)** The Chief People Officer provided key highlights where the Board Assurance Framework (BAF) risks were in relation to People and key actions to close those risks. The format had been tweaked since the last time it was sighted at the People Committee meeting. There had been new assurance levels which has been incorporated. The BAF shows progress against the actions. **Trust Risk Register 15+** The Chief People Officer presented the paper in the new format, this was a rework of the ongoing work to keep improving risk management processes. Non-Executive Director, Hazel Brand highlighted that the improved BAF allows a much clearer view and would welcome any constructive feedback from Mark Bright, Governor at the end of the meeting. Non-Executive Director, Lucy Nickson asked around the length of time should the extreme risks be tolerated and how to assess the mitigation given the sufficient workforce risk as an example. Nick Mallaband, as Chair of the Risk Management Board Committee advised that the number of risks had reduced, and all extreme risks now have an action plan. Significant improvements had been made; however it was still work in progress. The Chief Nurse added the importance of identifying the risk and there was a constant review of the mitigations which ultimately lead to that reduction. The Chair advised that if the trajectories of the risks are not reducing, there would be a challenge for the Trust. The Deputy Company Secretary highlighted where the Trust Risk Register was structured on agendas across some other committees in relation to the BAF, would this committee wish to adopt this practice. The Chief People Officer gave an example of what assurances can be shared around the sufficient workforce risk and reasons why the Workforce Supply and Demand paper was sighted on every agenda. The committee noted significant assurance, a risk register feeding into the BAF, however there are improvements and opportunities as this was work in progress.	
	The Committee: - ***Noted and took significant assurance from the Board Assurance Framework & Trust Risk Register 15+***	
PC05/11/B2	**People Strategy Assurance Report & IQPR** The Chief People Officer highlighted the report provides an update on key actions over the last two months against the strategy and key actions for the next two months. The report also indicates where there are success measures and the use of the Integrated Performance and Quality Report (IQPR) from the top people metrics perspective, highlighting risks or	

	escalations. Further to the request at the last People Committee meeting to build success measures from the annual staff survey into the IQPR dashboard. The Chief People Officer advised a meeting had been arranged with the Informatics team on 17 November to discuss how to build some staff survey metrics into the dashboard. Five themes have been identified and discussed with the Chair of the People Committee and the reasons are included within the paper. Early indications are that it may not be a quick process due to various demands within the Informatics team, however further information would be shared at the next People Committee meeting regarding timelines. The Chair confirmed that the Chief People Officer had previously discussed the more holistic look at the performance to take the key items from the staff survey against the elements of the strategy. The Chief People Officer confirmed the dashboard would include an annual comparison with DBTH year on year and Acute Trusts nationally. In response to a comment by the Chair around the significant risk about workforce. The Chief People Officer confirmed the various ways of reporting progress, workforce planning and advised that everything around that subject would be too big to pigeonhole into a specific metric. Turnover was one of the metrics in the IQPR. The Deputy Chief Executive suggested linking the strategy report with the BAF, connecting the overarching BAF risks with some of the actions and matrix to measure against the strategy. Further discussion to be held outside of the meeting to look at a consistent way of measuring strategies across committees. The Chair asked about success measures, mainly sickness absence. The Chief People Officer explained the ethos behind the different targets which had been discussed at previous meetings. The divisions/leadership teams had been empowered to manage the granular detail underneath, working within the principles set, which get scrutinised at Performance Overview and Support meetings for the sense check and consistency. A recent relaunch of the sickness absence policy provides a clearer approach to managing absence. In response to a question from Non-Executive Director, Lucy Nickson on the just culture engagement sessions feedback. In summary the sessions were extremely well attended and well received with many positive comments. The content for future sessions would be slimmed down. There was no formal measure put in place to capture representation from various areas across the Trust, one to look at for future. The Chair concluded significant assurance, a robust plan which would be monitored going forward and improvements as previous identified.	
	The Committee: - ***Noted and took significant assurance from the People Strategy Assurance Report & IQPR People Data***	
PC05/11/C1	**<u>Engagement and Leadership</u>** The Chief People Office highlighted a number of key points. - Staff survey, 60% was the latest response rate. The remaining teams are being encouraged to complete the survey which helped to see an improvement on prior year response rate of 65%.	

	- DBTH Way posters and visual displays are being displayed around the organisation. Some facilitated sessions have been held around the DBTH Way to help people understand what that means for colleagues and in particular what it means for individuals as leaders. - Health and Wellbeing Survey feedback was shared as part of the paper. In response to a question from Non-Executive Director, Hazel Brand, it was confirmed that certain areas are targeted where there are lower response rates for the staff survey. Non-Executive Director, Lucy Nickson asked when the evaluation of health and wellbeing was ready to take to Board showcasing the impact it was having. The Chair confirmed that it would be sighted at the People Committee in the first instance and then be covered as part of the Chief People Officer update at Board. The Head of Organisational Development, EDI, and Wellbeing confirmed a deeper summary would be included within the annual report. The Chair requested a joined-up report to include other measures such as sickness.	
	The Committee: - ***Noted, significant assurance was taken from the Engagement and Leadership Report***	
PC05/11/C2	**<u>Education Report</u>** The Director of Education and Research provided key highlights in the report. SET training continues to be a challenge, and this was not driven by trainer capacity. A business case awaiting approval would provide an increase in capacity to offer the training for resus and the outreach services. The other element was the challenge to ensure the team are working with accurate data, P&OD team and Informatics team are supporting with this. There has been an increase in resource for moving and handling training, which the Acting Executive Medical Director commented was a positive due to a number of reports that this training was difficult to book. The Director of Education and Research would go back to the data and compliance and advise. The Trust had recently completed the Self-Assessment(SA). This had been approved at the Trust Executive Group (TEG). Preparations for the annual assessment are underway, a new Quality Dean from NHSE had been allocated to South Yorkshire and would be involved in the visit. Included within the report was some high level information around actions from the General Medical Council National Training Survey. A summary report will be provided for the next People Committee meeting. In response to a question from Lucy Nickson, Non-Executive Director around what NHS England do with the self-assessment data. The Director of Education and Research explained the assessment was very much like a CQC visit but for education, recognising great practice, challenges and improvements. Non-Executive Director, Hazel Brand asked about the resuscitation training, there are 9 measures with 7 in red. The Director of Education and Research confirmed additional resource had been requested via the Corporate Investment Group. This support would assist with running Newborn Life Support training, which allows freer access. The challenge	

	around releasing colleagues to attend, however to mitigate the risk all junior doctors and the crash team do have a higher level of resuscitation training and the ward based colleagues have entry level basic life support training. This had been included in appraisal discussions and SET compliance is included in Clinical Excellence Awards this year, as well as encouraging managers to use the ESR data. In response to the Chair how to indicate the allowances for training, the Director of Education and Research confirmed the Learning Needs Analysis Business Planning which indicates the amount of training required. The introduction of RAP would help manage the right space to deliver the sessions and resource. The Chief People Officer contributed further information following an ICS meeting with HR Directors and the recommendations were that Workforce Planning and Business/Operational Planning go hand in hand, DBTH do have that in place. The Chair highlighted for consideration that assumptions are demonstrated and are being taken forward in the plan. The chair confirmed the committee took significant assurance on progress.	
	The Committee: - ***Noted and took assurance from the Education Report***	
PC05/11/C3	**<u>Equality, Diversity and Inclusion</u>** Head of Organisational Development, EDI and Wellbeing provided an overview on progress. Non-executive Director, Lucy Nickson sought clarity on what DBTH was trying to achieve with EDI. The Head of Organisational Development, EDI and Wellbeing emphasised the involvement of colleague networks and their effectiveness, staff survey engagements are a good indicator. In response to a second question around the recent publication around sexual harassment of female surgeons and understanding what it may mean for DBTH. The Head of Organisational Development, EDI and Wellbeing confirmed that if a network was set up for females, that would be a good indicator as to what was happening in the organisation, however there was also the freedom to speak up channel. The more networks, the more DBTH can dip test topics to provide that assurance. The Chief People Officer also contributed to the response that one of the ambitions in relation to EDI was to be representative of the communities from which we recruit as well as those we serve. Data sources such as staff survey also help to confirm that colleagues are able to bring their whole selves to work and feedback on discrimination etc. Changes nationally are to include questions around sexual harassment at work and DBTH have signed up to the sexual safety charter. In response to a question from the Deputy Chief Executive around succession planning, the Chief People Officer advised of the priorities in the EDI action plan around talent pipeline and leadership development. The Chair took significant assurance from the report, however further clarity was required on the overarching aim to provide assurance to be able to report back to the Board. It was agreed that at the People Committee meeting on 9 January would receive the outlining overall position against the EDI action plan including the 6 high impact action areas, ahead of the annual report later in the year and the next planned update paper.	
	The Committee: - ***Noted and took significant assurance from the Equality, Diversity and Inclusion Report***	

PC05/11/C4	**<u>Violence and Prevention Standards</u>** The Local Security Management Specialist (LSMS) took the paper as read and highlighted key points. - Update on the draft Security, Violence Prevention & Reduction Management Strategy and Strategy / Violence Prevention & Reduction Policy. - A new process for colleagues requesting security support when managing behaviours of concern. - Incident data for security, violence and aggression incidents. - Overview of the current VPR risks entered onto the Trust Risk Register, including mitigation progress updates against each risk. The Chair raised concerns around engagement, attendance for the stakeholder group looks to be challenging. In response the Head of Compliance shared a new process which would encourage attendance by way of circulating presentations in readiness for the meeting, which in turn would generate the conversation. The assurance of progress was linked to NHS England and Violence Prevention and Reduction action plans and strategies evidencing progress. The Chair took assurance from the report, however further evidence was required for engagement with the wider teams. The bi-annual report would return in 6 months, therefore a further update would be shared with the committee. The Chair and Executive Lead to hold an offline conversation prior to this update for further assurance.	**MB/KW/ ST**
	The Committee: - ***Noted the Violence and Prevention Standards Report***	
PC05/11/C5	**<u>Revalidation for Doctors – Annual Report & Statement of Compliance</u>** The Associate Medical Director for Revalidation and Professional Standards introduced himself to the committee. In response to an earlier question by Non-Executive Director, Hazel Brand around the medical appraisals process. The appraisals are mandated by the General Medical Council (GMS) and NHS England, all clinicians require a licence to practice. In order to obtain a licence, the information for revalidation feeds through the appraisal route. The Acting Medical Director confirmed that in order to practice the GMC register, have both the designated body and a Responsible Officer attached to the Trust. The GMC have a duty to track that across the place and that this system keeps the governance in line. The Associate Medical Director for Revalidation and Professional Standards provided an overview of the report, NHS England requires an annual submission usually by the end of October. The committee were required to note the content in readiness for submission to the Board for assurance. The Chair confirmed the committee took full assurance from the report.	
	The Committee: - ***Noted and took assurance from the Revalidation for Doctors Report***	
PC05/11/C6	**<u>Speaking Up Strategy (Draft)</u>** The Freedom to Speak Up Guardian provided an overview of the draft strategy for the next 5 years and described the wide engagement which had supported the development. The	

	committee was asked to consider and provide feedback prior to presenting at the Board meeting. Non-Executive Director, Hazel Brand supported the draft strategy which provides consistency across the organisation. A request to share the strategy with all Non-Executive Directors who are not part of the People Committee and for the Freedom to Speak Up Guardian to be available to take any questions outside of the committee was made. The Chief People Officer clarified that the draft strategy had been sighted at the Trust Executive Group (TEG) prior to this committee. The process would be for it to be sighted at this committee, feedback to be gathered and brought back through to TEG before going to Board in January for approval. Due to technical difficulties and in the absence of the Freedom to Speak Up Guardian (FTSU), the Chair confirmed that questions from the Non-Executive Directors are sighted outside of the meeting with an agreed date for feedback to the Freedom to Speak Up Guardian. In response to an observation from Non-Executive Director, Mark Day around the long-term strategy beyond 2027. The Chief People Officer confirmed the intent was to get to a point where the FTSU Guardians were not required; however, this was not a nationally stated intent and the role was currently a national requirement. In response to a further question from Non-Executive Director, Mark Day regarding the Senior Independent Director (SID) role, which an interest was declared. The Chief People Officer has previously raised similar questions to national bodies around information on the role of the SID, however, would discuss with the FTSU Guardian in relation to the speaking up process. The FTSU Guardian return to the meeting understanding that the committee and Non-Executive Directors would channel any questions within a two-week deadline.	**PH** **PH**
	The Committee: - ***Noted and took assurance from the Speaking Up Strategy (Draft)Report***	
PC05/11/D1	**<u>Widening Participation Report</u>** The Deputy Director of Education and Research provided an overview of the report for the committee to ask questions for assurance. The dates for the 'we care into the future events in 2024' would be communicated by the Deputy Director of Education and Research, 5th July for Doncaster, Bassetlaw to be confirmed. In response to a question from the Chair regarding capturing how people are made aware of these events, the Deputy Director of Education and Research advised it would be possible to capture this type of data using QR coding or similar. The Chair took assurance from the report and requested a link to be shared on the Panjango virtual tour.	**AS** **AS**
	The Committee: - ***Noted and took significant assurance from the Widening Participation Report***	
PC05/11/D2	**<u>Overview of Improvement Projects</u>**	

	The Acting Director of Communication and Engagement provided a summary of the completed and planned actions relating to the awards process and commitment to gain local, regional and national recognition for individuals and areas of award-winning work within the Trust. Non-Executive Director, Hazel Brand thanked the team for a fabulous Stars Award Event which was well attended and received. In response to a question around the pending Communications Team Award. The Acting Director of Communication and Engagement highlighted there are three award ceremonies coming up, Chamber Awards, Nursing Times Workforce Awards and the Corporate Communications Awards. DBTH are the only NHS organisation who are nominated in the latter.	
	The Committee: - ***Noted and took assurance from the Overview of Improvement Projects (Award Entries) report***	
PC05/11/D3	**Workforce Supply and Demand** It was agreed due to time constraints, the full report and demo of the tool would be presented in January 2024, however the Deputy Director of People and Organisational Development would be happy to take any questions outside of the meeting.	
PC05/11/D4	**Bi-Annual Nursing Workforce Review** The Chief Nurse provided an overview of the bi-annual establishment review update which was a requirement of the National Quality Board and NHS England guidance. The report provides a Trust wide and divisional breakdown. In response to a question from Non-Executive Director, Hazel Brand around the Safer Nursing Care Tool (SNCT) taking into account that DBTH are a multi site organisation. The Chief Nurse confirmed that it wasn't a requirement from SNCT, but a responsibility of the Trust. The SNCT would be setting the establishment, the reality of staff in post would be very different. The Chair summarised the assurance of increased attention and a return to standards. The Chief Nurse raised a concern around the skill mix which needs to be addressed by the divisions, however this was not a quick resolution. **Safe Staffing** The report was taken as read, the committee took significant assurance as a group.	
	The Committee: - ***Noted and took assurance from the Bi-Annual Nursing Workforce Review & Safe Staffing Report***	
PC05/11/E1	**People Committee Terms of Reference** The Chief People Officer presented the revised terms of reference which has been shaped around People Strategy themes. The committee approved the terms of reference recognising possible changes following a wider piece of governance work by the Deputy Chief Executive.	
	The Committee: - ***Noted the People Committee Terms of Reference***	

PC05/11/E2	**<u>360 Assurance (Return to Work)</u>** The Chief People Officer highlighted key points from the report which had also been received at the Audit & Risk Committee. The audit was a retention based audit specifically addressing the return to work process reviews. The outcome of the audit was strong assurance that return to work conversations were being undertaken and most colleagues felt they were valuable conversations. Recommendations recorded within the report are being addressed including processes and improvements to training, how data is recorded etc. Some of the actions have been set longer deadlines to allow more time as a couple of managers are just starting in their new roles. The action plans/recommendations would be built into Monday.com and will be monitored through the monthly steering group for the Agency and Sickness Management Project. In response to a question from Non-Executive Director, Hazel Brand, the Chief People Officer agreed the People Committee would see sight of progress and completion at future meetings.	**ZL**
	The Committee: - ***Approved the 360 Assurance (Return to Work) Report***	
PC05/11/F1	**<u>Governor Observations (Verbal)</u>** Mark Bright, Governor noted the meeting was very robust, good challenges. A question was raised for the Chief Nurse to respond. The Governor raised concerns around the skill mix and how it would compare with other organisations within the ICS. The Chief Nurse advised there was no comparison between one other organisation within the South Yorkshire patch. DBTH skill mix was correct, with the positive changes made at budget setting, it was found to be in a better position. Mark Bright, Governor shared a desire to have the BAF as a subject of a Governor briefing to explain some of the finer points of the integrated BAF elements. The Deputy Chief Executive Officer agreed that this detail could be shared once the process has been embedded as the BAF was still work in progress.	
	The Committee: - ***Thanked the Governor observer for his observations.***	
PC05/11/G1	**<u>Minutes of the Sub-Committee Meeting</u>**	
	The Committee noted: i) Teaching Hospital Board Minutes – 8.6.23 ii) Equality, Diversity, and Inclusion Minutes – 11.8.23 iii) Health & Wellbeing Committee Minutes – 14.8.23 iv) Speaking Up Forum Minutes – 27.7.23 v) Workforce Education Committee Minutes – 11.8.23	
PC05/11/H1	**<u>Any Other Business (Verbal)</u>** The Chief People Officer has today received a congratulatory email from the National Director for People, congratulating the Trust on their 2022 national staff survey results.	
PC05/11/H2	**<u>Minutes of the Meeting held on 4 July 2023</u>**	

	The minutes were approved by the committee as a true record.	
	The Committee: - ***Approved the minutes of the meeting held on 4 July 2023***	
PC05/11/H3	**Items of escalation to the Board of Directors (Verbal)**	
	There were no items of escalation to/from: i. People Sub-Committees ii. Board Sub-committees iii. Board of Directors	
PC05/11/H4	**Assurance Summary (Verbal)**	
	The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Are there any emerging new risks identified?	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting*** ***- Progress against committee associated Executive's objectives,*** **- Are there any emerging new risks identified?**	
PC05/11/H5	**Date and time of next meeting (Verbal)**	
	Date: Tuesday 9 January 2023 **Time: 9.00am** **Venue: Microsoft Teams**	
PC05/11/I1	Meeting closed at: 11:54	

2401 - H6 - MINUTES OF THE QUALITY & EFFECTIVENESS COMMITTEE ? 3 OCTOBER 2023

Information Item

Jo Gander, Non-executive Director

REFERENCES

Only PDFs are attached

H6 - Quality & Effectiveness Committee Minutes - 3 October 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 3 October 2023 at 13.00
via Microsoft Teams

Members:	Hazel Brand - Non-executive Director Jo Gander - Non-executive Director (Chair) Karen Jessop - Chief Nurse Emyr Jones - Non-executive Director	
In attendance:	Fiona Dunn - Director Corporate Affairs / Company Secretary (from agenda item F1) Janine Grayson - Lead Midwife Equity & Equality (agenda B1) Heather Jackson - Director of Allied Health Professionals Nick Mallaband - Medical Director for Workforce & Specialty Development Lois Mellor - Director of Midwifery Angela O'Mara - Deputy Company Secretary (minutes)	
To Observe:	Lynne Logan - Public Governor – Doncaster	
Apologies:	Lucy Nickson - Non-executive Director Tim Noble - Executive Medical Director	
		ACTION
QEC23/10/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed members and those in attendance. The above apologies for absence were received and no declarations of interest were made.	
QEC23/10/A2	**Request for Any Other Business**	
	No items of other business were raised.	
QEC23/10/A3	**Actions from Previous Meeting**	
	Action 2. QEC23/04/CI Learning from Tendable Audits – the action was deferred to February 2024 **Action 3. QEC23/04/E1 Risk ID 3209 – Patient Tracking Inaccuracies** – the action would remain open until fully implemented, update to be received in December 2023. **Action 4. QEC23/04/E1 Hospital Standardised Mortality Ratio (HSMR)** – HSMR and SHMI data and the findings of the Mortality Data Assurance Group to be incorporated into the Executive Medical Directors Report going forwards. **Action to be closed.**	

	Action 6. QEC23/08/E1 Learning from Deaths Report - quarterly learning from deaths report to be incorporated within the Executive Medical Directors report. **Action to be closed**. **Action 7. Clinical Audit Deep Dive** - Committee Chair to share with the Chief Nurse areas for consideration. Meeting arranged for 20/11/2023 **Action 8. Quality & Effectiveness Committee Work Plan** - workplan included on the agenda @ F5. **Action to be closed.**	
QEC23/10/B1	**Equality & Equity in Midwifery**	
	The Chair welcomed the Lead Midwife for Equity & Equality to the meeting. An overview of the four pledges to improve equity for mothers and babies and race equality for staff was provided, which formed the Local Maternity & Neonatal Equity and Equality Plan. The local context was considered, as 37.7% of South Yorkshire's population fell within the top 20% of the most deprived areas, which equated to an average of 2050 births annually. The impact of deprivation on maternity outcomes was shared and the disparity in maternal mortality highlighted between Black, Asian, and Minority Ethnic (BAME) groups and White women. Since joining the Trust the Lead Midwife had engaged with the Maternity & Neonatal Voices Partnership (MNVP), the Local Maternity & Neonatal System (LMNS), Head of Patient Engagement & Experience, third sector organisations and stakeholders. The current service provision had been considered, through a check and challenge of local processes, guidance and audit work. At a system level she has worked alongside the Health Inequalities Lead and been involved in system wide stakeholder engagement. Nationally, the Lead Midwife had been a panel member, topic expert and authored a chapter for the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) triennial review, which considered the outcomes for babies of White, Asian, and Black mothers and she co-chaired NHSE's Maternity Equality, Diversity & Inclusion Midwives, Leads and Cultural Specialist Group. Changes to maternity specialist services at the Trust had seen the introduction of a maternal medicine midwife, early intervention and inclusivity midwife, Public Health midwife and a consultant lead for equity and equality. In terms of next steps, whilst the MBRRACE report was focused on outcomes, there was a need to explore experience to support the quantitative data, an increase had been seen in feedback from BAME groups, which was welcomed. Non-executive Director, Emyr Jones shared his appreciation of the informative presentation and recognised the change in local population and the requirement to adapt to its needs.	

	The Chair highlighted the work of the Clinical Entrepreneur Programme in relation to equality and equity and agreed to share the information, the Lead Midwife was signposted to the FutureNHS Platform for Core20PLUS5 material. In response to a question from Non-executive Director, Hazel Brand, the Equity & Equality Midwife confirmed she did not have a clinical caseload, but worked closely with the Head of Midwifery and Specialist Midwives and was extensively involved in stakeholder engagement. Outreach opportunities were taken by the MNVP to ensure a broad exposure to all community groups. The Chair thanked the Lead Midwife for sharing her work with the Committee.	
	The Committee: - ***Noted the Equality & Equity in Midwifery Presentation***	
QEC23/10/C1	**<u>Chief Nurse Report - Quality</u>**	
	The Chief Nurse brought the Committee's attention to the key highlights of the report, noting sustained improvements in falls audits, the recording of lying and standing blood pressure for patients aged 65+ and a year to date total of 29 cases of C.difficile, against a trajectory of 42. Learning from antimicrobial usage had been identified and would be incorporated into the action plan. The Acting Executive Medical Director acknowledged that despite the number of reported cases, the Trust's position was below the national average rate of infection and future reports would provide benchmarking data for comparison. An update was provided in respect of the CQC core service inspection, which had seen unannounced visits to Urgent and Emergency Care, Maternity Services, Medicine and Surgery. A further visit to Diagnostics and Imaging had taken place last week across all four sites, which now mirrored the scope of the 2019 inspection. The Well-led review was now in train, a draft report was likely to be received in November for factual accuracy checking, with a final report expected by 31 December 2023. The immediate action plan was included within the paper and would be tracked via Monday.com. In view of the medicines management related actions, Non-executive Director, Emyr Jones sought confirmation of the governance route for such matters, the Chief Nurse confirmed the Committee would receive information via the Clinical Governance Committee. The frequency of medicine management audits had been adjusted accordingly and no patient safety issue had been escalated to the Chief Nurse as part of the inspection. The need for failsafe processes relating to out of date medicines was reinforced by the non-executive director, the Chief Nurse clarified the actions related to the storage, rather than administration of, out of date drugs which would be identified as part of right drug, right place process.	

	The Committee: - ***Noted and took assurance from the Chief Nurse Report – Quality***	
QEC23/10/C2	**<u>Chief Nurse Report – Patient Safety</u>**	
	The Chief Nurse confirmed a review of open serious incident actions had taken place, to understand and support an improvement in closure rates, most delays related to the administrative processes to close down and/or upload evidence. Whilst undertaking the review it had become apparent that actions were not reported as overdue until 3 months after the deadline and a recommendation had been made to align reporting with the deadline date. As a consequence, an increase in overdue actions should be expected. To support the transition to Learn from Patient Safety Events (LFPSE), a national fix was required to the Datix system.	
	The Committee: - ***Noted and took assurance from the Chief Nurse Report – Patient Safety***	
QEC23/10/C3	**<u>Patient Safety Incident Response Plan (PSIRP)</u>**	
	The Chief Nurse recognised the significant progress to date in implementing the Patient Safety Incident Response Framework. The Patient Safety Incident Response Plan, received for approval, would inform patient safety priorities for learning and investigating. A thematic review had been undertaken, learning from early adopters considered and the proposals externally validated. Over time it was recognised that the priorities would change. Non-executive Director, Emyr Jones, recognised the work to develop the comprehensive plan, reflective of the national framework and the local population and noted the lack of reference to surgical interventions. The Chief Nurse confirmed this was not identified as a priority, whilst accepting that there may be learning, but the transition required a focus on identifying and embedding learning, rather than investigation of all incidents. The Chair enquired how the learning would be shared, which would continue to be included in the Sharing How We Care newsletters. In addition, a series of quality and safety seminars would commence to share learning, with a broad range of communication utilised to meet the various learning styles and needs. Outside of the meeting the Chief Nurse agreed to give some thought as to how this could be translated into reporting that provided assurance to the Committee. The Chair thanked the Chief Nurse and her team for the progress made to date.	**KJ**
	The Committee: - ***Approved the Patient Safety Incident Response Plan***	

QEC23/10/C4	**<u>Patent Experience & Involvement Annual Report</u>**	
	The Committee received the Patient Experience & Involvement Annual Report. A revised copy would be circulated post meeting which included a correction to the summary tables of the Urgent & Emergency Care and Maternity inpatient surveys.	
	The Committee: - ***Noted and took assurance from the Patient Experience & Involvement Annual Report***	
QEC23/10/C5	**<u>Safeguarding Annual Report</u>**	
	The Committee received the Safeguarding Annual Report.	
	The Committee: - ***Noted and took assurance from the Safeguarding Annual Report***	
QEC23/10/C6	**<u>Infection Prevention & Control Annual Report</u>**	
	The Committee received the Infection, Prevention and Control Annual Report. Non-executive Director, Hazel Brand noted the low level of attendance of antimicrobial pharmacists, the Chief Nurse indicated this may be due to the limitation of non-clinical time, which was being considered as part of the C. difficile action plan.	
	The Committee: - ***Noted and took assurance from the Infection, Prevention & Control Annual Report***	
QEC23/10/D1	**<u>Maternity & Neonatal Transformation Report</u>**	
	The Director of Midwifery presented the first iteration of the combined maternity and neonatal transformation report. The Committee were reminded that the cut-off date for CNST training compliance was 5 December, ahead of the submission date of 1 February 2024. Progress continued to be monitored by the Oversight Committee. The single delivery plan had been cross referenced to guidance, an initial gap analysis against the four themes had been completed and would be brought to the next meeting. The Director of Midwifery shared with the Committee recent positive feedback from the Maternity & Neonatal Voices Partnership, recognising the changes to processes, improved literature, access and the Serenity Suite provision.	

	In response to a question from the Chair with regards to assistance required to achieve the required training compliance, the Director of Midwifery confirmed the support of all professionals was in place, escalation of concerns within the division had supported progress and if required non-attendance could be escalated to the Chief Nurse and Executive Medical Director. Non-executive Director, Hazel Brand highlighted the reference within the single delivery plan that staff who work together, must train together, and enquired what challenges this presented. The Director of Midwifery acknowledged that PRactical Obstetric Multi-Professional Training (PROMPT) was a multi-professional approach and whilst it did add a level of complexity to arrangements it was not a new requirement. Reflecting on national maternity safety reviews Hazel Brand identified communication and duty of candour as consistent themes for improvement, however, this did not appear to be referenced in the single delivery plan and asked what proactive steps were being taken to address this. The Director of Midwifery confirmed communication was included within PROMPT training, key to incident review panels, audits, senior midwifery and obstetrics team development, with a focus on difficult conversations and opportunities to speak up and within NHSE's leadership training. Non-executive Director, Emyr Jones, recognised the impact of non-compliance of the CNST training standard, with a perceived increase in risk and asked if the Board recognised and took ownership of the impact from a financial and patient safety perspective. The Director of Midwifery confirmed that training compliance for the CNST standard was carefully managed, with appropriate oversight, the risk was articulated on the divisional risk register, reported to Board as part of the maternity update and included within the Chair's assurance log. Safety was assessed on an ongoing basis, with appropriate plans and mitigating actions put in place, the compliance rate was not the sole determinant of a safe service. The Chief Nurse confirmed that all possible actions to facilitate compliance were being taken.	
	The Committee: - ***Noted and took assurance from the Maternity & Neonatal Report***	
QEC23/10/E1	**<u>Executive Medical Directors Report</u>**	
	The Executive Medical Director's report summarised the business considered by the Clinical Governance Committee at its July meeting. Since the report had been written and in response to an identified theme in serious incident reporting, work was underway to implement standard operating procedures to support silver trauma. There was a need to align clinical audit work with trust priorities, clarify the lines of responsibility and embed within the divisions. Non-executive Director, Emyr Jones recognised the need for clarity in respect of clinical audit but encouraged cross professional collaborative working. In respect of the clinical governance review the Chief Nurse highlighted the volume of business currently routed via the Clinical Governance Committee and recognised the opportunity, with the	

	implementation of the Patient Safety Incident Response Framework, to realign governance routes.	
	The Committee: - ***Noted and took assurance from the Executive Medical Directors Report***	
QEC23/10/E2	**Clinical Audit & Effectiveness Status Update (verbal)**	
	The agenda item was deferred to the next meeting.	
QEC23/10/E3	**Mortality Data Assurance Group Report**	
	The agenda item was deferred to the next meeting.	
QEC23/10/F1	**Trust Risk Register 15+**	
	The Company Secretary confirmed the change of name from the Corporate Risk Register to the Trust Risk Register, which contained all 15+ risks as a core report, to be provided to the Risk Management Board, Trust Executive Group, the Board and its Committees. The report provided themes, Risk Management Board status, overarching risks and overdue actions, the detailed information of which was contained within Datix. In response to a question from the Chair, the Company Secretary confirmed the risk owner was able to raise 15+ risks at the Trust Executive Group where concerns related to mitigating actions, to ensure a collective decision could be taken and this avenue remained open for CNST, if required.	
	The Committee: - ***Noted & took assurance from the Trust Risk Register***	
QEC23/10/F2	**Radiation Safety / IRMER Standards Compliance Update Report**	
	The agenda item was deferred to the next meeting.	
QEC23/10/F3	**Quality & Effectiveness Committee Effectiveness Review**	
	The Company Secretary presented the base line assessment, the findings of which were broadly in line with the other Board Committees. Since the assessment, the Committee had seen the introduction of; the Chair's assurance log, use of Team Engine and revisions to the cover sheet template. The Chair recognised the limited sample size and committed to seek soundings of what worked well and areas for improvement, as part of an iterative process.	
	The Committee: - ***Approved the Quality & Effectiveness Committee Review***	

QEC23/10/F4	**<u>Quality & Effectiveness Committee Terms of Reference</u>**	
	The Committee reviewed the draft terms of reference, the following amendments were suggested: **Membership:** in the absence of an executive director, a deputy should attend **In attendance:** remove the Deputy Chief Nurse and add the Director of Midwifery and Director of Allied Health Professionals **Quorum:** – to include a minimum of one executive director **Duties and work programme:** the first bullet point to read - the Trust wide quality objectives as part of the Nursing, Midwifery & Allied Health Professionals Quality Strategy 2023-27	
	The Committee: - ***Approved the Quality & Effectiveness Committee Terms of Reference, subject to the above amendments***	
QEC23/10/F5	**<u>Quality & Effectiveness Committee Work Plan</u>**	
	The workplan had been refreshed and agreed by the executive and non-executive members. The workplan would continue to be developed and would be brought back to the Committee on a quarterly basis.	
	The Committee: - ***Approved the Quality & Effectiveness Committee Work Plan***	
QEC23/10/G1	**<u>Governor Observations</u>**	
	Lynne Logan, Public Governor welcomed the Equity & Equality presentation. In respect of the serious incident timeline, the Chief Nurse clarified that incident reporting would be expected to be completed within the three month window, however the closure of actions and implementation of learning would not necessarily be completed and embedded within that timeframe.	
QEC23/10/H1	**<u>Sub-Committee Meetings</u>** - Clinical Governance Committee Minutes – 21 July 2023 - Patient Experience & Involvement Committee – 5 July 2023	
	The Committee: - ***Noted the Sub-Committee minutes***	
QEC23/10/I1	**<u>Corporate Objectives</u>**	
	The Committee: - ***Noted the Corporate Objectives***	

QEC23/10/I2	**Any Other Business**		
	The Chair sought feedback on the meeting, receipt of three annual reports increased the quantity of papers for review, however, it was agreed that delayed receipt was not appropriate for annual reports.		
QEC23/10/I3	**Minutes of the meeting held on 1 August 2023**		
	The Committee: - ***Noted and approved the minutes from the meeting held on 1 August 2023***		
QEC23/10/I5	***Issues escalated from/to:*** i) QEC Sub-Committees ii) Board Sub-Committees iii) Audit & Risk Committee		
QEC23/10/I4	**Assurance Summary** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters of Concern/Key Risks to Escalate, - Major Actions Commissioned/Work Underway - Positive Assurance to Provide - Decisions Made - Progress against committee associated Executive's objectives		
	The Committee: - *Was assured on the above matters.*		
QEC23/10/I6	**Date and time of next meeting (Verbal)**		
	Date: **Time:** **Venue:**	**Tuesday 5 December 2023** **13:00** **Microsoft Teams**	
QEC23/10/J	**Meeting End time**	16.08	

2401 - H7 MINUTES OF CHARITABLE FUNDS COMMITTEE - 29 SEPTEMBER 2023

Information Item

Richard Parker OBE, Chief Executive

REFERENCES

Only PDFs are attached

H7 - Charitable Funds Committee Minutes - 29 September 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee
Held on Friday 29 September 2023 at 13.00
via Microsoft Teams

Trustees:	Mark Bailey - Non-executive Director Suzy Brain England OBE - Chair of the Board Hazel Brand - Non-executive Director (Chair) Karen Jessop - Chief Nurse Emyr Jones - Non-executive Director Nick Mallaband, Acting Executive Medical Director Lucy Nickson - Non-executive Director Jon Sargeant - Chief Financial Officer/Executive Director of Recovery, Innovation & Transformation	
In attendance:	Fiona Dunn - Director Corporate Affairs / Company Secretary Shaina O'Hara - PA to the Deputy Chief Executive (minutes) Angela O'Mara - Deputy Company Secretary Emma Shaheen, Director of Communications and Engagement	
To Observe:	Mick Muddiman – Public Governor (Bassetlaw) Sheila Walsh - Public Governor (Bassetlaw)	
Apologies:	Matthew Bancroft - Head of Financial Control Norma Brindley - Executors and Representatives of the Fred & Ann Green Legacy Mark Day - Non-executive Director Jo Gander - Non-executive Director Zoe Lintin - Chief People Officer Richard Parker - Chief Executive Kath Smart - Non-executive Director Denise Smith, Chief Operating Officer Adam Tingle - Acting Director of Communications and Engagement	
		ACTION
CFC23/09/A1	**Welcome and Apologies for Absence (Verbal)** The Chair welcomed the trustees and those in attendance to the meeting. The above apologies for absence were noted.	
CFC23/09/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
CFC23/09/A3	**Actions from previous meeting** Action 1 - CFC22/12/B3 – Portfolio Ethical Considerations – in readiness for the next discussion, all responses forwarded by Hazel Brand to Jon Sargeant. Action 2 – CFC23/09/B1 – Investment Portfolio Review – **review December 2023.** Action 3 – CFC23/09/C1 – Fundraising Strategy – **revised deadline of December 2023.**	

	Action 4 - CFC23/06/B1 – Content of Review of Funds Balance Report **–** part of the agenda. **Action closed.** Action 5 - CFC23/06/B3 - Charitable Funds Development Committee Report - **Action closed.** Action 6 - CFC23/06/D2 - Committee Workplan **–** agreed to present on a quarterly basis. **Action closed.**	
	The Committee: - ***Noted the updates and agreed actions to be closed***	
CFC23/09/B1	**Financial Update**	
	The Chief Financial Officer provided a fund balance and general funds update to the committee. The main update was around the investment gains which are normally allocated at the end of each financial year, however this practice had slipped. The Charitable Funds Committee should have authorised the investment gains to be moved to the General Fund each year. Adjustments to the funds location would require permission from the committee to move the growth money from last year and the year before which would be reflective of the financial position at the end of the year. The closing fund balance on the General Funds would be £440K after expected monies spent. There are some dormant funds which would be moved across, these would be captured in the new governance practices. The Chair of the Board highlighted previous concerns with the financial administration and asked for more consistency with the management of these funds. In response to a question from the Chief Nurse regarding funds allocated to the Charitable Funds Development Committee, the Chief Financial Officer confirmed the budget set was what the committee had been allocated, however the funds adjustment process hadn't been followed correctly. The Chief Financial Officer assured the committee the funds are available, the discrepancy of the funds being recorded in the wrong area. The Chief Financial Officer confirmed the overall funds are classed as the General Fund balance. Emyr Jones clarified these funds are not related to the Fred and Ann Green Legacy, the process which the Chief Financial Officer proposed provides a more rigorously regulated process which allows quicker movement of funds. The dormant funds policy to be circulated by the Chief Financial Officer to clarify the definition and use of these funds. The Chair raised concerns about the many dormant funds. In response the Chief Financial Officer explained to help reduce and manage accounts, any fund-raising ideas are now pushed through the General Fund. Lucy Nickson, Non-Executive Director reassured the committee that other Trusts have a similar issue, 120 dormant funds wasn't high in comparison. The committee approved the allocation of the 22/23 investment income gains into the General Fund. The allocation of 21/22 capital investment gains into the General Fund which had previously been allocated across all funds. The committee approved the consolidation of the DRI, Bassetlaw and Montagu General Funds(not the Fred and Ann Green Legacy) together into one General Fund and the consolidation and closure of a number of dormant funds.	**JS**

	The Chair questioned the balance of expenditure as there was a considerable gap between patient benefit and staff benefit and if the Trustees were happy with the spend. The Chief Nurse highlighted the difficulty of identifing the split between colleague and patient, an example would be colleague training would ultimately benefit the patients. Emyr Jones, Non-Executive Director highlighted that many donations are aimed at colleagues so the original intention would need to be considered. Charitable funds should not be supporting mainstream NHS funded activity. Lucy Nickson, Non-Executive Director expressed concerns around the number of posts requiring funding by the Trust, which would in turn be subject to additional costs. It was also highlighted that with charitable expenditure, there would be a need to demonstrate that there had been an impact.	
	The Committee: - ***Noted the Financial update.***	
CFC23/09/B2	**<u>Approval of Expenditure</u>**	
	The Chief Financial Officer highlighted the following potential cases requesting funding from the Fred and Ann Green Legacy. a) Theatre Robot – Doncaster. A business case would be presented at the Corporate Investment Group. b) Rehab Unit – New equipment and small building extension request for Montagu. A business case would be presented at the Corporate Investment Group. c) Hydrotherapy Pool – Montagu. The case was presented at the Corporate Investment Group meeting who recommended that it be presented at the Charitable Funds Committee. The next Charitable Funds Committee would see sight of all three business cases. The Chief Financial Officer advised that the Corporate Investment Group had approved for recommendation to the committee a pilot scheme Music Therapist (£50K) who would be attached to the Therapy Unit at Montagu. The intention was to run the pilot for a year, review successes and if it was successful the Trust would pick up the costs. The Chief Financial Officer stated it was seen as innovative and a good opportunity to trial a new offer, the business case would be shared with the committee outside of the meeting. Mark Bailey, Non-Executive Director requested at the next meeting a full explanation of funds which the Fred and Ann Green Legacy had funded, including the Montagu Bus. The Chief Financial Officer agreed to bring all the details to the next meeting to assist with the evaluation of these funds. In response to a question from Emyr Jones, Non-Executive Director in respect of the time delay presenting these cases to the committee especially if there was a clinical interest. The Chief Financial Officer confirmed the divisions are kept informed of the progression of the theatre robot and rehab unit business cases. Further understanding of the decision to relocate the hydrotherapy pool to Montagu which in turn would delay the original request. The Acting Executive Medical Director highlighted that different options should have been	JS

	explored looking at a different area at the Doncaster site due to the existing area being deemed as not suitable. In response to a further question from Emyr Jones, Non-Executive Director regarding meeting the criteria of additionality, projects which could be funded from the Trust's capital funding. The Chief Financial Officer explained the Board's decision pre COVID regarding to close the therapy pool due to it not being fit for purpose and the affordability of the running costs, therefore this was not a classed as a service the Trust would provide. The Chair of the Board highlighted that Montagu site was seen as the Centre of Excellence for rehabilitation service and reminded the committee of previous conversations around agreeing to be a Hyper Acute Stroke Unit and to increase rehabilitation on behalf of local Trusts. This would help the case to move forward to enable patients stay with DBTH rather than be rehabilitated elsewhere. The Chief Financial Officer shared the next steps from a governance process for all three business cases and would be sighted at the December Charitable Funds Committee meeting.	
	The Committee: - ***Not approved, to be sighted at the meeting in December.***	
CFC23/09/B4	**Charitable Funds Development Committee Report**	
	The Chief Nurse presented the report and highlighted the further detail included in the bids, following a requested from the last meeting. The next Development Committee meeting is Monday 2nd October. The communication approach has been refreshed to encourage bids. The Chief Nurse supported the challenge on how funds were spent, however felt the assurance received from the training session from an external company earlier on in the year advising how Trust funds should be spent. The Chief Nurse highlighted the need for the practice development posts in the appendix, which form a larger strategy of support for the newly qualified nurses. The Chief Nurse would then follow the Trust process should the need to create substantive posts. Emyr Jones, Non-Executive Director said that the short term funded posts should be clear from the outset that they would not be continuously funded and would then be subject to an appropriate business case and follow the Trust process. The Chief Financial Officer confirmed the post would be advertised as a fixed term contract. Lucy Nickson, Non-Executive Director highlighted a concern that there was no income plan and once the Fred and Ann Green Legacy was spent, the income would be exposed. As there would not be a long-term income plan, these types of posts would pose a question. Another point Lucy Nickson, Non-Executive Director made was around the transparency of the donations for the public. The Chief Financial Officer agreed that if the proposal was to spend the funds from the Fred and Ann Green Legacy this would leave a small amount of funds, therefore generating funds for the future would be essential as the curtailment of funds for the Charitable Funds Development Committee would be significant. In response to a question from the Chair regarding effectiveness of the funds. The Chief Nurse confirmed it would be very specific to the post, however an example was given for a	

	Paediatric Sepsis post which was put in place to deliver an action plan. The subsequent audit would determine the effectiveness of the post. In response to the statement regarding transparency, the Director of Communications and Engagement shared that in previous years the expectation was anyone awarded funds had an evaluation piece to feed back to the annual report. The Director of Communications and Engagement would ensure this is picked back up.	**ES**
	The Committee: - ***Noted the Charitable Funds Development Committee Report.***	
CFC23/09/C1	**Draft Fundraising Strategy**	
	The report was deferred to December's meeting.	
CFC23/09/C2	**Overview of Current and Planned Activities**	
	Director of Communications and Engagement highlighted that the team are neatening the policies. The report was taken as read.	
	The Committee: - ***Approved the Overview of Current and Planned Activities***	
CFC23/09/D1	**Review of Charitable Fund Policy and Terms of Reference**	
	The Chair confirmed there were minor changes are required to the policy. The Chief Nurse highlighted that the policy would need to be updated to match the Terms of Reference, the membership i.e. job titles and the additional members added into the policy doesn't match the new Terms of Reference. The Trustboard Office would make the necessary changes. The committee agreed that the policy was reviewed, and a shortened review date would be set to allow for the strategy to be agreed.	**FD/AO** **FD/AO**
	The Committee: - ***Noted the Review of Charitable Fund Policy and Terms of Reference***	
CFC23/09/E1	**Governor Observations (Verbal)**	
	The Chair welcomed both attending Governors. In response to a question from Sheila Walsh regarding the dormant fund accounts automatically closing, the Chief Financial Officer confirmed the process to encourage those fund holders to spend the fund on what it was intended for. In the event it wouldn't be spent, funds would then be moved over. A further question from Sheila Walsh regarding clear guidelines and decision-making criteria on whether funds should be used for roles within the Trust. The Chief Nurse confirmed the additionality, and those posts would not be included within the Trust's establishment unless	

	they go through the Trust process. Sheila Walsh asked if the public perceive that charitable funds are being used for what the Trust should be funding itself, there would be a risk of deterring the public from donating. The Director of Communications and Engagement said that any communication would have a clear distinction albeit in formal communication or one to one conversation. In response to a final question from Sheila Walsh regarding the hospital bus service, Doncaster to Mexborough. The Chief Financial Officer reassured the Governors that the bus service, would be kept running, all factors are to be considered when making such decisions.	
CFC23/09/F1	**Minutes of the Sub-Committee Meeting**	
	The Committee: - ***Noted the minutes of the Charitable Funds Development Committee of 5 June 2023, 4 July 2023, 7 August 2023.***	
CFC23/09/F2	**Minutes of the Charitable Funds Committee Meeting held on 5 June 2023**	
	The Committee - ***Approved the minutes from the Charitable Funds Committee of 15 June 2023***	
CFC21/12/F3	**Any Other Business**	
	No items of other business were received.	
CFC22/12/F4	**Assurance Summary** The Committee is asked if it is assured, on behalf of the Board of Directors on the following matters. Any matters where assurance is not received, will be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process **The committee was assured.**	
CFC22/12/F5	**Date and time of next meeting** Thursday 7 December 2023 Via MS Teams Time 13:30	
	Meeting closed: 14:15	

2401 - H8 MINUTES OF AUDIT & RISK COMMITTEE - 19 OCTOBER 2023

REFERENCES

Only PDFs are attached

H8 - Audit & Risk Committee Minutes - 19 October 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Thursday 19 October 2023 at 09:30 via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director Mark Day, Non-Executive Director Jo Gander, Non-Executive Director Emyr Jones, Non-Executive Director Kath Smart, Non-Executive Director (Chair)	
In attendance:	Mark Bishop, Local Counter Fraud Specialist Laura Brookshaw, 360 Assurance Hayley Clark, Ernst & Young Alex Crickmar, Deputy Director of Finance Fiona Dunn, Director Corporate Affairs / Company Secretary Mathew Gleadall, Acting Deputy Director of Estates and Facilities Zoe Lintin, Chief People Officer Nick Mallaband, Action Executive Medical Director Shaina O'Hara, PA to the Deputy Chief Executive (Minutes) Angela O'Mara, Deputy Company Secretary Jon Sargeant, Chief Financial Officer Denise Smith, Chief Operating Officer Dan Spiller, Ernst & Young Ruth Vernon, 360 Assurance Kerry Williams, Local Security Management Specialist	
Observer:	Karen Jessop, Chief Nurse Zara Jones, Deputy Chief Executive Paula Marchetti, Consultant Clinical Scientist – Biochemistry	
Apologies:	No apologies	
AR23/10/A0	**Welcome, apologies for absence and declarations of interest (Verbal)**	**ACTION**
	The Chair welcomed members, attendees and observers to the meeting. There was full attendance for the meeting and no apologies for absence were noted. No declarations of interest were made other than for item F4, the Internal/External Effectiveness Review, and 360 Assurance and EY Audit colleagues would leave the meeting for that particular discussion. The paper had been circulated separately prior to the meeting.	
AR23/10/A1	**Actions from previous meeting (Enclosure A1)**	
	AR23/04/C2 - Risk Management Training. Action closed. The training date remains as originally agreed as part of the Internal Audit Review.	

	AR23/07/C1 - <u>360 Assurance Progress Report</u>. LB confirmed all KPMG actions had closed, one remaining relating to job planning, 3 have revised dates. 360 Assurance would keep sight of the 3 remaining. **Action closed.** **AR23/07/C2 - <u>Bank & Agency Spend.</u> Action closed.** **AR23/07/F1 - <u>Board Assurance Framework Progress Update.</u> Action closed.** **AR23/07/F2 – <u>Risk Management Board - Progress & Metrics.</u> Action closed.** **AR23/07/F3 – <u>Declarations of Interest, Standards of Business Conduct Update.</u> Action closed.** **AR23/07/G1 – <u>Board Committees Annual Report.</u> Action closed.** **AR23/07/H2 – <u>Health and Safety Bi-Annual Report – Deep Dive Sharps</u>**. The Sharps Group would investigate the findings further and feedback any key actions to the most appropriate committee i.e. ARC/People. **Revised deadline January 2024** **AR23/07/H2 - <u>Health and Safety Bi-Annual Report -</u>** Internal health and safety alert system. **Revised deadline January 2024.**	
AR23/10/J1	**<u>Request for any other business (Verbal)</u>**	
	No requests for any other business were received.	
AR23/10/B1	**<u>LCFS Progress Report</u>**	
	The Local Counter Fraud Specialist (LCFS) shared the key points from the progress report. In response to a question from Mark Bailey, Non-Executive Director around pushing the outstanding number of investigations along. The LCFS advised that it was out of the hands of the LCFS, the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) conclude their own investigations in their timescales, out with the Trust process. The Chair asked about the local proactive exercise on working elsewhere which has caused issues in the past. The LCFS confirmed there was a good culture within the Trust, and it was down to the individual to declare. The Director of Corporate Affairs/Company Secretary supported the statement and confirmed liaison with the Comms Department to encourage teams to disclose, also use of CIVICA and weekly bulletins reinforce the message.	
	The Committee: - ***Noted and took assurance from the LCFS Progress Report***	
AR23/10/C1	**<u>360 Assurance Progress Report</u>**	
	360 Assurance took the paper as read, highlighting key actions and the current position. 3 reports had been issued since the last Audit & Risk Committee. The year end opinion was reported as being on track and looking positive for this year. There are 3 historic actions which would track to completion, a positive percentage and a good improvement on the previous position was reported. Recent events held, one for the NHS Board Members on procurement and another was a presentation on a review and identity documents which was delivered by Counter Terrorism Police, some colleagues from HR and Medical staffing attended. The final Board Member session on provider collaboratives would be held in December. The links would be circulated through the Director of Corporate Affairs/Company Secretary. Patient Safety Incident Response Framework (PSIRF) forums continue, it was positively reported that DBTH representatives were one of the highest attenders at the PSIRF Forum. A request for an approval to defer the Complaints Audit until 24/25 due to the policy being updated and subsequent training being undertaken and audit wishing to revie the revised processes. The Chief Nurse advised the audit would certainly not be deferred beyond 24/25.	**RV/KJ**

	Jo Gander, Non-Executive Director supported the deferral, the paper was shared at the recent Quality Effectiveness Committee meeting (QEC) which showed significant improvement in the response rates to complaints. For additional assurance this was referenced in the Quadrant report which would be sighted at Board. The Chair noted the level of internal audit recommendations closure rate, which was a real step forward for the Trust and congratulated the team on their hard work to deliver in a timely manner. Before the end of the year there are several recommendations still to be completed, the Chair stated that to continue to deliver to that high standard.	
	The Committee: - ***Noted and took assurance from the 360 Assurance Progress Report;*** - ***Approved deferring the Complaints Audit until 24/25 audit plan***	
AR23/10/C1	**360 Assurance Progress Report**	
	Waiting List Clinical Prioritisation – Limited Assurance 360 Assurance reported the review was to assess how patients are prioritised based on clinical risk assessments and to test the consistency of that application across the trust. It was identified that the control framework supporting clinical risk assessments had a draft Standard Operating Procedure (SOP) in place and some of the sections were incomplete, therefore it was not evidenced that the completed sections were consistently being used in practise. It was also identified that the SOP differed from national guidance in respect of the patient categorisation thresholds. Two medium risk findings were raised in respect of the key documents. A further medium risk was raised in respect of availability, completeness, and chronology of patient records. It was acknowledged that this would present a low risk to prioritisation of the patient, however, the risk would be greater when considering the impact on patient care. The audit raised a high risk on the basis of the sample testing and data analytics exercises identified limited evidence of justification for category ratings across the Trust's patient treatment list. Actions have been agreed with the Executive Medical Director and the Chief Operating Officer. The actions would then form the content of the revised SOP to ensure a more consistent documentation of categorisations in the future. In response the Chief Operating Officer accepted the findings and confirmed that she would adopt lead Executive role to ensure the actions are concluded with the support of the Executive Medical Director. Emyr Jones, Non-Executive Director asked a question around the two categories the Trust was not using that related to patients who were deferred due to COVID/Non COVID reasons. The Chief Operating Officer confirmed the decision was taken at the point of guidance issued, however the new policy and any associated standard operating procedures would reflect current national guidance. A deeper conversation was held around those patients without a categorisation rating and recovery plan associated. It was confirmed that an audit action for the Executive Medical Director to undertake a deep dive to review whether there was justified deviation from the categorisation, this would inform what was to be documented (SOP) in the future. A further discussion to be undertaken between the Chief Operating Officer and the Executive Medical Director to agree to either go over the whole waiting list or undertake what has been agreed as part of the action plan. In response to a question from the Chair, the Chief Operating Officer	

	was unable to confirm if non categorisation had led to cause harm to patients and would take on that point. In response to a question from Mark Day, Non-Executive Director around a future follow up audit to address compliance, the Chief Operating Officer agreed that a snap shot of audits to be undertaken as part of business as usual working. The Chair suggested that follow up work should be reported into Finance and Performance Committee to get assurance and oversight on the %age compliance with categorisation priority rating and the data quality. The Chair noted this as an action to be referred into Finance and Performance. The Chair concluded there are 2 high and 3 medium recommendations with an end date of 31st December. The Chief Operating Officer advised a plan to undertake some actions by the end of November, however aim to conclude by the end of December. The Chief Operating Officer agreed to feedback following a full review of the gaps in the patient tracking list and report the root cause as the Chair and the Chief Operating Officer were keen to be sighted on this. **Head of internal Audit Stage 1** 360 Assurance highlighted this was the first stage of their work to support the year end opinion. The work the Trust had undertaken to review the Board Assurance Framework and how the extreme risks are reported to Board and the committees had been recognised. The 15+ risks paper had been sighted at this meeting, 360 Assurance understood that it had recently gone through QEC but had not seen them go through Board or the committees. Agreed actions to utilise the BAF and the Trust 15+ Risk Register as live documents to support the management of strategic risk. The Chair confirmed there would be further discussions with the Non-Executive Directors at an away day around use of the Chairs log, consistent assurance levels, testing and challenge of the current scores on the BAF to make if more fit for purpose. **Staff Retention – Return to Work Conversations – Moderate Assurance** 360 Assurance highlighted the Trust had recently refreshed the sickness absence policy and the development of the supporting documentation and training tools for use by managers. As part of the audit sample testing, interviews with line managers were undertaken and a staff survey was undertaken receiving over 600 responses. The exercises indicated that over 80% of colleagues were having return to work conversations following a period of absence. Wider feedback on the testing highlighted that some areas indicated that the process could be improved. 3 medium risks and 4 actions agreed. The Chief People Officer had taken on board the actions raised. The actions had been allocated to Team Members who would be moving into new posts, therefore the timelines reflect the moves. The Chair highlighted the assurance that 80% of colleagues reported to have had return to work conversations. There are some comments that don't have actions and reference that the Health and Wellbeing Policy review was overdue, last reviewed in March 2023. The Chief People Officer to confirm when this would be reviewed. In response to another question from the Chair around training new managers to capture return to work conversations and other appraisal type tasks. The Chief People Officer confirmed there was a combined approach to capture this type of training.	**DS/KS** **DS** **ZL**

	Jo Gander Non-Executive Director asked if all comments/conversations were captured in the spirit intended and questioned the quality of the conversations. In response the Chief People Officer confirmed some negative comments were relating to tick box questions, however the majority of the comments were positive. The Chair questioned how to gain the assurance going forward. In response 360 Assurance reiterated the scope of the audit and establishing who was and wasn't' receiving return to work conversations. The data indicated more colleagues were having these conversations. The Chief People Officer raised that it would come down to leadership and the difference between a good leader who would have supportive conversations, the amends would pick up the action to help structure conversations. The Chair explained to the committee the Chief People Officer was in attendance at this meeting due to the moderate assurance given. It was confirmed that this paper would be discussed at the next People Committee Meeting on 7 November.	**ZL**
	The Committee: - ***Noted and took assurance from the 360 Assurance Progress Report***	
AR23/10/D1	**External Audit Report – Auditors Annual Report**	
	Hayley Clark, Ernst & Young explained the report closes the audit along side the certificate which was issued in August for completeness. The report had also been presented at Board in September. Dan Spiller, Ernst & Young highlighted the differences between the audit results report and the Auditors Annual Report. The Chair wanted the Auditors Annual Reporting to be sighted at this meeting for completeness. The Chair confirmed the audit recommendations would be revisited in January as a committee.	
	The Committee: - ***Noted and took assurance from the Auditors Annual Report***	
AR23/10/E1	**Single Tender Waiver Report**	
	The standard report was taken as read. The Chief Financial Officer to confirm when the Procurement Strategy and Policy are being renewed.	**JS**
	The Committee: - ***Noted and took assurance from the Single Tender Waiver Report***	
AR23/10/E2	**Losses and Compensation**	
	The standard report was taken as read.	

	The Chair noted two needle stick injuries which would be picked up as part of the Audit Committee action log.	
	The Committee: - ***Noted and took assurance the Losses and Compensation Report***	
AR23/10/F1	**Risk Management Board - Progress & Metrics, Training**	
	Acting Executive Medical Director provided a brief reminder of the process of reviewing risks at the Risk Management Board Meeting and detailed how the risk management system was improving. The Risk Management team recently discussed how to get the system risks through to the ICB. Andrew Ibbotson from the ICB has been invited to the Risk Management Board meetings, escalation of risks would go internally to Trust Executive Group (TEG) and then externally to Care Quality Review Group (CQRG) due to those risks which were out of the Trust's control. Work continues with divisions to gain a better understanding of the overarching risks and what level these risks should be graded to acquire consistency. Progress had been made and it was reported that all extreme risks now have an action plan. The risk register continues to build overarching risks with supporting risks underneath them. The Director of Corporate Affairs/Company Secretary confirmed the matrix indicating the shift of new risks going on and old ones being removed, this core standard report would be sighted across all committees including Board. The Deputy Chief Executive suggested a bit more work to link the strategic risks and themes which come from the Boad Assurance Framework (BAF). The other point made was around the significant number of duties within the Terms of Reference (ToR) which could be streamlined to further understand divisional roles and other committee roles are and to hone in on what was important. In response the Chair agreed with the points made, including a review of the ToR would be welcomed. The Chair noted that there had been good progress made and utilising Datix evidenced the "one source of the truth" from a risk perspective. However, it was noted that Trust Risk register report now states 29 a reduction from last month's figures of 36, the Chair believed this figure was still high for a Board to focus on that many significant risks, but accepting there was "work in progress". The Chair suggested that internal audit colleagues could provide the Trust with comparable figures from other Trusts to benchmark against. The Chair also raised concerns around the mitigating actions and the scrutiny around deliverable end dates and who is responsible for looking at these. In response the Acting Executive Medical Director confirmed that the Risk Management Board (RMB) were sighted on each action plan and challenged/escalated appropriately. The Director of Corporate Affairs/Company Secretary supported the statement confirming the use of the Datix system, minutes and the role of the RMB to highlight risks for escalation and monitoring of those action plans. The Deputy Chief Executive agreed that the RMB should take another look at simplifying the process and how the Committees and Board get assurance of the mitigating actions. The Chair clarified for the purposes of accuracy that the report had not been presented at September's Board, however it was due at October's Board.	**ZJ/FD/ NM**
	The Committee: - ***Noted the Risk Management Board - Progress & Metrics, Training Report***	

AR23/10/F2	**<u>Board Assurance Framework Update</u>** **<u>Trust Risk Register (15+)</u>**	
	The Director of Corporate Affairs summarised key points. The BAF had been updated following a review at each of the committee meetings held after July. The BAF had been updated following recommendations from the Head of Internal Audit Opinion during 22/23 to clearly understand the strategic risks that could impact on the strategic objectives. The BAF would be presented quarterly to the Board along with the Trust Risk Register 15+ and the quarterly Corporate Objectives update (April, July, October, January) commencing from October 2023. DBTH would continue to develop and embed the Risk Management processes. The Risk Management policy had been reviewed and would be presented at a future meeting. The Non-Executive Directors confirmed that QEC and People Committee had seen sight of the BAF. In the absence of the Chair of Finance and Performance Committee, Mark Day, the Chair confirmed that the BAF was sighted at the meeting in September and confirmed the new assurance definitions had started to be used. A slightly different model had been adopted than previously seen at QEC and People Committee and was circulated to all the Board. There had been some challenge put forward around the controls, however the actions plans were robust. It was indicated there were inconsistent links to operational risks in BAF 3 and Estates, however BAF 5 (Finance) was found to be solid. Work was required on Quality Improvement, Partners/Prevention and the collaboration to bring them up to the same level as BAF 5. It was agreed to use the new assurance rating going forward. As 5 of the 7 BAFs currently sit with Jon Sargeant/Finance and Performance Committee, the Chief Financial Officer and the Deputy Chief Executive to provide a proposal of where the BAF would sit amongst committees. The Chair required to note that BAF 6 “Partnerships” does not fit with Audit Risk Committee Terms of Reference, Executives to discuss which Committee this BAF sits with. **<u>Trust Risk Register (15+)</u>** The Director of Corporate Affairs highlighted key points from the report. The whole idea of the report was to make it less manual. This format is the core data trust risk report, over time it would be revised and amended as appropriate. As the TRR had been discussed at length in the previous agenda item, there were no further queries.	**JS/ZJ** **ED**
	The Committee: - ***Noted the Board Assurance Framework Update and Trust Risk Register***	
AR23/10/F3	**<u>Draft Risk Management Policy</u>**	
	The Director of Corporate Affairs/Company Secretary provided an overview on where the Risk Management Policy had been sighted and the main changes which also reflect the new changes made to the BAF. The Terms of Reference (ToR) had also been attached to the report, again reflecting the changes. The policy would then be sighted at Board in October for ratification.	

	The Chair advised the ToR would be noted. The Chair highlighted the long list of functions for the Risk Management Board to review and understand which are achievable and realistic which the DCOE and MD are currently reviewing. The committee approved the policy.	
	The Committee: - ***Noted and took assurance from the Draft Risk Management Policy***	
AR23/10/F4	**Internal Audit – Review Effectiveness** **External Audit – Review Effectiveness**	
	The Internal and External Auditors left the meeting to enable the Committee to evaluate the feedback. A separate document to be circulated on key points shared to those in attendance at the confidential meeting.	
	The Committee: - ***Noted and took assurance from the Internal/External Audit – Review Effectiveness Update***	
AR23/10/G1	**ARC Committee Effectiveness**	
	The Chair agreed with the committee to defer the effectiveness report to the first quarter of next year, in line with other committees.	
AR23/10/H1	**Local Security Management Bi-Annual Report**	
	Acting Deputy Director of Estates and Facilities summarised key highlights on the report and took the report as read. The Chair congratulated the Local Security Management Specialist (LSMS) on completing the Level 7 Violence Prevention and Reduction course, which demonstrates the Trust's commitment to training and VPR. In response to a question from Mark Bailey, Non-Executive Director on hot spots, the Local Security Management Specialist confirmed vulnerable hot spots are addressed. There are bi-annual meetings with the Crime Prevention team who walk the site noting any recommendations. A further question around incidents within key wards at the Trust. The LSMS reminded the committee of the 24-hour bed watch. The LSMS meet weekly with the Professional Nurse Advocate (PNA) who offer support within hot spot areas undertaking historic supervision sessions with colleague groups, work continues with the clinical teams to highlight areas where support can be put in place. The Chair asked that sharing prosecutions would also demonstrate the Trust's commitment to security and safety, which would encourage colleagues to report incidents. The LSMS confirmed regular meetings with the Comms Team to include this type of detail within the Buzz publication. In response to a question from the Chair on the lone working devices which are not being used by colleagues. The LSMS confirmed working progress on use of the devices, the team are testing different approaches to encourage colleagues to use these devices. One way was to advise colleagues that the devices were part of ensuring their personal safety, which has been	

	positively received. Risk assessments are reviewed to establish the continuing use of the devices in areas and the lists are updated to reflect the changes. The Chair raised concerns, which would be included in the Chair's assurance report, around firmer actions on how to move this issue forward. The Chief Financial Officer agreed to provide further information on the benchmarking and appropriate actions to provide that particular assurance the committee requires. The Chief Financial Officer would agree with the Chief People Officer where this update would appropriately sit, either within the Audit and Risk Committee or the People Committee.	**JS/KW**
	The Committee: - ***Noted and took assurance from the Local Security Management Bi-Annual Report***	
AR23/10/H2	**<u>Emergency Preparedness Resilience and Response (EPRR)</u>**	
	The Chief Operating Officer took the paper as read. The key items to note, there are 62 core standards, and the Trust has to self-assess against each of the core standards. The initial self-assessment was fully compliant with 41, and 21 partially compliant. To reach the overall organisational compliance, the expectation would be to self-assess as 100% compliant with every core standard the Trust has. The self-assessment brought the Trust out at 66%, which was an overall organisational rating of non-compliance. Once the feedback has been received, the Trusts have 5 days to turn around, respond and resubmit any additional evidence. The Chief Operating Officer explained that the focus over the next 12 months was to get all the basics back in place on emergency planning, resilience and response, to ensure all policies are correct, up to date and focus on core standards. In response to a question from Mark Bailey, Non-Executive Director on the risk within the Estates establishment. The Chief Operating Officer advised of a separate piece of work being undertaken. Having a robust business continuity arrangement was a key area of focus. The Chief Operating Officer confirmed that recent testing indicated these arrangements work. The Chair asked if business continuity was still a focus, the Chief Operating Officer confirmed that initial work had been undertaken around a template for a business continuity plan which was circulated to each service, there are still some returns outstanding which would be picked up especially as the EPRR group meet monthly. In response to a question from the Chair around training the Chief Operating Officer confirmed that an up-to-date record of who has attended or are attending the Strategic Commanders and the Tactical Commanders training. The biggest gap was to look back through the Trust's internal training, the Director of Education & Research was supporting with access to Oracle Learning Management (OLM) to help and monitor and keep focus. The COO also highlighted that several neighbouring Trusts had been through an evidence review and had their self-assessed grades reduced.	
	The Committee: - ***Noted the Emergency Preparedness Resilience and Response (EPRR)***	
AR23/10/I1	**<u>Governor Observations</u>**	
	The Director of Corporate Affairs/Company Secretary confirmed the appointments for new Governors. Communication to the Governors for their expressions of interest to join appropriate vacancies on committees would be issued in due course with a view to have all vacancies filled.	

AR23/10/J1	**Any Other Business**		
	No items of other business were received.		
AR23/10/K1	**Sub Committee Minutes**		
	The Committee noted: i) Health & Safety Committee - n/a ii) Information Governance Committee Minutes – n/a		
AR23/10/L1	**Information Item**		
	There were no items to note.		
AR23/10/M1	**Minutes of the Meeting Held on 20 July 2023**		
	The minutes of the above meeting were approved.		
AR23/10/M2	**Audit and Risk Committee Work Plan**		
	Not discussed.		
AR23/10/M3	Issues escalated from/to: i) QEC, F&P, and People Committees ii) ARC Sub-Committees iii) Board of Directors F&P – Internal Audit Report - Waiting list prioritisation People Committee – Internal Audit Report - Return to work interviews *Kath Smart, Chair*		
AR23/10/M4	**Assurance Summary** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting - Progress against committee associated Executive's objectives - Any new Emerging risks that have been identified from the meeting?		
AR20/06/M5	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	16 January 2024 09:30 Microsoft Teams	
	Meeting Close:	12:35	

2401 - I OTHER ITEMS

2401 - I1 MINUTES OF THE MEETING HELD ON 19 DECEMBER 2023

Decision Item | Suzy Brain England OBE, Chair of the Board | 12:50

5 minutes

REFERENCES

Only PDFs are attached

I1 - Public Board of Directors Minutes - 19 December 2023 v3.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 19 December 2023 at 09:30 via MS Teams

Present:
Mark Bailey - Non-executive Director
Suzy Brain England OBE - Chair of the Board (Chair)
Hazel Brand - Non-executive Director
Mark Day - Non-executive Director
Jo Gander - Non-executive Director
Dr Emyr Jones - Non-executive Director
Karen Jessop - Chief Nurse
Zara Jones - Deputy Chief Executive
Zoe Lintin - Chief People Officer
Dr Nick Mallaband - Acting Executive Medical Director
Lucy Nickson - Non-executive Director
Richard Parker OBE - Chief Executive
Kath Smart - Non-executive Director
Denise Smith - Chief Operating Officer

In attendance:
Alex Crickmar - Deputy Director of Finance
Lois Mellor - Director of Midwifery
Angela O'Mara - Deputy Company Secretary (Minutes)
Emma Shaheen - Director of Communications & Engagement

Public in attendance:
Denise Carr - Public Governor Bassetlaw
Gina Holmes - Staff Side
Annette Johnson - Public Governor Doncaster
George Kirk - Public Governor Doncaster
Lynne Logan - Public Governor Doncaster
Andrew Middleton - Public Governor Bassetlaw
Joseph Money - Staff Governor
Lynne Schuller - Public Governor Bassetlaw
Clive Smith - Public Governor Doncaster

Apologies:
Fiona Dunn - Director of Corporate Affairs / Company Secretary
Jon Sargeant - Chief Financial Officer

P23/12/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

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

P23/12/A2 **Actions from Previous Meetings**

There were no active actions.

P23/12/B1 **Chair's Assurance Log – Quality & Effectiveness Committee (enclosure B1)**

Emyr Jones, Deputy Chair of the Quality & Effectiveness Committee provided an overview of the four quadrants of the Chair's assurance log, positive assurance, areas of major works, areas of focus and decisions made.

Non-executive Director, Kath Smart welcomed the review by the Committee of the Ionising Radiation (Medical Exposure) Regulations (IRMER) and sought clarity of next steps to ensure compliance. The Deputy Chair confirmed that work continued to progress outstanding actions, closure of which would be reported to the Committee for assurance purposes.

The Chief Executive acknowledged historical concerns raised as part of the Care Quality Commission's (CQC) inspection in 2019, however, the service had been subject to an unannounced CQC inspection in September 2023 when no immediate concerns had been raised. The draft CQC inspection report was expected in January 2024 and would be triangulated with existing internal and external assurance.

The Board:

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

P23/12/B2 **Clinical Negligence Scheme for Trusts (CNST) Year 5 Board Declaration (Enclosure B2)**

The Director of Midwifery presented the Year 5 CNST Board Declaration. The Obstetrics & Gynaecology Clinical Director was unable to attend the Board and his apologies were noted.

Of the ten maternity safety actions, eight were fully compliant. Action six in respect of the implementation of Saving Babies Lives Care Bundle (version three) and action eight, related to training compliance were currently not compliant, however, compliance was expected to be declared prior to the submission date of 1 February 2024.

A review of standards had been assessed by the Local Maternity & Neonatal System (LMNS) as part of an assurance visit in October and November 2023, feedback from the earlier visit was provided within the report, as external assurance.

The action plan to support training compliance of 90% by 23 February 2024 was appended to the presentation for approval, since the time of writing the Director of Midwifery confirmed the 90% standard had been reached across some staff groups.

The Board's attention was drawn to the evidence required to declare compliance, including the requirement for approved minutes of the Board of Directors. In order to facilitate a timely submission the Chair of the Board proposed the minutes of this meeting would be circulated for approval, to be ratified at the Board meeting on 30 January 2024.

The Board considered the evidence and provided approval for the Chief Executive to sign off the submission ahead of the 1 February 2024 deadline.

The Board recognised the significant effort and contribution required by the Director of Midwifery and her team in evidencing compliance with the standards.

The Board:

- ***Considered the evidence provided and offered its approval for the Chief Executive to sign off the Clinical Negligence Scheme for Trusts (CNST) Year 5 Board Declaration and approved the training action plan.***

P23/12/B3 **Maternity & Neonatal Update (Enclosure B3)**

The report provided an overview of the progress made against the national standards within maternity and neonatal services. In view of an earlier than usual Board meeting not all data and supporting dashboards were available, they would be provided next month, along with the recommendation from a recently received Maternity and Newborn Safety Investigation (MNSI) report.

The Board's attention was drawn to an increased number of stillbirths, early in pregnancy; antenatal rapid reviews had been undertaken with no immediate learning identified. Communications to raise awareness of reduced foetal movements and supporting action would be shared. In response to a question from Non-executive Director, Lucy Nickson, the Director of Midwifery recognised the impact on colleagues, support was offered from a health and wellbeing perspective from the senior team, Professional Midwifery Advocate and bereavement team.

Non-executive Director, Kath Smart noted differences between the Trust and LMNS's assessment of elements of the Saving Babies Lives Care Bundle (version 3), the Director of Midwifery confirmed a strict evidenced based approach by the Trust.

As Chair of the LMNS and working alongside the Integrated Care Board's Chief Nurse, the Chief Executive confirmed the strategy for the LMNS was to be sighted on the early identification of challenges in maternity and neonatal services, ensuring system learning to support delivery of "good" CQC rated services. The opportunity for a Maternity and Neonatal Independent Senior Advocate to work with the LMNS was currently being progressed with NHSE, the independence of this role was being considered in order to provide an additional layer of external assurance.

Non-executive Director, Hazel Brand noted the investment required to meet the British Association of Perinatal Medicine (BAPM) standards and enquired if this work was underway. The Chief Nurse confirmed that following discussions at the Trust Executive Group the development of a phased business plan would take place, to be progressed through the Trust's internal processes to the Capital Investment Group. The Chair of the Board noted the value of the investment over time, as a national priority the Chief Executive acknowledged adherence to such standards may impact upon other areas of investment, with the potential for funding to be ring fenced.

The Board approved the training action plan appended to the report.

The Board:

- ***Noted and took assurance from the Maternity & Neonatal Update and approved the training action plan***

P23/12/C1 Operational Performance Update (verbal)

The Chief Operating Officer confirmed junior doctors' industrial action would take place from 7am on 20 December to 7am on 23 December, with a further six days of action between 7am on 3 January to 7am on 9 January 2024. The final rotas had now been confirmed and provided safe cover for essential services. In terms of cancelled activity, outpatient cancellations were lower than seen previously due to annual leave during this period. 23 elective theatre lists had been cancelled, with all urgent and cancer cases protected.

In respect of emergency access, winter plans were now operational and despite attendances during November being largely static when compared to the previous year, an increase in attendance by ambulance had been seen, with 892 more ambulances arriving in November 2023 compared to November 2022; despite this an improved ambulance handover performance was noted. Place partners would work together to mitigate the impact of winter to reduce ambulance conveyances, maximising streaming opportunities at the front door and the facilitation of timely, safe discharge.

With one of the highest conveyance rates in the region, the Chief Executive recognised the impact on the workforce and in view of the demand commended the improved ambulance handover performance. There was a need to understand the conveyance rate and consider alternative access to community services. Senior Place partners would join the Chief Executive on a visit of Doncaster Royal Infirmary's Emergency Department to highlight the challenges faced and consider the required support. The Trust's bed base was currently 99% occupied, the recommended occupancy rate of <92% had not been achieved since 2020 and members of the public were encouraged to attend the most appropriate healthcare service across the community, with attendances at the Emergency Department for urgent and emergency care only. Attendance for minor injuries or illnesses may result in extended waits and care could be better met by alternative healthcare services. With an increase in winter illnesses the importance of adopting hands, face and space preventative measures was emphasised.

In response to a question from Non-executive Director, Lucy Nickson, the Chief Operating Officer confirmed the Trust currently had approximately 40 patients on Virtual Wards, whilst numbers were now consistently above 30 there remained scope to increase occupancy further and opportunities were being promoted by the Executive Medical Director's office.

Non-executive Director, Mark Bailey noted the Trust's bed occupancy rate and enquired how this compared to neighbouring acute providers, the Chief Operating Officer confirmed high levels of bed occupancy across the system, with the Trust at the higher end.

In view of the high levels of conveyance, Non-executive Director, Kath Smart enquired how patient safety was maintained, the Chief Operating Officer confirmed through the support of early senior assessment, or where a timely handover was not possible Trust colleagues

would assess patients on the ambulance. The current escalation process was also in the process of being reviewed.

Non-executive Director, Emyr Jones highlighted the opportunity to receive care at the Urgent Treatment Centre at Montagu Hospital, recently featured in a Health Service Journal publication. In addition, a same day health service was available at Cavendish Court in Doncaster.

Ahead of the Christmas break, Non-executive Director, Hazel Brand enquired of planned communication across Place, the Director of Communication & Engagement confirmed the Trust continued to work closely with Place partners. The Chief Executive noted a reduced level of interest in the vaccination programme, other than those with underlying health conditions and encouraged colleagues and members of the public to continue to take advantage of preventative measures.

The Board:

- ***Noted and took assurance from Operational Performance Update***

P23/12/C2 **Finance Update (Enclosure C2)**

The Deputy Director of Finance reported a month eight surplus of £1.2m, £1.7m favourable to plan; the year to date deficit was £23.6m, £0.4m favourable to plan. For clarity, the Deputy Director of Finance confirmed the plan referenced was the original plan for 2023/24 and not the stretch target.

Capital spend in month eight was £7m, £2.7m favourable to plan. The year to date position was £22.6m, £6.6m adverse to plan. The main underspend was against the Community Diagnostic Centre and Bassetlaw Emergency Village, the Trust was expected to deliver its year end capital plan.

The cash balance at the end of November was £20.9m, an increase in month of £5.5m. This was as a result of the Trust receiving £7.2m in cash via Public Dividend Capital (PDC), partially offset by cash spent on capital expenditure of £3.7m. The Trust had submitted a cash drawdown request of £5.6m for Quarter 4, in line with the Trust's deficit position.

The Trust had delivered £1.7m of savings in month, £0.9m adverse to plan.

The Chief Executive acknowledged the challenging national financial position, with all 42 ICBs reporting a deficit position. At a system level, South Yorkshire ICB had declared a deficit of £109m, the Trust had already taken a series of difficult decisions on the assumption there would be no further industrial action and the ability to earn elective recovery funding; as a result the imminent junior doctors' industrial action and the resultant impact on activity was of significant concern.

In response to a question from Non-executive Director, Emyr Jones, the Deputy Director of Finance confirmed the cash draw down attracted a 3.5% charge and resulted in subsequent monitoring by the national team. The Trust had sought external assurance of its assessment of the drivers of the deficit position, alongside a review by the national finance team. Going forwards the Chief Executive anticipated all organisations would be subject to external scrutiny and the importance of collaborative partnership working

would be key to transform service delivery in line with workforce and financial limitations.

The Board:

- ***Noted the Finance Update***

P23/12/D1 **Chair's Assurance Log – Charitable Funds Committee (Enclosure D1)**

Non-executive Director, Hazel Brand provided an overview of the four quadrants of the Chair's assurance log, positive assurance, areas of major works, areas of focus and decisions made.

The Committee had confirmed its support to progress business cases for a rehabilitation robot at Montagu Hospital and a surgical robot which would be located at Doncaster Royal Infirmary, to be funded by the Fred and Ann Green legacy. Both cases had received support from the Trustees of the fund.

An external review of the work of the Trust's Charity and its strategic direction was conducted by the More Partnership in November 2022 and a proposal from Doncaster & Bassetlaw Healthcare Services Ltd. to progress the recommendations of the review had been considered by the Committee. A Task and Finish group, to be chaired by the Deputy Chief Executive, would consider next steps, including transitional arrangements.

Non-executive Director, Mark Bailey welcomed the innovative proposals for use of the Fred and Ann Green legacy to support service transformation.

The Board:

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

P23/12/D2 **Use of Trust Seal (Enclosure D2)**

The report confirmed the use of the Trust Seal on four occasions between 21 November and 13 December. All contracts and deeds had been subject to scrutiny by the Head of Contracts and the Chief Financial Officer.

The Board:

- ***Noted the use of the Trust Seal***

P23/12/E1 **Any other business (to be agreed with the Chair prior to the meeting)**

The Chief Executive reflected on the Trust's achievements during 2023, which included:

- the first Trust to have removed reinforced autoclaved aerated concrete from its estate
- the development of Bassetlaw Emergency Village, a future-proof facility which through improved co-locations supports increased productivity, efficiency, and patient experience with the facility for overnight paediatric observations

- the opening of Mexborough Elective Orthopaedic Centre as a Centre of Excellence, an example of partnership working with Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust, capable of fulfilling 2,200 procedures per year and supporting recovery of the waiting list
- the opening of the endoscopy suite within the Community Development Centre at Montagu Hospital
- development of business cases to support innovative ways of working, including the use of robotics, supported by the Fred & Ann Green legacy
- long service events, recognising colleagues loyal service to the NHS, from 10 to 50 years
- awarded Employer of the Year and Campaign of the Year at the Doncaster Business Awards

P23/12/E2 **Governor Questions regarding the business of the meeting (10 minutes) ***

On behalf of the Council of Governors, the Lead Governor asked the following questions:

Page 89 of the papers the Board is asked to note the Year-to-Date deficit of £23.6m, which is around 5% of our income. (Last year was £17m deficit). Such deficits are inconsistent with True North Strategic Objective No 4 of being in recurrent surplus. We would like to know if there is a plan in place to work towards a budget surplus and if this is so could we please have this plan shared for assurance.

The Deputy Director of Finance confirmed the Trust had commissioned an external review of its underlying deficit, the findings of which validated its analysis. Operational, strategic, and structural drivers were identified, which included the use of temporary staffing, the need for improved partnership working to support effective and efficient service delivery and the challenged estate. The Chief Executive confirmed the Trust's approach to delivery of its financial plan was communicated to the Finance & Performance Committee and the Board, which focused on the appropriate use of limited resources. Pre-covid the Trust had made significant progress in reducing its deficit position, however, it was important to consider the Trust's position against the national context, with the NHS having declared a £1.4bn deficit at month six. The system had declared a deficit plan of £109m, with unidentified savings, and whilst some challenges were local issues, others such as the impact of the BMA rate card on pay spend, had seen the costs of medical cover for industrial action and additional sessions increase by 50% as compared to the previous year. The importance of working collaboratively with partners would be critical to future service delivery.

Page 87 performance against the Better Payment Practice Code is reported as 79% - we are aware on benchmarking against 2 local NHS organisations of figures achieved in the high 90s%, which is positive for supporting local businesses.
Does the Trust have a plan to achieve the 90 + rate to work towards best practice? if so, how will this be achieved.

The Deputy Director of Finance confirmed the Trust continued to make payments in a timely manner, with no supplier concerns raised at the weekly review meeting.

We note that the Fred & Ann Green Trust fund is adding additionality to the trust, specifically within the Mexborough area. We also note that the fund is reaching the end of its life. This will leave a gap in charitable funding. We would like to understand what the strategy is moving forward in relation to fundraising and filling the void this fund may leave.

The Chair of the Charitable Funds Committee confirmed a proposal to progress the work of the Trust's Charity had been received at the December meeting, in line with the recommendations of the More Partnership. A task and finish group would meet in January 2024 to determine transitional arrangements. There had always been an intention to utilise the funds within the legacy, in accordance with Fred and Ann Green's wishes and the future funding of charitable funds' projects would be a focus on the development of a fundraising strategy to increase donations.

The Lead Governor shared with the Board feedback on the positive impact of the health wellbeing package on colleague recruitment and retention in maternity services.
Also, feedback from a member of the public who had been brought by ambulance to the Emergency Department at Doncaster Royal Infirmary and reported an efficient and effective experience.

On behalf of the Council of Governors, the Lead Governor wished the Board a Merry Christmas.

The Chair of the Board thanked governors for their continued support and engagement and shared season's greetings with all directors and governors and looked forward to working together in the year ahead.

The Board:

- ***Noted the governor question***

P23/12/E3 **Minutes of the meeting held on 28 November 2023 (Enclosure E3)**

- ***The Board approved the minutes of the meeting held on 28 November 2023***

P23/12/E4 **Date and time of next meeting (Verbal)**

Date: Tuesday 30 January 2024
Time: 09:30am
Venue: MS Teams

P23/12/F **Close of meeting (Verbal)**

The meeting closed at 11:01

2401 - I2 ANY OTHER BUSINESS (TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING)

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:55

2401 - I3 GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:55

10 minutes

2401 - I4 DATE AND TIME OF NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 13:05

Date: 27 February 2024
Time: 9:30
MS Teams

2401 - J MEETING CLOSE

13:05