Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING

BOARD MEETING

3 September 2024

09:30 GMT+1 Europe/London

Virtual - MS Teams

Join the meeting now

AGENDA

2409 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 3 September 2024 v5.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 3 September 2024 at 09:30
Via MS Teams

		Purpose	Page	Time
A	**OPENING ITEMS**			**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 *Suzy Brain England OBE, Chair of the Board*	*Review*		
A3	Chair's Report *Suzy Brain England OBE, Chair of the Board*	*Information*		10
A4	Chief Executive's Report *Richard Parker OBE, Chief Executive*	*Information*		10
B	**BOARD LEARNING & REFLECTION**			**10:00**
B1	Wendy's Story *Karen Jessop, Chief Nurse* *Julie Wragg, Person Centred Care Practitioner*	*Assurance*		20
C	**STRATEGY, PLANNING & PARTNERSHIPS**			**10:20**
C1	Winter Plan Briefing 2024/25 *Denise Smith, Chief Operating Officer*	*Note*		10
C2	Strategic Priorities – Delivery Update *Rebecca Allen, Associate Director Strategy, Partnerships & Governance*	*Assurance*		5
D	**ASSURANCE & GOVERNANCE**			**10:35**
D1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
D2	Financial Position & Financial Plan Update *Jon Sargeant, Chief Financial Officer*	*Note*		10
D3	Healthcare Support Worker Band 2 / 3 Project *Zoe Lintin, Chief People Officer*	*Note*		5

BREAK 11:10 – 11:20				
D4	Research & Innovation Bi-annual Report *Zoe Lintin, Chief People Officer* *Professor Sam Debbage, Director Education & Research* *Dr Jane Fearnside, Head of Research*	*Assurance*		10
D5	Patient Experience Annual Report *Karen Jessop, Chief Nurse* *Simon Brown, Deputy Chief Nurse*	*Assurance*		5
D6	Board Assurance Framework & Trust Risk Register *Rebecca Allen, Associate Director Strategy, Partnerships & Governance* *Executive Directors*	*Assurance*		20
D7	Chair's Assurance Log – Quality & Effectiveness Committee *Emyr Jones, Non-executive Director*	*Assurance*		5
D8	Chair's Assurance Log – Charitable Funds Committee *Hazel Brand, Non-executive Director*	*Assurance*		5
D9	Trust Governance Re-evaluation & Recommendations *Rebecca Allen, Associate Director Strategy, Partnerships & Governance*	*Approve*		10
E	**STATUTORY & REGULATORY**			**12:15**
E1	Maternity & Neonatal Update - Maternity & Neonatal Independent Senior Advocate Project & Outcomes *Karen Jessop, Chief Nurse* *Danielle Bhanvra, Head of Midwifery* *Abbey Harris, Maternity & Neonatal Independent Senior Advocate*	*Assurance*		20
E2	The NHS Premises Assurance Model *Jon Sargeant, Chief Financial Officer*	*Approve*		10
E3	Safeguarding Annual Report *Karen Jessop, Chief Nurse* *Denise Phillip, Head of Safeguarding*	*Assurance*		5
E4	Infection Prevention & Control Annual Report *Karen Jessop, Chief Nurse* *Dr Ken Agwuh, Director of Infection, Prevention & Control*	*Assurance*		5
F	**INFORMATION**			**12:55**
F1	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-
F2	Appointment of Internal & External Auditors *Jon Sargeant, Chief Financial Officer*	*Information*		-

G	CLOSING ITEMS			12:55
G1	Minutes of the meeting held on 2 July 2024 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
G2	Pre-submitted Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
G3	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
G4	**Date and time of next meeting:** **Date:** Tuesday 5 November 2024 **Time:** 9:30 **Venue:** MS Teams	*Information*		
G5	**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*		
H	**MEETING CLOSE**			**13:20**

***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 pre-submitted questions to be tabled by the Chair at an appointed time. Governors should submit their questions to the Trust Board Office in writing to dbth.trustboardoffice@nhs.net by 3pm on the day prior to the meeting.

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

- Questions at the meeting must relate to papers being presented on the day.
- If questions are not answered at the meeting the Trust Board Office will coordinate a response to all Governors, via the Governor database.
- 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

2409 - 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 (28.8.2024).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

Non-executive Director - InCommunities Limited (Housing Provider)
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
Charity Trustee – Ashgate Hospice
Executive Coach – NHS Leadership Academy (voluntary)
Non-Executive Director for MEDQP Ltd (Voluntary)

Jo Gander, Non-Executive Director

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, a registered 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 Audit & Governance Committees
Parish Councillor, Misterton

(as at 28 August 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 Sheffield 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

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 28 August 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 28 August 2024)

2409 - A2 ACTIONS FROM PREVIOUS MEETING

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

10 minutes

REFERENCES

Only PDFs are attached

A2 -BoD Action Log - 2 July 2024.pdf

Action notes prepared by: Angela O'Mara
Updated: 2 July 2024

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	7 May 2024

KEY
Completed
On Track
In progress, some issues
Issues causing progress to stall/stop

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P24/05/B1**	**Health & Wellbeing Offer** – to better understand the impact of the health and wellbeing offer from a governance perspective	**ZJ/ZL/LN**	**July 2024**	Meeting took place 6 June, verbal update to be provided @ the meeting of 2 July 2024. **Update 2/7/2024** – impact of H&WB offer to be considered going forwards, including how assurance can be brought back to the Board. Content with progress - **action to be closed**.
2.	**P24/05/C2**	**Strategic Priorities** – to determine how success would be measured	**ZJ**	**July 2024**	Included on the agenda at B1. **Action to be closed.**
3.	**P24/05/D1**	**Integrated Quality & Performance Report** – to further develop the use of data to ensure effective reporting with supportive narrative	**EDs**	**September 2024**	Included on the agenda @ D1

Action notes prepared by: Angela O'Mara
Updated: 2 July 2024

No.	Minute No.	Action	Responsibility	Target Date	Update
4.	**P24/05/D1**	**L2P Medical Appraisal system** – to provide post implementation feedback to the Board of Directors	**NM**	**November 2024**	
5.	**P24/05/D6**	**Refresh of Board Assurance Framework** To refresh the Board Assurance Framework following the review of the risk appetite statement, strategic risks and priorities. To progress through the oversight committees in preparation for September's Board of Directors meeting	**EDs**	**3 September 2024**	Updated BAF included on the agenda @ D6
6.	**P24/05/D6**	**Board Assurance Framework 3 (Operational Performance)** As part of the BAF refresh consider the feedback from the Chair of the Audit & Risk Committee. Updated copy to be taken to the Finance & Performance Committee before presentation at September's Board of Directors meeting	**DS**	**Mid July 2024**	Updated BAF included on the agenda @ D6
7.	**P24/07/B1**	**Progress Report - Strategic Priority Success Measures** To provide a report summarising delivery against the success measures.	**ZJ**	**September 2024**	Included on the agenda @ C2
8.	**P24/07/D3**	**Immediate Safety Concerns Exception Reports** To incorporate an update on the immediate safety concerns reported in July in the next Guardian of Safe Working Report to Board.	**MK**	**November 2024**	

2409 - A3 CHAIR'S REPORT

Information Item | Suzy Brain England OBE, Chair of the Board | 09:40

10 minutes

REFERENCES

Only PDFs are attached

A3 - Chair's Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**A3**
Report Title:	**Chair's Report**		
Sponsor:	Suzy Brain England OBE - Chair of the Board		
Author:	Adam Tingle, Deputy Director of Communications and Engagement		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

The report provides an insight into the Chair's activities since the last Board report in July 2024, including visits, duties and areas of interest as Chair of the Board and Council of Governors.

Recommendation:	The Board is asked to note the report.			
Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	**Information only**

Healthier together – delivering exceptional care for all

	PATIENTS	PEOPLE	PARTNERSHIP	POUNDS
Relationship to strategic priorities:	*We deliver safe, exceptional, person-centred care.*	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	NA		**NA**	

Implications

Relationship to Board assurance framework:		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
		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
		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
		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
		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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:			
Resources:	N/A		
Assurance Route			
Previously considered by:			N/A
Date:			
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

Chair's Board Paper

September 2024

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Providers Governor Conference

The annual governor focus conference took place on 9 July 2024, hosted on this occasion via Zoom to support ease of access to NHS governors across the country. This dedicated governor event is always a popular feature in NHS Providers programme of activities and this year was no exception, with over 300 delegates and 11 speakers in attendance. NHS Providers' Chair, Sir Ron Kerr welcomed the delegates before handing over to Sir Julian Hartley, Chief Executive to provide an overview of those key issues currently facing providers with a focus on areas of greatest concern to governors. Governors were able to hear first-hand experiences from a range of colleagues, which included how to grow member participation and how best to hold non-executive directors to account for performance of the board, whilst providing support, in what is a challenging time for the NHS. As in previous years the conference welcomed individual organisations to showcase examples of good practice and delegates were able to engage in topical discussions in facilitated breakout groups, which myself and Rebecca Allen, Associate Director of Strategy, Partnerships & Governance supported.

Governor Elections

The Trust's latest round of governor elections is now underway. Voting opened on 27 August following a window of opportunity in which a total of 15 nominations were received from residents in our local communities of Doncaster and Bassetlaw. 10 nominations related to the constituency of Doncaster, the remaining five for Bassetlaw, with three seats to fill in each constituency. Voting will close at 5pm on 19 September, with results announced the next day. I would encourage all members to cast their vote and look forward to welcoming those newly elected governors to the Trust's Council of Governors.

Colleague Engagement

Since my last board report I have had the pleasure of meeting with colleagues who have recently joined the Trust, including Jonah Aburrow-Jones who takes up the role of the Programme Director for the Electronic Patient Record, leading a significant programme of work to enhance the Trust's digital maturity. Also, Duncan Batty, who joins as Head of the Doncaster & Bassetlaw Teaching Hospitals Charity. Duncan brings with him a wealth of charity experience which will enable him to build on the existing successes and develop the charity's capacity.

Partner Engagement

I continue to work closely and collaboratively with partner organisations and during the course of the last two months have been involved in in discussions with the South Yorkshire Integrated Care Board's Chair and Chief Executive on trust and Acute Federation matters. I take up the responsibility of chairing the Acute Federation Board meeting in September which is rotated across the Chairs of the provider organisations; as part of this role, I have met with the lead Chief Executive for the Acute Federation, Ruth Brown and fellow Chairs to identify improved ways of working.

Members Engagement

Later this month the Trust will host its Annual Members Meeting, over recent years we have taken the decision to pre-record this event, as this has resulted in a much wider level of engagement. The link to the recording will be made available at 6pm on 26 September via the Trust's website and will be shared on social media. Members, colleagues, and the general public will be able to hear about the Trust's operational and financial performance during the 2023/24 financial year, including local, regional and national health and social care developments. I will be joined by the Chief Executive, Chief Financial Officer and wider team members; please do submit any questions you may have to the Trust Board Office at dbth.trustboardoffice@nhs.net

Non-executive Director(NED) Champion Roles & Activity

As non-executive board safety champion for Maternity and Neonatal services, Emyr Jones has visited the Central Delivery Suite at Doncaster Royal Infirmary and the Labour Ward at Bassetlaw Hospital. He has attended meetings at both hospital sites with the senior leadership team for maternity and neonatal services, the quadrumvirate and on 16-17th July, attended a two-day course organised by 'Baby Lifeline Training' on 'Governance, Assurance and Improving Quality and Safety in Your Maternity Services'

In her role as NED Champion of Freedom to Speak Up, Hazel Brand attended the first part of the regular DBTH Speaking Up Forum in July, where the data from quarter 1 was discussed. There were 19 cases brought to the Speaking Up Guardian, involving 39 individual members of staff. Nurses and midwives were the staff raising most concerns and the most common element was worker safety or wellbeing. Full details will be given in the Speaking Up Guardian's next report to the Board. In August, Hazel had her regular meeting with Paula Hill, Speaking Up Guardian, and Zoe Lintin, Chief People Officer, where this data was further explored. Staff have had an invitation to comment on the Speaking Up process, anonymously if preferred, and Paula has held three open events for staff to comment on the process. A theme emerging from these events was the concern around 'detriment' – staff might be penalised for speaking up. This was a theme that had been picked up by the National Guardian for Speaking Up, Dr Jayne Chidgey-Clark, at an NHS Providers NED workshop that Hazel attended in July. The National Guardian emphasised the need for the Board to set an open and 'patient safety first' culture where NEDs key role is to bring an independent perspective, to seek to ensure that risk is subject to appropriate challenge, and that the Board seeks robust assurance that what they think they know is supported by evidence. In 2023/24, there were 32,167 concerns raised nationally with Speaking Up Guardians across the country, almost a 28% increase on the year before. More and more people are coming to their Freedom to Speak Up Guardians, which is a credit to their efforts to foster trust and break down barriers to speaking up within their organisations.

2409 - A4 CHIEF EXECUTIVE'S REPORT

Information Item | Richard Parker OBE, Chief Executive | 09:50

10 minutes

REFERENCES

Only PDFs are attached

A4 - Chief Executive's Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**A4**
Report Title:	**Chief Executive's Report**		
Sponsor:	Richard Parker OBE, Chief Executive		
Author:	Emma Shaheen, Director of Communications & Engagement		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

The report provides an overview of areas of interest and focus at a local, system and national level connected to the work of the Trust and aligned to its four strategic priorities.

Recommendation:	The Board is asked to note the report.			
Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	**Information only**

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	NA		**NA**	

Implications

Relationship to Board assurance framework:	**x**	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
	x	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
		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
		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
	x	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

	x	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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:	N/A		
Resources:	N/A		
Assurance Route			
Previously considered by:		N/A	
Date:			
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Chief Executive Board Paper

September 2024

This report present updates categorised under our four strategic priorities.

- Patients - We deliver safe, exceptional, person-centred care
- People - We are supportive, positive and welcoming
- Partnership - We work together to enhance our services with clear goals for our communities
- Pounds - We are efficient and spend public money wisely

Patients - *We deliver safe, exceptional, person-centred care*

Inpatient Survey results

At the end of August, the CQC published the Inpatient Survey 2023 results. Doncaster and Bassetlaw Teaching Hospitals (DBTH) received significant improvements in patient satisfaction compared to previous results and our Overall Patient Experience Score was 8.2, placing us above the national average of 8.1.

These enhancements are particularly evident in areas related to food quality and assistance with meals, underscoring the Trust's commitment to enhancing the overall patient experience during their care.

In 2023, DBTH transitioned to a new food supplier, reinstating a full menu with a variety of options to suit patient preferences and dietary needs. As a result, 71% of patients rated the food as very good or fairly good, marking a notable 9% increase in positive responses from last year.

To further enhance the dining experience, DBTH introduced pictorial menus, providing patients with a visual guide to meals, beverages, and snacks. This initiative has been especially beneficial for patients with dietary restrictions and those needing additional assistance in making meal choices.

The Adult Inpatient Survey, conducted annually, is a vital measure of patient satisfaction. All eligible organisations in England are required to participate, with the 2023 questionnaire developed by the Care Quality Commission (CQC) and their Survey Coordination Centre.

The Trust has already held an action planning workshop and begun drafting an action plan to address where further improvements can be made.

The Chief Nurse will update on the annual patient experience report to Board.

Active Together welcomes first patient in Doncaster and Bassetlaw

A new programme to help people with cancer prepare for and recover from treatment welcomes its first patient in Doncaster and Bassetlaw area.

The pioneering exercise, nutrition and wellbeing service has helped more than 1,000 people in Sheffield prepare for and recover from cancer treatment has now expanded to Doncaster and Bassetlaw.

The cancer support service, known as Active Together, has been designed by experts at Sheffield Hallam University's Advanced Wellbeing Research Centre (AWRC) with funding from Yorkshire Cancer Research. It is already well-established in Sheffield and has been supporting people in the city since early 2022.

Active Together offers free, personalised fitness, nutrition, and wellbeing support to help people with cancer prepare for, respond to, and recover after treatment. It aims to increase cancer treatment options, reduce side-effects, speed up recovery and improve long-term health outcomes.

Patient feedback for MEOC

The Mexborough Elective Orthopaedic Centre of Excellence (MEOC) received an impressive overall score of 4.9 out of 5 for its Friends and Family Test feedback in May and June this year.

One patient rated their experience a full 5 stars, commenting: "Everything from start to finish was just perfect, I felt really looked after by everyone involved in my surgery and at ease the whole day, such lovely staff, nothing was too much trouble, admission through to leaving was 5 star."

Patients requiring orthopaedic surgery are encouraged to discuss referrals to the MEOC with their consultants. However, individuals with complex cases or additional medical conditions may still need treatment in an acute hospital setting.

People - *We are supportive, positive and welcoming*

Supporting colleagues in times of civil unrest

As I reported in my last Board report (July) we have made the move to adopt the NHS developed, anti-racist framework to affirm ourselves as an anti-racist organisation.

In light of the events that unfolded across the country in early August, we encouraged all colleagues who may be feeling anxious to reach out to their line-managers and not to hesitate to escalate any issues that require immediate attention.

We reminded colleagues to remain vigilant and supportive, and of our steadfast commitment to a zero-tolerance policy towards discrimination and our strong stance as an anti-racist organisation. We also developed specific guidance for international recruits and also provided information for if individuals did find themselves nearby any protests.

Star awards shortlist announced

Congratulations to the outstanding colleagues who have been shortlisted for the Star awards by representing the DBTH Way values and behaviours, going above and beyond for our patients.

I look forward to celebrating with shortlisted teams and individuals at the event, which is supported by sponsorship and charitable funds, on 10 October at the Doncaster Dome.

New regional chief nurse announced

David Purdue has been appointed as the new Regional Chief Nurse for the North East and Yorkshire Region. David previously worked as an Executive Director at DBTH as both the Chief Operating Officer and Chief Nurse.

Partnerships - *We work together to enhance our services with clear goals for our communities*

Humber Acute Services – Programme Update

DBTH provided feedback in January as part of a consultation on the future of Humber acute services. The feedback report from the consultation which supported their decision making process was published in full at their Board meeting in July.

As a result of the consultation some of their original proposals changed. The feedback they received and their updated recommendations can be found here:
Humber Acute Services Public Consultation – Feedback and Recommendations (icb.nhs.uk)

DBTH and DN College Group formal partnership

DBTH and DN College Group (DNCG) have worked closely together for many years and are each a critical partner in widening access to careers in the Health and Care sector and inevitably leading to better health outcomes for our communities. Our shared desire to improve opportunities for all people of all backgrounds drives our ambition to continue to innovate and develop new and exciting ways of working together as a major employer and major education provider in the region.

We will now move to formalise our partnership formally launching and publicising a comprehensive and combined delivery plan (2024 to 2030 and in line with the Doncaster Education and Skills Strategy) with the overall vision of working together to change lives.

Acute Federation update

DBTH leadership team took part in a SYBAF leadership team event was held in June which covered the findings of the corporate and clinical sustainability reviews and surfaced key enablers: future devolved budgets, the potential vertical integration with community services, developing a service model for the future and opportunities for partnership collaboration.

The Acute Federation has been making progress on its seven priority programmes, including collaboration to strengthen patient services through the Urology Area Network and Acute Paediatrics Improvement Programme. This continues with particular focus on Benign Prostatic Hyperplasia pathways, improving access to paediatric elective Ear, Nose & Throat and Dental services and Virtual Ward for children.

One of the focuses for the next period will be to accelerate integration through the Imaging Network.

South Yorkshire ICB Chief Exec report (from meeting on July)

The South Yorkshire Chief Executive report highlights updates affecting NHS organisations including cyber security and industrial action.

The report also covers the positive regional news from the previous two months. Significant updates include progress on DBTH's Community Diagnostic Centre, South Yorkshire being one of seven pilot ICBs to identify operational changes and improvements needed to optimise the general practice operating model, and the award for £3.5m for the WorkWell scheme, building on the Working Win scheme supporting people with a disability, or physical or mental health issue to start, stay or succeed in work.

All the details can be found in the full report:
CEO_Board_Report_July_2024_3.0.docx (live.com)

Nottingham and Nottinghamshire ICB Chief Executive report (from meeting on 11 July)

Like the NHS South Yorkshire report the Nottingham and Nottinghamshire report highlights nationwide issues. The report also explains the ICB enforcement undertakings as part of NHS England's Investigation and Intervention.

The report also highlights that the Health and Care Awards 2024, aimed at celebrating best practice in line with the aims and principles of the Integrated Care Strategy, are now open for nominations. Categories include health inequalities, prevention, value for money and partnership awards.

All the details can be found in the full report:
notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/ICB-board-public-July-24.pdf

Pounds - *We are efficient and spend public money wisely*

Our financial position

NHS South Yorkshire was recently named one of nine integrated care systems under review by NHS England (NHSE) due to an unexpected financial deficit reported in May and June 2024.

In response, all local NHS organisations within the region are collaborating with NHSE and external consultants to address overspending.

The financial strain is driven by rising demand, staffing costs, and inflation, leading to underperformance in the first quarter of 2024/25.

If current trends continue, as a Trust we are also projected to exceed our planned deficit by £23.9 million, which by March 2025 would lead to a total deficit of £50.1 million compared to the planned and agreed deficit of £26.2 million.

Our financial pressures are being driven by a shortfall in income, overspending on pay costs, increased costs of clinical supplies, and under-delivery of the Cost Improvement Programme (CIP).

As a key partner in the South Yorkshire Integrated Care System, it's clear that we can't continue as we are; action is necessary, and we must work differently to address the deficit. However, as we do so, it's crucial that we keep in mind the three core pillars of safety, quality and finance, and that a focus on one doesn't overshadow the others, ensuring that these elements are balanced and work together effectively as we move forward.

To support our recovery, we will concentrate on the following key areas:

- Maximising theatre and outpatient throughput to achieve at least the same levels as in 2019. This will enable us to receive additional funding from the Elective Recovery Fund (ERF).
- Revitalising our CIP Plan to deliver at least £17.7 million of savings, as we have done in previous years.
- Aligning pay expenditure with previous years, which we can achieve by reducing temporary staffing costs and, in some areas, freezing vacancies.
- Reducing clinical supply costs by reviewing diagnostic usage and treatment protocols, as well as managing the cost of medicines.

Additionally, steps will need to be taken to further strengthen financial controls and this will include tightened processes for our Vacancy Control Panel, reassessing unfilled, advertised posts, and enforcing stricter controls on temporary staffing by providing appropriate executive oversight.

Non-essential spending will be cut, and we will strengthen our Drugs and Therapeutics Group to manage high-cost products better. Diagnostic ordering will be reviewed to remove replicated testing and ensure adherence to best practice, and we will enhance financial reporting, including Grip and Control, for Divisions and Directorates while providing additional training and support on the key issues.

We will also explore ways to increase income from non-patient sources.

This may seem like a daunting challenge, but Team DBTH has a very strong history of overcoming financial difficulties.

However, it's important to recognise that without strong financial management, we could face serious consequences. These might include running out of cash, being unable to borrow funds, and difficulties in paying suppliers—each of which would directly impact our ability to deliver care. Additionally, this could lead to external scrutiny and intervention, which would be broader, more challenging, and far more difficult for the organisation to manage.

We believe that by focusing on doing the right things around CIP delivery, cost control, and productivity improvements, we are confident that we can reduce our deficit and improve the Trust's financial position, ensuring continued support for health and care services both locally and across South Yorkshire and Nottinghamshire and all whilst maintaining control of our own destiny.

With NHS finances under unprecedented pressure nationwide, it's more important than ever that we make every penny count while remaining steadfast in our commitment to delivering the highest quality care for our patients.

Successfully navigating this challenging period requires a delicate balance between our financial responsibilities and our dedication to safety and quality. As we've emphasised earlier, and it's worth reiterating – these priorities must not only run in tandem but also complement each other to ensure that neither is compromised.

To ensure we meet this ambition, we have a Board of Directors with expertise in clinical (both nursing and medical), financial, and corporate areas. They will maintain oversight, ensuring our efforts are holistic and aligned with our core values.

The coming months will be tough, but as we've shown time and again, Team DBTH is fully capable of meeting the challenge, and will do so again, emerging stronger as a result.

To provide further transparency and keep everyone informed, we have created a dedicated Hive page that outlines our current financial position, the key drivers behind our deficit, and the steps we are taking to return to plan in the near future. You can find this information at: https://extranet.dbth.nhs.uk/financial-recovery/

REFERENCES

Only PDFs are attached

B1 - Wendy's Story.pdf

NHS 75

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The Experience of Wendy Sharps

Patient Living with Dementia

Julie Wragg
Person Centred Care Practitioner

We care

Background

- Wendy started with symptoms of Dementia at 35
- GP told her she was just stressed
- 5 years later she was finally diagnosed with early onset Dementia

Present Situation

- Wendy is now in her mid 50’s and lives with her husband.
- Husband is still working therefore Wendy has employed a PA to support her so that she can continue to live independently.
- Wendy is vice chair for the Doncaster Dementia Collaborative and plays an active part in improving services for people with Dementia in the Doncaster Community.
- Wendy has provided online talks to different trust partners such as ECHO and agreed to be interviewed to support our training on Dementia Care within DBTH.

Initial Situation (Spring 2022)

- A few years ago, Wendy was playing with her grandchildren in the paddling pool.
- Wendy ended up slipping on the kitchen floor and needed an ambulance.
- Initially the paramedics didn’t accept she had Dementia.
- Waited in the ambulance outside ED for several hours.

Wendy's Concerns

- Wendy raised lots of concerns about the care she received ranging from being moved without explanation, left in bed for 3 days without an assessment, told to 'just wet yourself' when she needed the toilet.
- Wendy also described how she was left pain without sufficient pain relief, ignored when she tried to explain she was missing some medications and told it was her Dementia that was causing her to be getting information wrong, when in fact she was right.

Wendy’s Concerns continued

- Meal choices were not offered to Wendy as they should be to all patients and even when Wendy was allowed to choose, the meal delivered was wrong.

Wendy's Complaint to PALS (30th August 2022)

- Training has been undertaken by the Complaints team and Divisions on: "Getting it write" which is intended to improve the quality of our complaint responses. There are four staff trained to be facilitators of complaints training and this continues be to rolled out across the trust.
- The complaints manager is conducting fortnightly complaints management reporting which is identifying if there are any complaints outstanding and these are escalated to the divisional nurse.
- We have reviewed the complaints policy and procedure to be aligned with the PHSO standards 2022 and presented at the Caring committee for for sign off.
- Learning from complaints is tracked through the patient experience and involvement group which has had recently amended terms of reference. This feeds up to the new caring committee chaired by the chief nurse.

Initial Response

Excellence in care day shares Wendy's story.

Focus is on:- Person Centred Care

Early mobility of patients, getting them up and out of bed
Preventing deconditioning
Hello my name is….. And John's campaign
#call me…..
Regular pain relief instead of PRN
Different types of pain relief and how to assess for pain with non verbal cues
Mealtimes matter and positioning of patients in bed to eat and drink
Patient continence and the need to support patients to hold on to this
Restorative practice and PNA sessions
Just culture, open and honest conversations

Making Changes - Learning

- Dementia Tour Bus Experience
- Some wards have purchased different coloured plates/cutlery
- Mobility champions on wards
- Speedier referral to physios
- Dementia interpreter training for staff
- QI project around the use of regular analgesia
- Relaunch of John's campaign
- Promotion of pain tool
- #call me campaign
- Carers charter
- NMAHP Quality Strategy – strategic theme for vulnerable patients.

Dementia Tour Bus

Dementia Interpreters

Making Changes Cont….

Added training on deconditioning to foundations of care
Most importantly, we have restructured the entire Person Centred Care Day and called it Excellence in Care Day with Wendy as the central story.
Every single staff member who have so far taken part in the day now know Wendy and her story!

Colleagues Feedback on Wendy

We should and could do better!

Brilliant to learn from patient own experience.

Gave great insight into how patient's feel.

Shocked to hear but learnt to change some things!

Amazing story and lady!

Really educational and informative.

Loved this, enjoyed listening to Wendy so much!

Enjoyed watching and listening to Wendy. Really opened my eyes!

Loved it! Loved Wendy!

Wendy's story helped me understand a lot more about younger people and Dementia.

Evidence based learning.

Touching to hear a patient's perspective and the importance of person centred care.

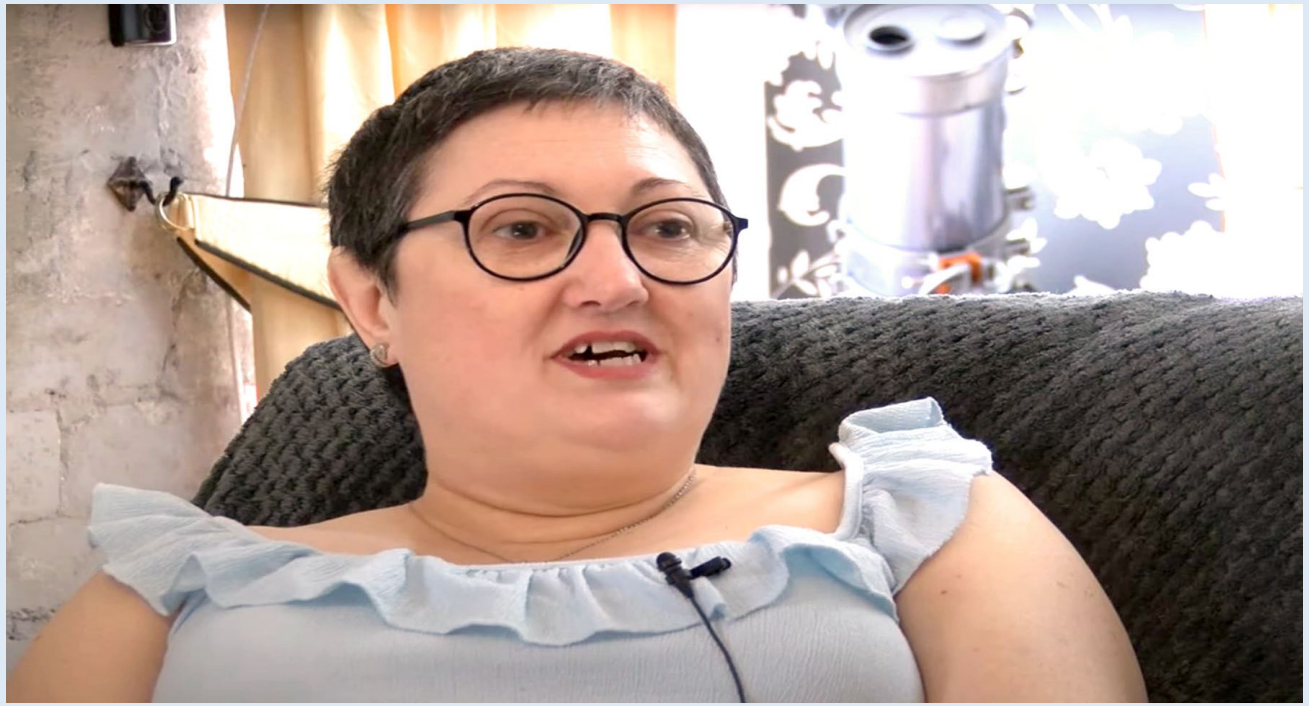
Fabulous!

Such an inspiring lady!

Wendy's Response…

- Didn't want to get anyone into trouble, just wanted someone to listen.
- Really happy that people are being educated.
- Great that the hospital is trying to make a difference.
- Wendy has done the tour bus experience and said it is exactly how it feels.
- Wendy thinks the changes we are trying to make are absolutely brilliant!
- She is going to share at her day group what we have been doing.

Wendy’s Advice to Health Professionals



Assurances

- Audit of the John's campaign principles
- Review of themes from complaints and learning at patient experience and involvement group
- Nursing, Midwifery and Allied Health Professionals Quality strategy KPI's into QEC
- National Dementia Audit
- Ward Accreditation process and patient partner involvement
- Patient Led Assessment of the Care Environment inspections
- You said we did
- Regular engagement programme with local community for feedback
- Friends and Family Test
- Continual evaluation of the excellence in care study day

Thank you, any questions?

2409 - B1 WENDY'S STORY

Discussion Item

Karen Jessop, Chief Nurse & Julie Wragg, Person Centred Care Practitioner

20 minutes

2409 - B STRATEGY, PLANNING & PARTNERSHIPS

2409 - C1 WINTER PLAN BRIEFING 2024/25

Information Item | Denise Smith, Chief Operating Officer | 10:20

10 minutes

REFERENCES

Only PDFs are attached

C1 - Winter Plan Briefing 2024-25.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**C1**
Report Title:	**Winter Plan Briefing 2024/25**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:	N/A		

Report Summary

Purpose of the report & Executive Summary

This paper sets out the forecast demand and approach to winter planning for 2024/25. The Trust approach will be focussed on delivering the high impact priority interventions from the NHS England UEC recovery plan:

- Maintaining the **capacity expansion** delivered through 2023/24
- **Increasing the productivity** of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
- Continuing to develop services that **shift activity from acute hospital settings** to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

Recommendation:	The Trust Board is asked to receive the paper for INFORMATION ONLY			
Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	**Information only**

Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications			
Relationship to Board assurance framework:		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
		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
	X	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
		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
	X	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
	X	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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:	Identify if the purpose of the report is linked to a legal requirement (e.g. Health and Social Care Act / HSE) or regulatory requirements (e.g. CQC). If so, indicate impact. *N/A*		
Resources:	The winter plan requires an increase in capacity to meet the peaks in winter demand.		
Assurance Route			
Previously considered by:	N/A		
Date:			
Any outcomes / next steps	The winter plan will be submitted to the following for approval: • Trust Leadership Team • Finance and Performance Committee • Trust Board of Directors		
Previously circulated reports to supplement this paper:	N/A		

1. Introduction

This paper sets out the forecast demand and Trust approach to winter planning for 2024/25.

2. Background

NHS England published the Urgent and Emergency Care Recovery Plan in January 2023, underpinned by an extensive programme of work to deliver improvements across urgent and emergency care ahead of winter. This plan, along with the NHS's primary care and elective recovery plans, and the broader strategic and operational plans and priorities for the NHS, provides a firm basis for preparing for the 2024/25 winter period.

The Urgent and Emergency Care Recovery Plan is a 2-year plan. The level of ambition for 2024/25 was set out in the NHS priorities and operational planning guidance:

- Improve A&E performance with 78% of patients being admitted, transferred or discharged within 4 hours by March 2025
- Improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25

This operational planning guidance asked systems to focus on 3 areas to deliver these ambitions:

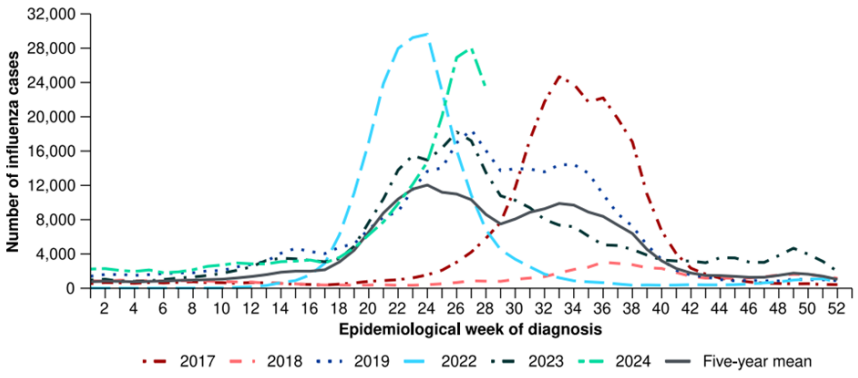
1. Maintaining the capacity expansion delivered through 2023/24
2. Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
3. Continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

NHS England winter planning guidance has not yet been published for 2024/25.

3. National Forecasting

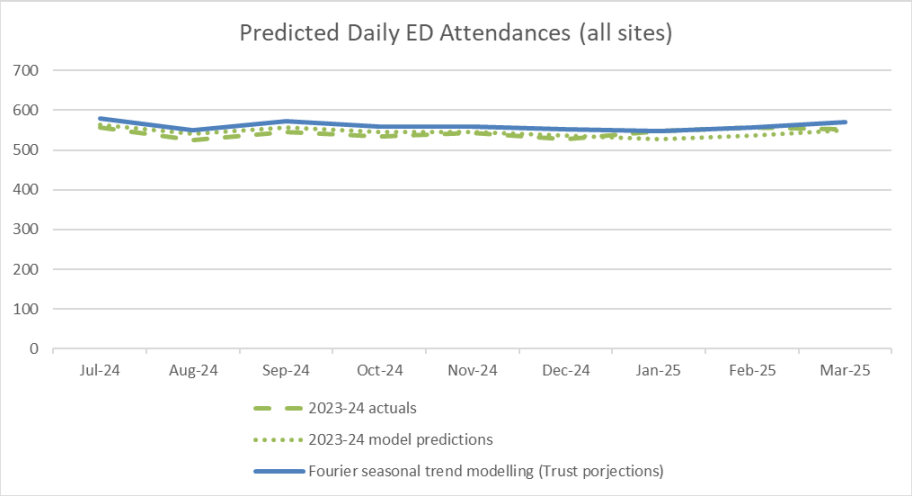
Influenza from the southern hemisphere has been higher than observed in 2023 and looks similar to 2022 patterns. The northern hemisphere usually follows southern hemisphere trends, indicating the Trust needs to plan for higher flu admissions / incidence than in 2023.

Figure 6: Influenza cases notified to the NNDSS and five-year mean* by year and week of diagnosis, Australia, 2017 to 14 July 2024



4. Emergency Department Forecast Demand

Overall, the Trust is forecasting a 2.6% increase in Emergency Department attendances between November 2024 and March 2025, compared to the same period last year. Whilst there is little seasonal variation in total Emergency Department attendances, the case mix does vary, with November seeing a peak in Paediatric attendances (often due to respiratory illnesses) 17% above the summer average, and December seeing a peak in attendances requiring resuscitation facilities, 3.2% above summer average.



Total Monthly ED Attendances	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Fourier seasonal trend modelling (Trust porjections)	17985	17075	17195	17327	16772	17135	16948	15597	17649
2023-24 model predictions	17457	16754	16716	16934	16363	16645	16355	15546	17027
2023-24 actuals	17254	16262	16351	16566	16292	16349	16970	16135	17132

Average Daily ED Attendances	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Fourier seasonal trend modelling (Trust porjections)	580	551	573	559	559	553	547	557	569
2023-24 model predictions	563	540	557	546	545	537	528	536	549
2023-24 actuals	557	525	545	534	543	527	547	556	553

5. Inpatient Forecast Demand

Overall the Trust is forecasting a c. 1.7% increase in demand for inpatient G&A beds between November 2024 and March 2025, compared to the same period last year. This is based on the growth rate in bed occupancy over the past 3 years.

At Doncaster, the current G&A funded bed capacity is 572 beds, projected average bed demand will peak in February 2025 at 560 beds. However, due to the range of day to day variation in bed demand, the Trust may see individual days with bed demand as high as 592. Overall, the Trust we can expect bed demand to exceed current funded capacity on 7 out of 28 days in February, as well as 5 days in January, and 4 days in March.

At Bassetlaw, the current G&A funded bed capacity is 138 beds, the peak in bed occupancy is forecast in December 2024, with a projected average occupancy demand of 135 beds. It is reasonably expected that there may be one day in December 2024 with a bed demand of 154 beds. Bassetlaw may see a shortfall in G&A beds over a more extended period than Doncaster, with demand projected to exceed capacity for at least seven days in each month from October 2024 – March 2025.

The majority of the winter demand is forecast for medical beds, in acute medicine and medical specialties.

The Trust is forecasting a peak in demand for paediatric beds in December 2024, with an average of 24 occupied beds. This is higher than the funded paediatric bed capacity of 20. However, this forecast peak in demand may include patients under the age of 18 who are in an adult bed and children who remain in the Trust at midnight but not in an inpatient bed, for example those requiring observation or same day emergency care.

6. Doncaster Place winter resilience principles

The Doncaster Place UEC Board agreed the following winter resilience principles for 2023/24, it is expected that these will remain in place for 2024/25:

(i) We will only use our resources where they are needed e.g. patients will not be transported to hospital if it is not clinically necessary
(ii) When patients / residents are ready to move onto the next phase of their pathway we will enable this as quickly as possible
(iii) The Doncaster UEC system is mutually dependent on each partner
(iv) We will deliver the lowest level of intervention that is appropriate
(v) Our approach is based on Trust between respective partners
(vi) Patients and staff are at the heart of our plans

7. Trust approach to managing winter demand

The Trust approach to managing winter 2024/25 will be focussed on delivering the high impact priority interventions from the NHS England UEC recovery plan:

7.1 Maintaining the **capacity expansion** delivered through 2023/24

Inpatient bed capacity will be maximised at all Trust sites to respond to the forecast demand each month from November 2024 to March 2025. Bed modelling has been undertaken and next steps are to agree the revised bed reconfiguration to align to demand, for core and escalation capacity. Essential to this will be to right size assessment capacity for all specialties so that patients can transfer from the Emergency Department to the relevant assessment area as soon as a referral to specialty has been made.

Further work is required with Doncaster and Bassetlaw Place to ensure sufficient bedded and non-bedded intermediate care capacity is in place to support timely hospital discharge and enable community step up care, thereby avoiding acute hospital admissions. The Trust will consider the development of a step down ward if sufficient community intermediate care capacity is not available, this would require discussion regarding the use of the Better Care Fund.

Virtual ward capacity is available to support step down from acute care, the Trust will need to maximise this through the winter period to reduce demand on acute beds. Work is in progress to develop step up virtual ward pathways, thereby avoiding acute hospital admission.

7.2 **Increasing the productivity** of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes

The Trust must reduce admitted and non-admitted time in the Emergency Department, the key drivers of this are:

- Maximise streaming to urgent treatment centres
- Reducing the time to initial assessment
- Reducing time to decision to admit
- Prompt admission to an assessment area once a decision to admit is made

The Trust must also reduce excess lengths of stay, particularly the number and proportion of patients with a length of stay > 14 days and > 21 days, the key driver of this is the embedding of the SAFER bundle of care across all inpatient wards.

7.3 Continuing to develop services that **shift activity from acute hospital settings** to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge

The Trust has a well-established same day emergency care service for Acute Medicine which is in place 12 hours a day, 7 days a week. The Trust must continue to develop same day emergency care services for Acute Surgery to provide alternative to inpatient admission.

As part of the bed modelling and reconfiguration exercise, the Trust will consider the capacity requirements for frailty assessment to ensure prompt admission from the Emergency Department and direct access for ambulance and primary care.

7. Summary

The forecast demand for winter 2024/25 at Trust and site level is understood and the approach to winter planning is aligned to the high impact priority interventions from the NHS England UEC recovery plan.

8. Recommendations

The Board is asked to note the forecast demand and approach to winter planning for 2024/25.

2409 - C2 STRATEGIC PRIORITIES - DELIVERY UPDATE

Discussion Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

10 minutes
cover sheet to follow

REFERENCES

Only PDFs are attached

C2 - Strategic Priorities Delivery Update V1.2.pdf

C2 - Appendix 1 Delivery Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**C2**
Report Title:	**Strategic Priorities – Delivery Update**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen, Associate Director of Strategy, Partnerships & Governance		
Appendices:	Appendix 1 – Delivery Update		

Report Summary

Purpose of the report & Executive Summary

The report provides a mid-year update on progress against the key success measures initially identified to support delivery of the Trust's strategic priorities, including planned next steps.

The Trust Strategy is currently out to wider consultation with all our people, public and partners to sense check these identified milestones and ensure that we are focussed on the priorities that will deliver our vision.

Board and Committee oversight and designated executive leads for each success measure were shared at July's Board meeting, together with routine reporting expected to provide the necessary evidence to demonstrate progress. As part of the wider governance review, these are now becoming embedded in the committee workplans, so that these measures are easily identified and monitored against their individual delivery plans.

The Board is asked to note the progress in the context of the current local and national financial restrictions faced by the NHS and the ongoing system work related to the procurement of an Electronic Patient Record.

A year-end update will be reported to the Board of Directors in March 2025.

Recommendation:	The Board is asked to note and take assurance from the report.			
Action Required:	~~Approval~~	**Review and discussion**	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	NA		**NA**	

Implications			
Relationship to Board assurance framework:	**x**	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
	x	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
	x	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
		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
	x	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
	x	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
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:	The Trust is required to review its strategy at regular intervals and manage this through its governance assurance framework.		
Resources:	N/A		

Assurance Route	
Previously considered by:	Board of Directors
Date:	2 July 2024
Any outcomes / next steps	Board Development Session on 3 December 2024 Year-end report to be received by the Board of Directors on 4 March 2025.
Previously circulated reports to supplement this paper:	Trust Vision Refresh & 2024/25 Priorities Framework - May 2024 Board of Directors Strategic Priorities – Measuring Success – July 2024 Board of Directors

September 2024 Delivery Update

Not started	R
Off track	A
On track	G
Complete	B

Success measures	Lead director progress update	Next steps and milestones	RAG
Creation of our Trust Strategy	• Engagement sessions held with the Board and Governors. • Surveys issued to partners and stakeholders with closing date of early September.	• September - October reviews of feedback and creation of framework for overall strategy. • November - December – more detailed work on content, utilising existing plans and alignment to wider partner strategies.	
Delivery of year 2 of the People enabling strategy	• Comprehensive review of year 1 of the People Strategy undertaken, presented to People Committee in June and communicated to colleagues June/July. • Achievements and open reflection on areas of challenge discussed at the Committee. Delivery plans on track at end of year 1. Committee reported full assurance. • Appraisal season 2024 – 93.52% achieved, highest at DBTH.	• Actions continue as outlined in delivery plans against the four pillars of the strategy: Looking after our people, Belonging in Team DBTH, Growing for the future, New ways of working and delivering care. Assurance report to be presented to People Committee in October. • New workstream on Anti-racism to be further progressed including involvement of EDI Committee/networks and working with system partners in Doncaster and South Yorkshire.	
Delivery of year 1 of Research & Innovation enabling strategy	• Review of year 0 of Research & Innovation Strategy presented to People Committee in June. Delivery plan on track. Key achievements include delivery of and above the Clinical Research Network contract, funding bids, partnership with Insigneo (University of Sheffield institute). Committee reported significant assurance.	• Q3/4 - Full business case to support Research & Innovation strategic priorities being drafted, aligned with University Teaching Hospital ambition. • September – Maternal, Child & Young People's Health conference arranged, the first specialist R&I conference under the new R&I strategy.	
Delivery of year 1 of Nursing Midwifery and Allied Health Professionals (NMAHPS) Quality enabling strategy	• Success measures redefined to demonstrate outputs. Each SRO is moving at pace with the objectives. All objectives on track. Update provided to QEC with full assurance.	• Continue with plan and collection of data for success measures.	

Success measures	Lead director progress update	Next steps and milestones	RAG
Delivery of Year 2 of the Three-year delivery plan for maternity and neonatal services	• Steady progress is being made on the Three-year plan, with oversight from the LMNS. There are no areas of concern at present.	• Continue with plan, oversight via the Maternity Safety and Quality Group chaired by the Chief Nurse, reporting via Director of Midwifery to Trust Board.	
Ensure clinically effective and efficient services through delivering strong performance against national standards and benchmarks	• Successful transition to L2P for Medical Appraisal and Job Planning. Above target performance for medical appraisals and continued improvement in job planning process ensuring job plans meet service needs, are manageable and less reliant on locum/agency cover. • Work continues on sepsis and mortality improvement, monitoring disease level mortality against benchmarks, strengthening structured judgement review process in line with national guidance, and measures to improve clinical coding and depth of coding. • National GIRFT programme focussing on specialty level performance to eliminate unnecessary variation, reduce 52 week waits through out-patient transformation, standardising HVLC pathways including day case. Locally, quarterly meetings with divisions and specialties are scheduled to review performance against priorities for 2024/25 benchmarked against Model Health data. Monthly monitoring commenced, divisions providing highlight reports at their performance meetings. • GIRFT Further Faster programme specialty meetings at national level, along with peer review sessions at regional system level. • Clinical Harm Review Policy currently going through Trust's governance and approval process, providing a standardised approach to assessing patients with excessive waits to identify whether physical or psychological harm has occurred as a consequence of their wait for treatment.	• Continued monthly monitoring of medical appraisal and job planning performance through the second half of the year. • September – Mortality data assurance group to be reconvened to review actions and agree further steps to be taken, in line with internal auditors recommendations. • September – findings and recommendations of the internal audit of mortality data quality assurance to be reported to Audit and Risk Committee. • September – specialty level GIRFT sessions to assess performance against national/regional benchmark position. Agree further actions as needed. GIRFT Orthopaedic adult trauma surgery deep dive scheduled for 12 September. • September – Clinical Harm Review Policy to be communicated to all divisional leadership teams and senior medical staff.	

Success measures	Lead director progress update	Next steps and milestones	RAG
Deliver our operational plan for 2024/25 to ensure our access and activity plans are achieved	The Trust is behind trajectory on the emergency care access standards. ED attendances remain above plan. Emergency care – redesign of the ED / UTC at DRI has commenced. Whole system discharge work in progress to streamline the discharge pathway. The Trust is on plan (YTD) for OP new activity and behind plan (YTD) for diagnostic, day case and elective activity. The Trust continues to deliver the Cancer FDS and 31 day diagnosis to treatment standards and is behind trajectory for the 62 day cancer standard.	Q3: reduce the number and proportion of patients spending > 12 hours in ED through improved escalation. Improve the non-admitted 4 hour performance through an improvement in waiting times for initial assessment. Q3: Deliver the elective recovery plan Q3: Deliver improvements in the 62 day cancer standard	
Demonstrating progress in becoming a digitally enabled organisation through delivery of our digital enabling strategy	The Trust is working on its EPR business case, however this is seriously behind programme having been delayed by the Acute Federation process for convergence. Following CEO/Chair discussions with the ICS support in moving this forward is now being given by NHSE to allow our Full Business Case to be completed. Significant work needs to be undertaken by the Acute Federation and partner trusts to ensure that there is proper infrastructure for a converged EPR in place to support the Trust moving forward on the proposed model.	• Production of the business case before December. • Agreement of system wide IT governance, timeline not clear at present, but needs to be in place before the contract is signed.	

Success measures	Lead director progress update	Next steps and milestones	RAG
Delivery of year 2 of the Health Inequalities enabling strategy	• We have presented introductory materials relating to health inequalities to a range of teams/divisions across DBTH including Equality Diversity & Inclusion Committee, Health and Wellbeing Committee, Project Management Team, Weekly Ops Meeting, Therapy Heads Meeting, Chief Nurse Exec Group, People & Organisation Development SLT, Medical Advisory Committee, Research & Innovation Team, Estates & Facilities Team. • We have developed a training pyramid ensuring all staff can access health inequalities training. • We have developed and are rolling out bespoke role-specific training on health inequalities. We have trained approx. 90 staff at DBTH so far in our "Change Initiators" training – this aims to provide an in depth understanding of health inequalities. We are also developing our "Health Inequalities Practitioner" training – this aims to provide tools and methods for practically tackling inequalities in our services.	• Toolkit to be updated to incorporate QI methods (December). • Session with Doncaster and Bassetlaw Place partners on 24th October 2024 to explore if the training we have developed is applicable to use across Place. • Similarly, we have two sessions planned with South Yorkshire partners (3rd October and 28th November) to explore the applicability of our training more widely across SY.	
Deliver our financial plan for 2024/25	The Trust is behind plan at the end of Month 4 with an adverse variance of £2.5m. The Trust Board reviewed a financial forecast on 14 August and agreed Executive team proposal for recovery actions to bring the finances back in line with plan. This plan is now being implemented and will be monitored through the Finance & Performance Committee.	• Implementation of recovery actions (September 2024) • Monitoring via Efficiency & Effectiveness and Finance & Performance Committees.	

2409 - D ASSURANCE & GOVERNANCE

2409 - D1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Executive Directors | 10:35

20 minutes

REFERENCES

Only PDFs are attached

D1 - Integrated Quality & Perfomance Report.pdf

D1 - IQPR.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**D1**
Report Title:	**Integrated Quality & Performance Report**		
Sponsor:	Jon Sargeant, Chief Financial Officer and Director of Recovery, Innovation and Transformation		
Author:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr Nick Mallaband, Acting Executive Medical Director Denise Smith, Chief Operating Officer		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

This report outlines the key performance and safety measures for July 2024. Work is in progress to further refine and triangulate the information the board receives against key metrics underpinned by the Integrated Quality and Performance report. The report contained below includes several further developments and work will continue over the coming months to finalise reporting on the remaining metrics and ensure integrated narrative of issues across the performance domains.

Within the July report 63 metrics has been included against agreed threshold levels. 18 of these are currently meeting the required level and 44 are not meeting the expected standard (1 no applicable target). 11 further metrics are being developed and national / local thresholds finalised to include in future reports.

Overall, the trust has ongoing challenges with high urgent and emergency care pressures leading to a drop in key access metrics in July driving cost pressures through opening escalation capacity / additional staffing and impacting quality metrics due to high occupancy rates.

In terms of elective recovery, the trust is not yet delivering planned activity levels leading to longer waits for patients and a significant risk on variable income from the elective recovery fund.

Recommendation:	The Board is asked to receive the report for assurance.			
Action Required:	~~Approval~~	**Review and discussion**	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***

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

Implications			
Relationship to Board assurance framework:	X	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
	X	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
	X	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
		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
	X	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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	N/A		
Legal/ Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements		
Resources:	N/A		

Assurance Route	
Previously considered by:	Contents shared with Finance & Performance Committee, QEC and People Committee
Date:	Various
Any outcomes/ next steps	
Previously circulated reports to supplement this paper:	

NHS 75

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Board Integrated Performance report

July 2024

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision is:

Healthier together – delivering exceptional care for all.

Our four strategic priorities are:

We care

Contents

Executive Summary

Overview	74 metrics have been identified based on their significance to be presented within the IQPR report to the Trust board. Of these 11 are being further developed or are pending national or local thresholds and will be included in future reports. Of the 63 included in this document 18 are currently being met and 44 are not meeting the expected standard (1 no applicable target), this is broken down as follows: Access – 27 metrics. 7 being met in month, 18 not meeting target (1 in development, 1 no applicable target) Quality – 29 metrics, 8 being met, 14 not meeting target, (7 in development) People – 8 metrics monitored monthly, 1 being met, 4 not meeting target (3 in development) Finance – 10 metrics, 2 being met, 8 not meeting target Overall the trust has ongoing challenges with high urgent and emergency care pressures leading to a drop in key access metrics in July driving cost pressures through opening escalation capacity / additional staffing and impacting quality metrics due to high occupancy rates. In terms of elective recovery the trust is not yet delivering planned activity levels leading to longer waits for patients and a significant risk on variable income from the elective recovery fund.
Access	Emergency care access remains below the national standard and the Trust continues to see an increase in demand compared to plan. Underperformance in diagnostic waiting times is driven by Audiology and Neurophysiology. The Trust is off trajectory for reducing long waits in elective care, this is driven by two specialities, ENT and T&O. The Trust continues to deliver the Faster Diagnosis Standard and the 31 day diagnosis to treatment standard. Performance against the 62 day standard is off trajectory for the month.
People	The Appraisal season was held 1 April – 31 July 2024, with a completion rate of 93.52% against a 90% target which is the highest achieved at DBTH. Robust planning, focused support and collective efforts have enabled this performance with work also ongoing to monitor the quality of appraisals. Sickness absence has increased to 6% against a target of 5% and actions/monitoring are in place at a local and Trust-wide level. SET stands at 88.93% against a target of 90%.
Quality	We await the national targets for our gram positive and negative infections, however our current numbers remain within trajectories from last year with on-going improvement work. The friends and family test response rate fell slightly during July, actions are in place to improve this going forward. There were four mixed accommodation breaches in July. The increase in HSMR is being further investigated and an external company has been engaged to review coding. VTE has improved with the change of system and will continue to be monitored.
Finance	The Trust's reported deficit in month 4 was £2.5m, which was £0.4m adverse to budget. YTD at month 4 was £16.0m, which was £2.5m adverse to budget. The main drivers of this position relate to underperformance on variable elective recovery fund income (£3.3m mainly relating to T&O), pay being overspent (£1.7m), which was partly offset with an underspend against Independent Sector usage (£1.2m) and one-off benefits (£1.0m).

Key Performance Indicators - Access

					Current month			Year to date		
Section	Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance
UEC	4 hour ED	78% by March 2025		Jul-24	75.64%	69.82%	-5.82%	77.13%	72.67%	-4.46%
UEC	12 hours in department	No more than 2%		Jul-24	2.00%	5.22%	-3.22%	2.00%	3.92%	-1.92%
UEC	Ambulance handovers - 15 minutes	65%		Jul-24	65.00%	32.24%	-32.76%	65.00%	37.74%	-27.26%
UEC	Ambulance handovers - 30 minutes	95%		Jul-24	95.00%	63.29%	-31.71%	95.00%	70.61%	-24.39%
UEC	Ambulance handovers - 60 minutes	0%		Jul-24	0.00%	15.94%	-15.94%	0.00%	10.65%	-10.65%
UEC	Average ambulance handover times - YAS	00:18:00		Jul-24	00:16:00	0:36:30	-20:30	00:15:30	00:29:56	-00:14:26
UEC	Number of arrivals	N/A		Jul-24	17877	17961	84	69656	69875	219
Diagnostics	Diagnostic waiting times	DM01 99%/ Operational guidance 95%		Jul-24	92.26%	77.73%	-14.53%			
Diagnostics	Diagnostic activity against plan *(where modality has a nationally submitted plan)*	N/A		Jul-24	19158	19526	368	74871	73637	-1234
Elective Care	% patients waiting less than 18 weeks from referral to treatment	92%		Jul-24	92.00%	60.10%	-31.90%			
Elective Care	78 weeks	0		Jul-24	0	6	-6			
Elective Care	65 weeks	0 by September 2024		Jul-24	15	207	-192			
Elective Care	Proportion of all outpatient attendances that are for first appointments or Fus attracting a procedure tariff	49%		Jul-24	49%	51.40%	2%	49%	51.20%	2%
Elective Care	No urgent operation to be cancelled for a second time	0	In development (data)							
Elective Care	Cancelled Operations Not Rebooked within 28 Days	0		Jul-24	0	3	-3	0	19	-19
Elective Care	Day Case Activity against Plan (Exlcuding MEOC, Including IS, Including CDC)	N/A		Jul-24	4717	4143	-574	17186	15539	-1647
Elective Care	Inpatient Elective Activity against Plan (Exlcuding MEOC, Including IS, Including CDC)	N/A		Jul-24	703	638	-65	2642	2468	-174
Elective Care	Outpatient New Activity against plan	N/A		Jul-24	15960	15367	-593	58898	58852	-46
Elective Care	Outpatient Follow Up Activity against plan	N/A		Jul-24	33762	30583	-3179	124126	115825	-8301
Cancer	Faster Diagnosis Standard	77% by March 2025		Jun-24	79.55%	84.30%	4.75%	78.51%	83.23%	4.72%
Cancer	31 day combined	96%		Jun-24	96%	96.90%	0.90%	96.00%	96.75%	0.75%
Cancer	62 day combined	70% by March 2025		Jun-24	73.71%	65.70%	-8.01%	72.44%	69.92%	-2.52%
Stroke	Proportion directly admitted to a stroke unit within 4 hours of clock start	75%		May-24	75%	39.22%	-35.78%	75.00%	51.04%	-23.96%
Stroke	Percentage treated by a stroke skilled Early Supported Discharge Team	>24%		May-24	24%	54.90%	30.90%	24.00%	58.33%	34.33%
Stroke	Percentage of eligible patients given thrombolysis	90%		May-24	90%	100.00%	10.00%	90.00%	100.00%	10.00%
Stroke	Proportion of patients scanned within 1 hour of clock start	48%		May-24	48%	49.02%	1.02%	48.00%	52.08%	4.08%
Stroke	Percentage discharged given a named person to contact after discharge	80%		May-24	80%	52.94%	-27.06%	80.00%	51.04%	-28.96%

Key Performance Indicators - Finance

Metric	Standard/threshold 24/25	Latest month reported	Current month Plan £'000	Current month Actual £'000	Current month Variance £'000		Year to date (YTD) Plan £'000	Year to date (YTD) Actual £'000	Year to date (YTD) Variance £'000	
YTD distance from financial plan I&E	£26.2m year-end deficit	Jul-24	2,132	2,531	399	A	13,421	15,962	2,541	A
ERF position		Jul-24	10,299	9,003	-1,296	A	38,055	34,734	-3,321	A
CIP delivery -vs Plan	£21.2m year-end CIP target	Jul-24	1,338	1,028	-310	A	3,096	3,064	-31	A
Substantive pay spend against plan		Jul-24	26,539	26,153	-386	F	107,817	105,325	-2,492	F
Additional sessions pay spend against plan		Jul-24	838	1,378	540	A	3,351	4,741	1,390	A
Bank pay spend against plan		Jul-24	400	1,436	1,035	A	1,605	5,639	4,034	A
Agency pay spend against plan		Jul-24	1,038	1,154	116	A	3,769	4,619	850	A
Capital position YTD versus plan	£38.5m year-end plan	Jul-24	974	2,099	1,125	A	5,125	5,424	299	A
Cash balance		Jul-24	13,369	14,096	727	F	13,369	14,096	727	F
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	Jul-24	95.0%	84.4%	-10.6%	A	95.0%	86.7%	-8.3%	A

Key Performance Indicators - People

				Current month			Year to date		
Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance
Employee Turnover	10%	In development (data)		10%		-10.00%			
Completed SET Training	90%		Jul-24	90%	88.35%	-1.65%			
Completed Appraisals	90% end July		Jul-24	90%	92.26%	2.26%			
Overall Sickness Absence	5%		Jul-24	5%	5.95%	-0.95%	5.00%	5.86%	-0.86%
Overall Vacancies		In development (data)							
Consultants with Signed Off Job Plans in EJP	90%		Jul-24	90%		-90.00%			
Time to hire (from TRAC authorisation - unconditional offer) A4C posts only	47 days		Jul-24	47	59	-12			
Medical Appraisals completed	90%		Jun-24	90%	38%	-52.00%			

Annual metrics

				Current month		
Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance
Flu vaccination for all colleagues		In development (data)	Mar-24	75%	41.10%	-33.90%

Section	Metric	DBTH score 2023
Staff survey	We are compassionate & inclusive	7.41
Staff survey	We each have a voice that counts	6.82
Staff survey	We are always learning	5.90
Staff survey	We are a team	6.81
Staff survey	Staff engagement	6.94

Key Performance Indicators - Quality

				Current month			Year to date		
Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance
Hospital Acquired MRSA (Colonisation) Cases Reported in Month	1.16		Jul-24	1.16	1	0.16	3.48	4	-0.52
Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0		Jul-24	0	0	0	0	0	0
Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month	3.5		Jul-24	3.5	5	-1.5	14	21	-7
Number of Community Onset Healthcare associated (COHA) C.Diff cases in month			Jul-24						
Overall numbers of HAPUs		In development (data)							
Inpatient Falls per 1000 bed days (currently showing actual Falls)	No standard		Jul-24		39			130	
Severe harm falls per 1000 bed days (currently showing actual Sever Harm Falls)	0		Jul-24	0	1	-1			
Claims CNST (patients) - new in month	No standard		Jul-24		13			37	
Claims LTPS - (staff) new in month	No standard		Jul-24		2			8	
Friends & Family Positive Response Rates - Trust	95%		Jul-24	95%	87.03%	-8.0%			
Friends & Family Postive Response Rates - ED	95%		Jul-24	95%	70.01%	-25.0%			
Friends & Family Positive Response Rates - Inpatient	95%		Jul-24	95%	93.62%	-1.4%			
Friends & Family Postive Response Rates - Outpatient	95%		Jul-24	95%	92.61%	-2.4%			
Friends & Family Positive Response Rates - Maternity	95%		Jul-24	95%	95.83%	0.8%			
Mixed Sex Accommodation - nationally reported breaches in month	0		Jul-24	0	4	-4	0	18	-18
Duty of Candour (failure to undertake in its entirety)	0	In development (data)							
Planned Vs Actual CHPPD RM	90%		Jul-24	90.00%	97.26%	7.26%	90.00%	98.46%	8.46%
Planned Vs Actual CHPPD RN	90%		Jul-24	90.00%	97.31%	7.31%	90.00%	96.25%	6.25%
Planned Vs Actual CHPPD Total	90%		Jul-24	90.00%	94.33%	4.33%	90.00%	99.35%	9.35%

Key Performance Indicators – Quality continued

				Current month			Year to date		
Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance
Hospital Services Mortality Rate (HSMR): (rolling 12 Months - Combined)	<100		May-24	100	110.04	-10.04			
Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months)	<100		May-24	100	106.52	-6.52			
Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months)	<100		May-24	100	110.13	-10.13			
NICE Guidance Response Rate Compliance	90%		Jul-24	90.00%	95.40%	5.40%			
NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%		Jul-24	10.00%	11.50%	-1.50%			
% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%		Jul-24	100%	100.0%	0.00%	100%	100.0%	0.00%
VTE - % of patients having a VTE Risk Assessment	95%		Jul-24	95%	90.08%	-4.92%	95%	95.93%	0.93%
Proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	90%		Jul-24	90%	45.52%	-44%	90%	45%	-45%
Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	90%		Jul-24	90%	62.96%	-27%	90%	44.27%	-46%
Number of incidents over 48 hours in the holding area	No standard		Jul-24		39				
PSIIs reported in month	No standard		Jul-24		2				

What is an SPC chart

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Recalculations

After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines

Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons

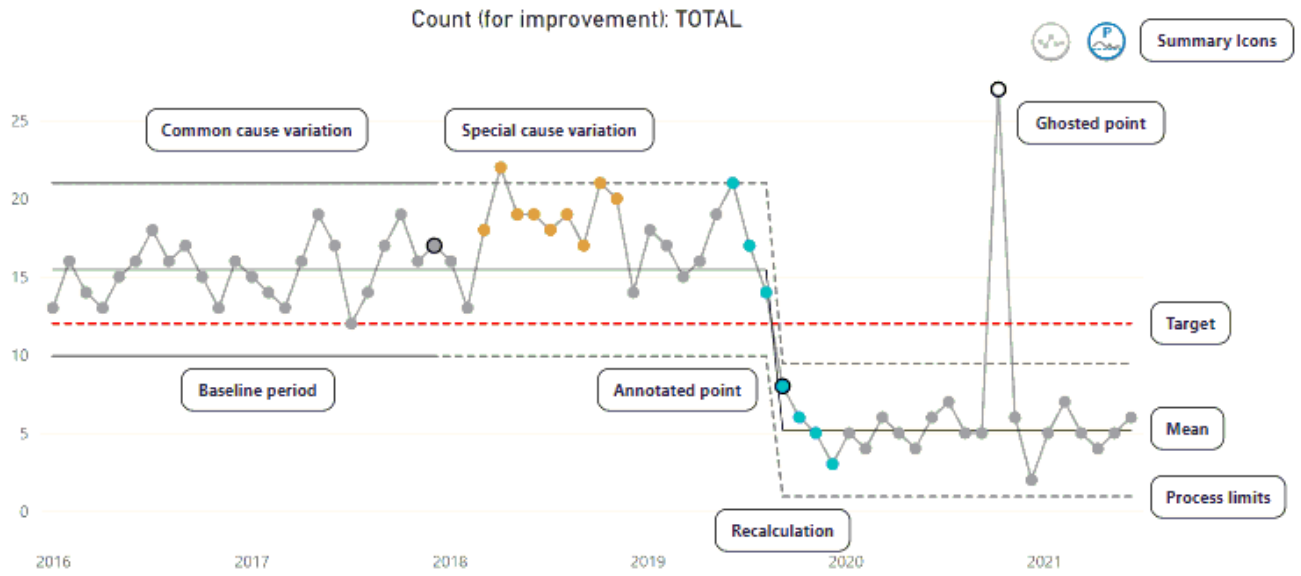
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

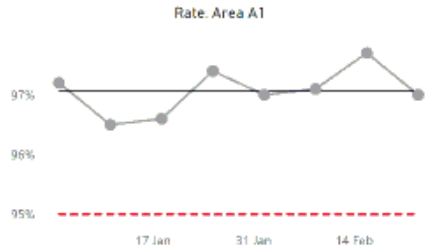
Annotations

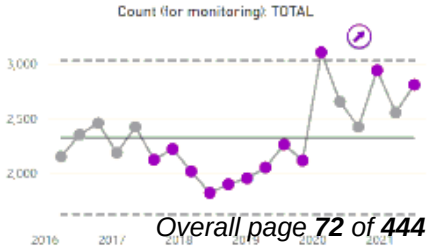
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.

Purple dots
It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.





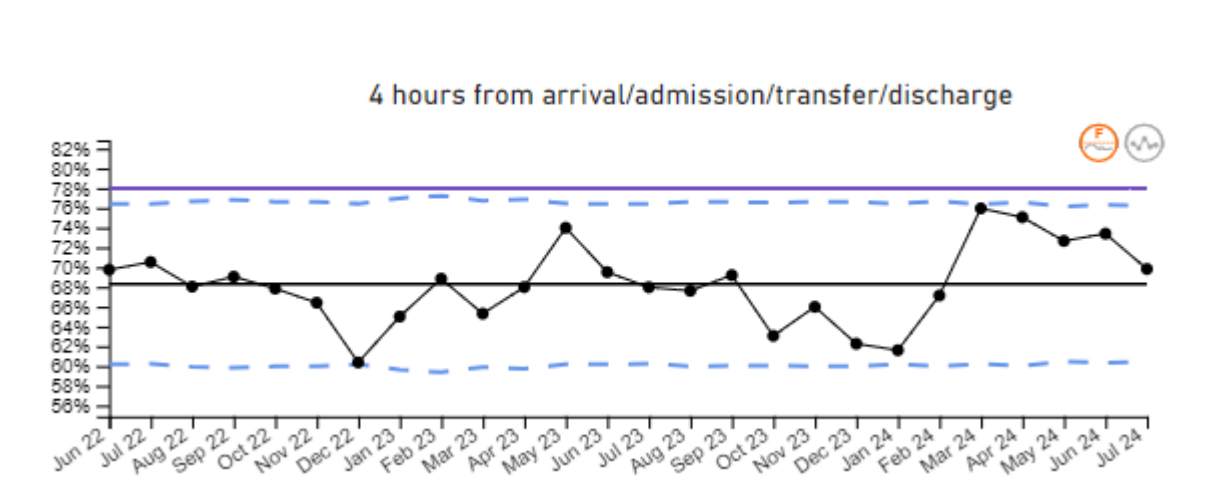
Icon descriptions

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(blank)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(blank)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

Assurance report

4 hour performance

Summary of challenges & risks	Performance in July 2024 was 69.8%, against the trajectory of 75.6%. ED attendances for the month were 17,961 which is above the plan of 17,877. The Trust ranked 103 out of 142 acute providers and is in the 3rd quartile nationally**.** The key drivers of underperformance are the wait time to see doctor, streaming < 20% to the UTC at DRI and delays in transfer to an inpatient bed.
Actions to address risks, issues and emerging concerns relating to performance and forecast	A review of the streaming criteria has been undertaken and this is being embedded with all streaming nurses to ensure streaming of all appropriate patients. A review of the front door model, led by Doncaster Place, has commenced.
Action timescales and assurance group or committee	A UEC improvement plan is in place for 2024/25 Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

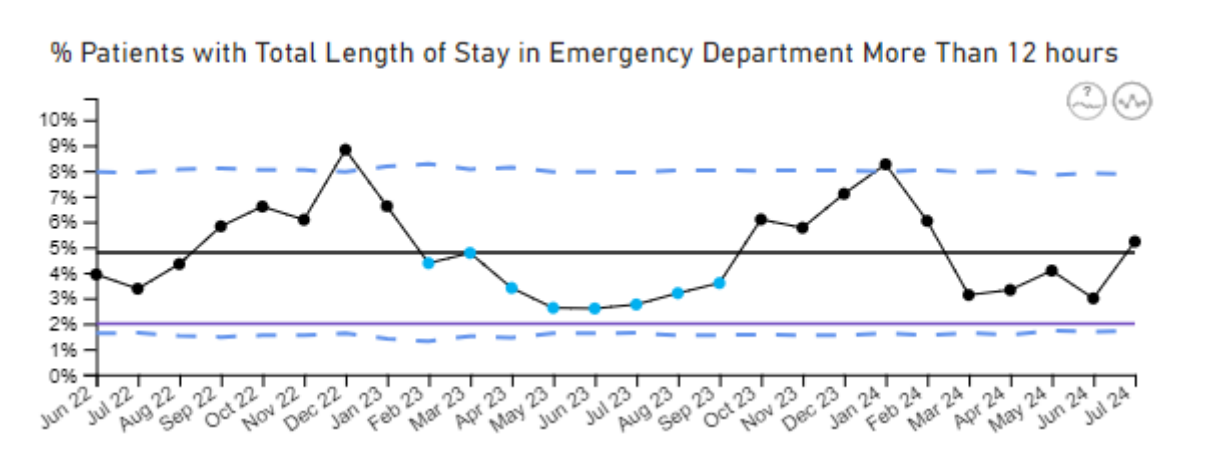


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

12 hour performance

Summary of challenges & risks	In July 2024, 5.22% of patients were in the Emergency Department > 12 hours from arrival, against the national standard of no more than 2%. The Trust ranked 52nd out of 124 Trusts and is in the 2nd quartile nationally. The key drivers of underperformance are the wait time to see doctor and delays in transfer to an inpatient bed.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Revised escalation process in place from August with all patients in the department > 8 hours from arrival being escalated to the Chief Operating Officer. Site Team oversight of bed availability and transfer of patients within 30 minutes of a bed becoming available. Forward planning of discharges to ensure early utilisation of the discharge lounge.
Action timescales and assurance group or committee	A UEC improvement plan is in place for 2024/25 Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

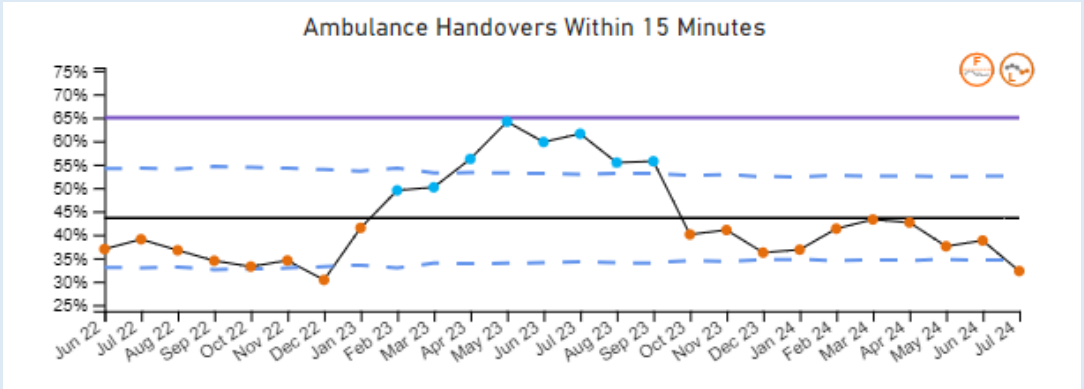


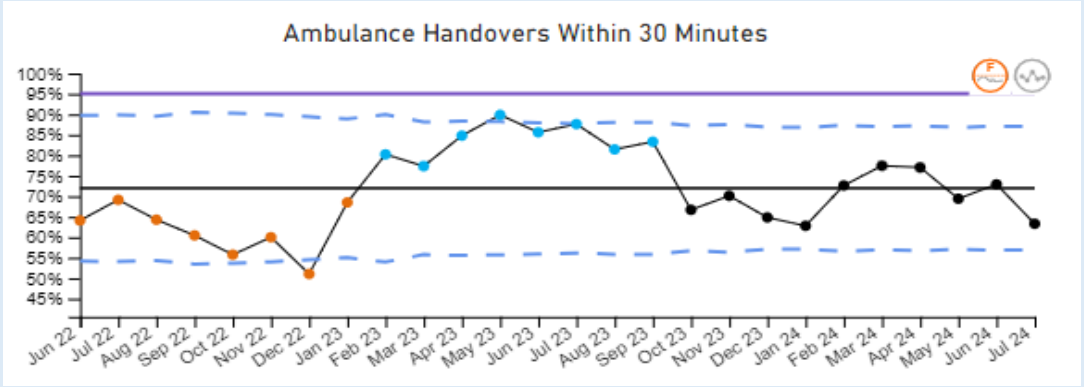
Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

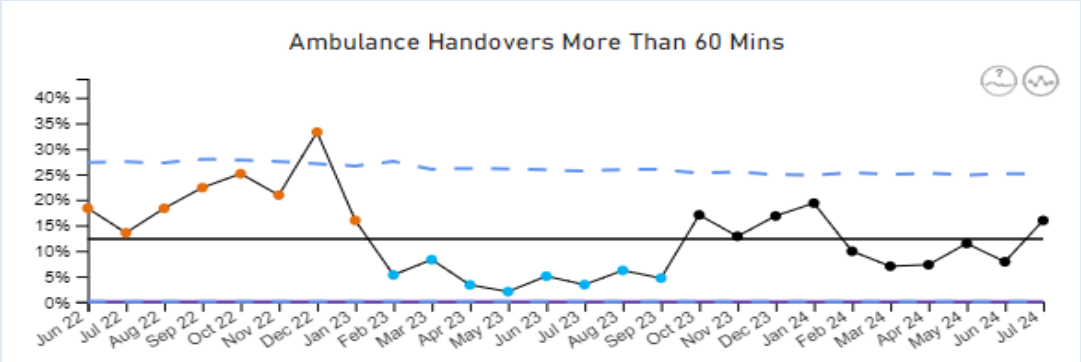
Assurance report

Ambulance Handover within 15/30/60 mins

Summary of challenges & risks	In July 2024, ambulance handovers were: • 32.24% within 15 minutes against the standard of 65% • 63.29% within 30 minutes against the standard of 95% • 84.06% within 60 minutes against the standard of 100%. The key drivers of underperformance were an increase in ambulance conveyances (10% increase compared to same period 23/24) and lack of capacity to take handover at times of peak demand when the ED is crowded.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Proactive planning to create capacity for forecast peaks in demand. Collaborative working with the ambulance service to enable ambulance conveyance direct to the SDEC unit.
Action timescales and assurance group or committee	A UEC improvement plan is in place for 2024/25 Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care





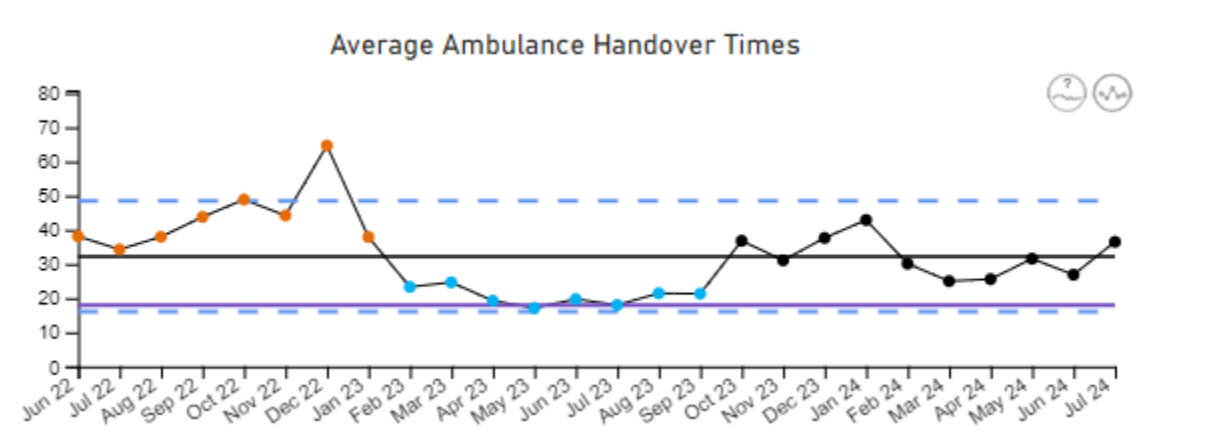


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Average Ambulance Handover Times

Summary of challenges & risks	Average handover times for YAS in July 2024 were 36:30 compared to the trajectory of 16:00 The key drivers of underperformance were an increase in ambulance conveyances (10% increase compared to same period 23/24) and lack of capacity to take handover at times of peak demand when the ED is crowded.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Proactive planning to create capacity for forecast peaks in demand. Collaborative working with the ambulance service to enable ambulance conveyance direct to the SDEC unit.
Action timescales and assurance group or committee	A UEC improvement plan is in place for 2024/25 Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

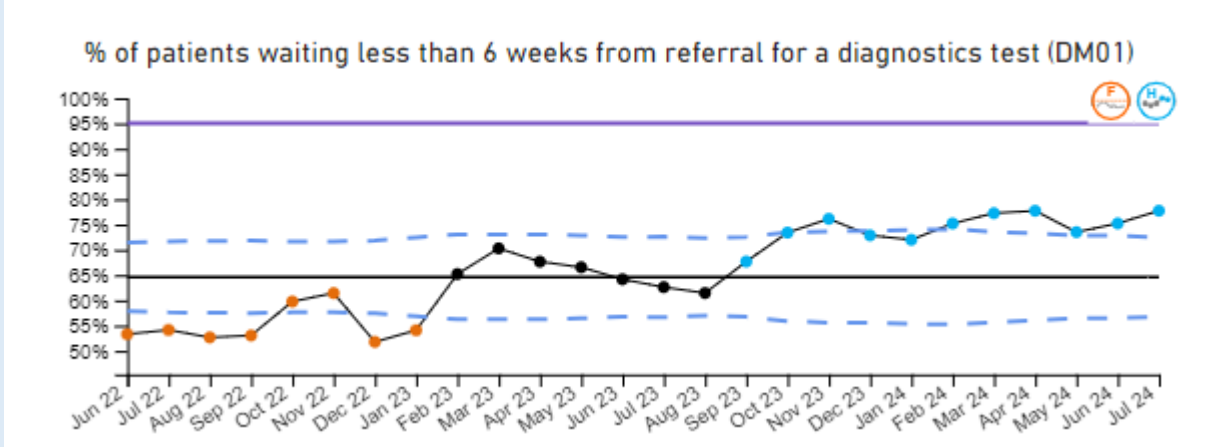


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Diagnostic Waiting Times

Summary of challenges & risks	In July 2024, 77.7% of patients received a diagnostic test within 6 weeks of referral, against the national planning requirement of 95% by March 2025.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Audiology and Nerve conduction studies are the key drivers of overall Trust underperformance. An Audiology improvement plan is in place and this includes additional capacity through outsourcing. To date, 200 adult patients have been outsourced. Discussions are ongoing regarding outsourcing for children. Neve conduction studies are currently provided via insourcing. To maximise the available capacity actions are being taken to reduce the number of missed appointments (DNAs). Further demand and capacity analysis will to be undertaken to identify any further actions required.
Action timescales and assurance group or committee	Once an improvement trajectory is agreed for Audiology an overall DM01 trajectory will be confirmed. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3434 Timely access to diagnostic services

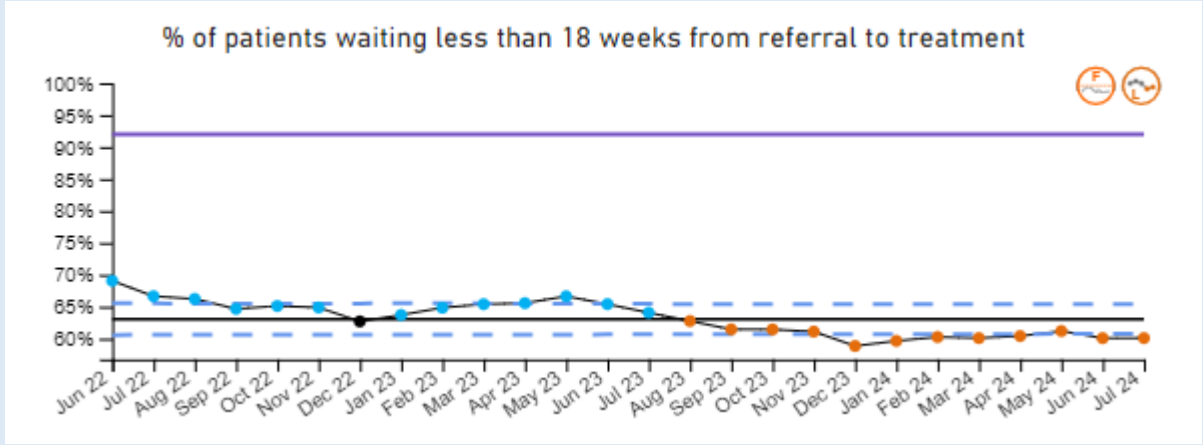


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

RTT Performance

Summary of challenges & risks	In July 2024, 60.1% of patients on the waiting list had been waiting for less than 18 weeks. The Trust benchmarks in the upper half, nationally, compared to other acute and combined providers.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ongoing work on increasing productivity within the outpatient and theatre improvement programmes will continue to ensure capacity to see waiting patients is used as effectively as possible. Senior operational oversight is in place with a focus on eliminating 65 / 78 week waits, except where patients choose to wait longer.
Action timescales and assurance group or committee	The standard is not forecast to deliver in 2024/25 and the national focus remains on virtually eliminating waits > 65 weeks. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care.

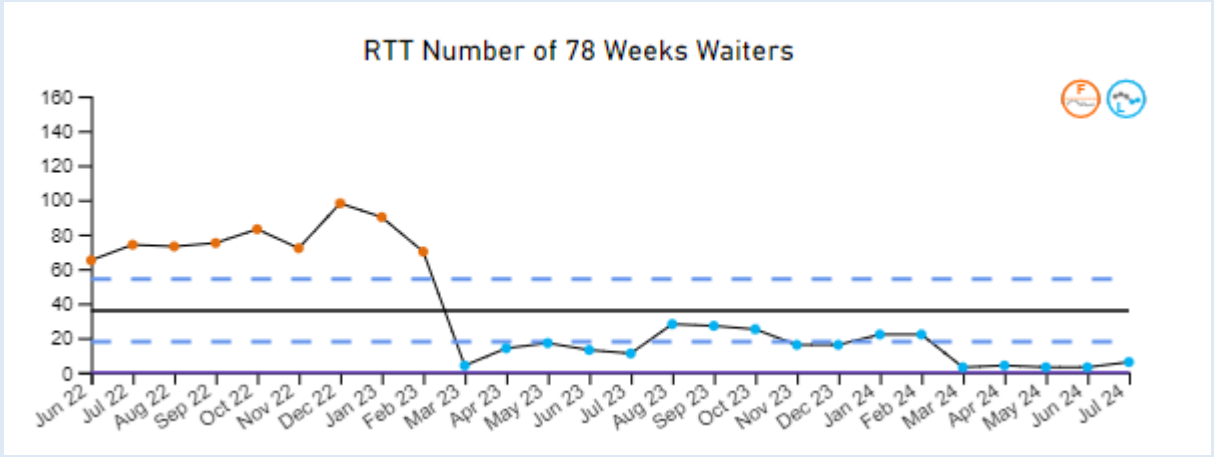


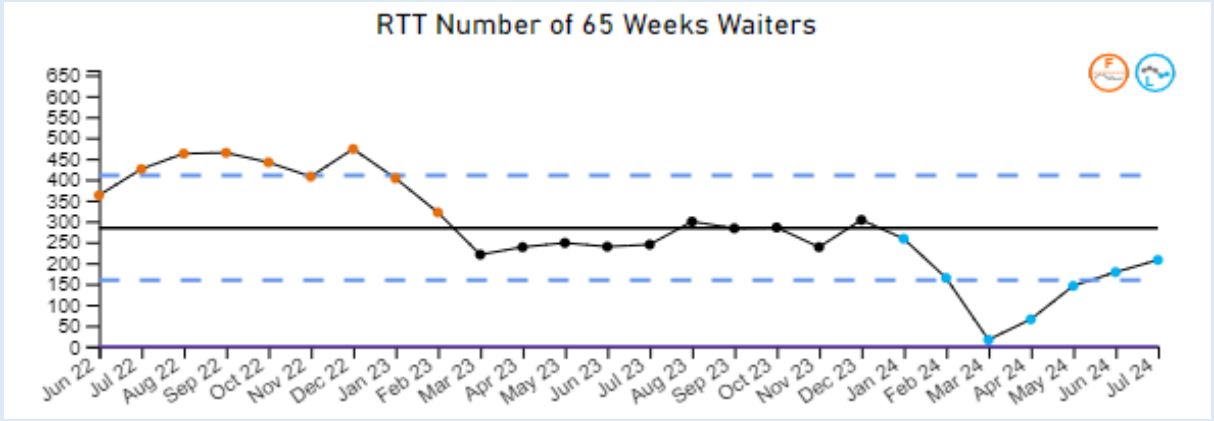
Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

RTT – 78+ / 65+ Week Waiters

Summary of challenges & risks	In July 2024, 6 patients were waiting > 78 weeks, against the trajectory of zero. In July 2024, there were 207 patients waiting > 65 weeks, against the trajectory of 15. The key drivers of underperformance are T&O and ENT, with > 80% of patients waiting > 65 weeks being in these two specialties.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Senior operational oversight is in place with a focus on eliminating 65 / 78 week waits, except where patients choose to wait longer Specific specialty level action plans are in place for T&O and ENT, these include: • ENT – maximising existing outpatient capacity, additional outpatient capacity, mutual aid request • T&O – maximising existing theatre capacity and additional theatre sessions
Action timescales and assurance group or committee	The Trust is currently forecasting c. 280 patients waiting > 65 weeks at the end of September. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



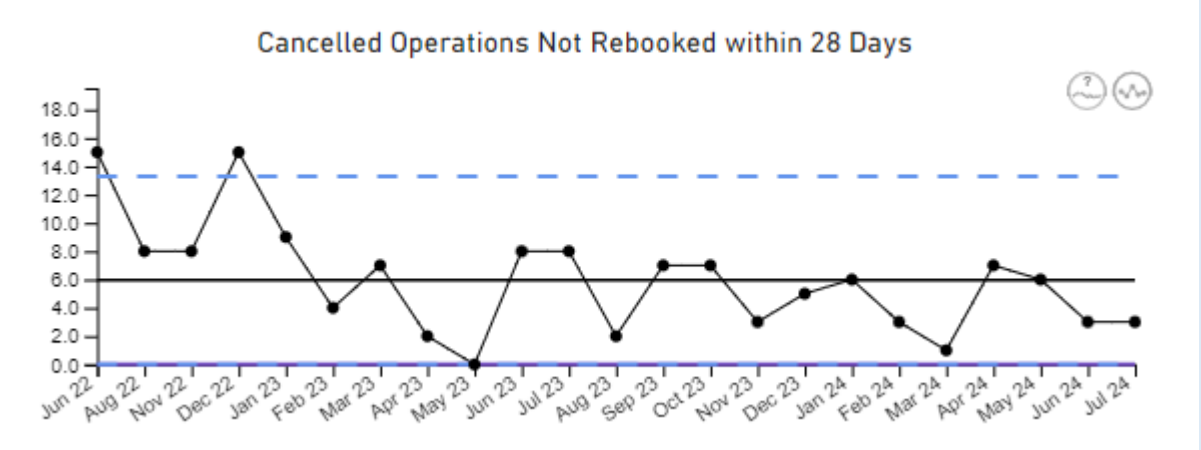


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Cancelled Operations Not Rebooked within 28 Days

Summary of challenges & risks	There were 3 breaches of the 28-day guarantee in July 2024: • Trauma and Orthopaedics x 1 • ENT x 2 The key driver of underperformance is surgeon availability and capacity within 28 days of a cancellation.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Revised oversight and escalation in place within the Division.
Action timescales and assurance group or committee	The Trust trajectory remains zero breaches of the 28 day guarantee. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

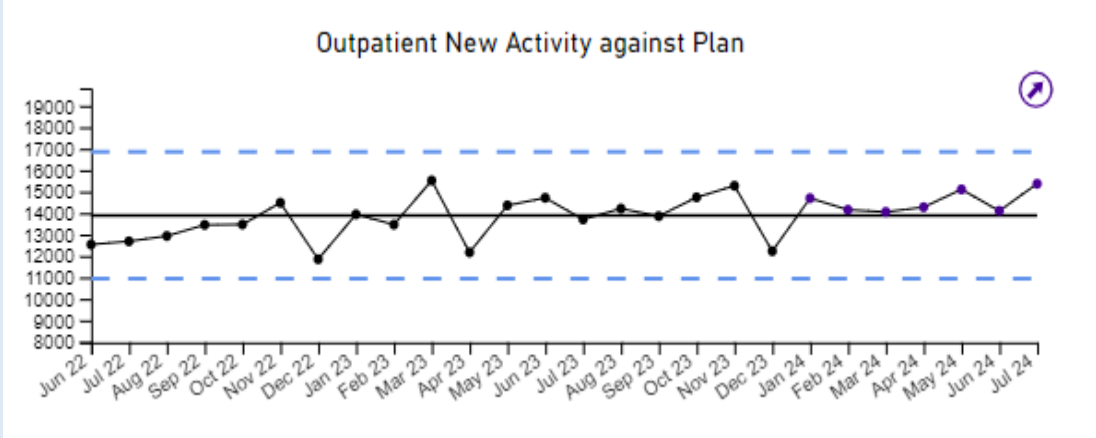


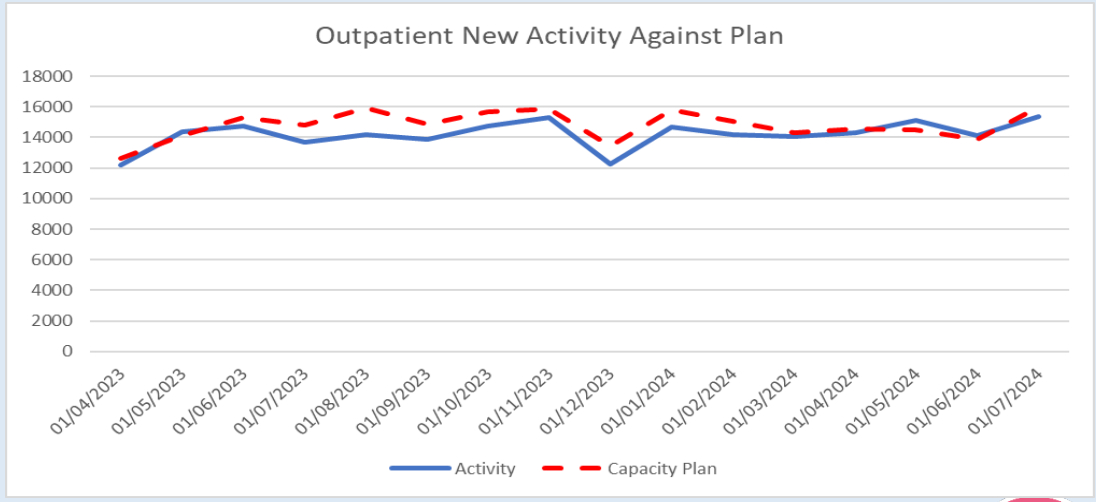
Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Outpatient New Activity Against Plan

Summary of challenges & risks	In July 2024, the Trust delivered 96.3% of plan for new outpatient appointments.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ophthalmology remains one of the key challenges, with workforce gaps impacting on outpatient and day case activity. Additional sessions are booked where Consultant capacity is available and the retired Consultant Ophthalmologist is continuing to undertake some activity. Successful recruitment will also bridge the gap from Q4. The outpatient improvement programme continues to focus on utilisation of all clinic sessions and reducing the DNA rates.
Action timescales and assurance group or committee	An elective recovery plan is being developed for the remainder of 24/25. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

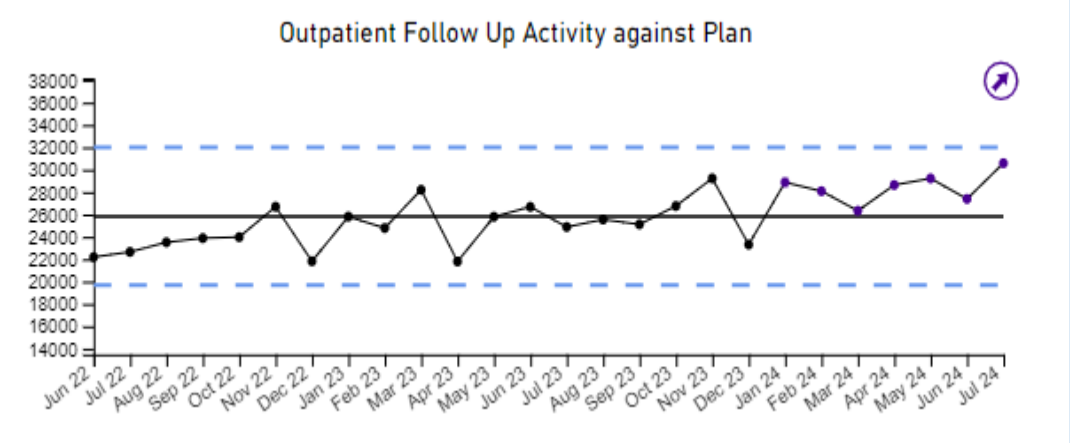


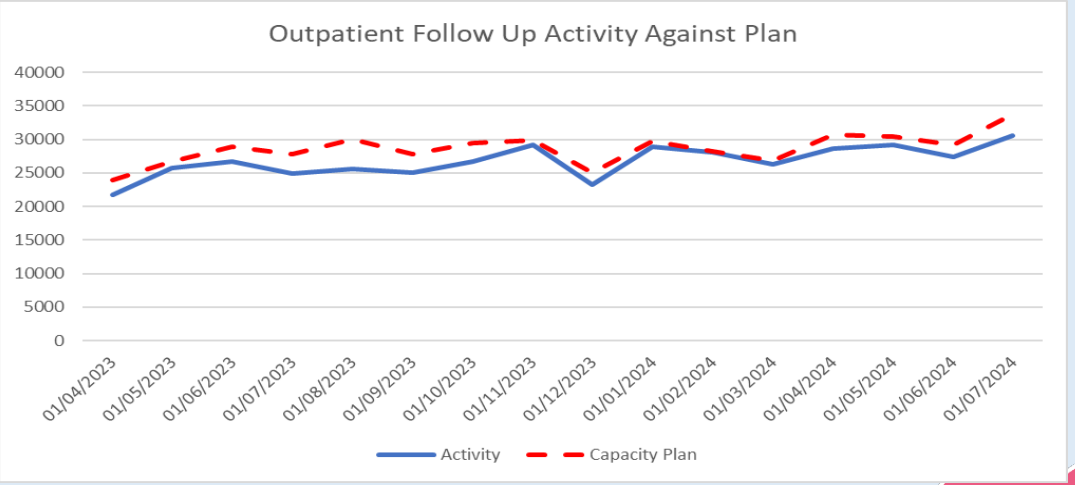


Assurance report

Outpatient Follow Up Activity Against Plan

Summary of challenges & risks	In July 2024, the Trust delivered 90.6% of plan for outpatient follow up appointments.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The outpatient improvement programme continues to focus on utilisation of all clinic sessions and reducing the DNA rates.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



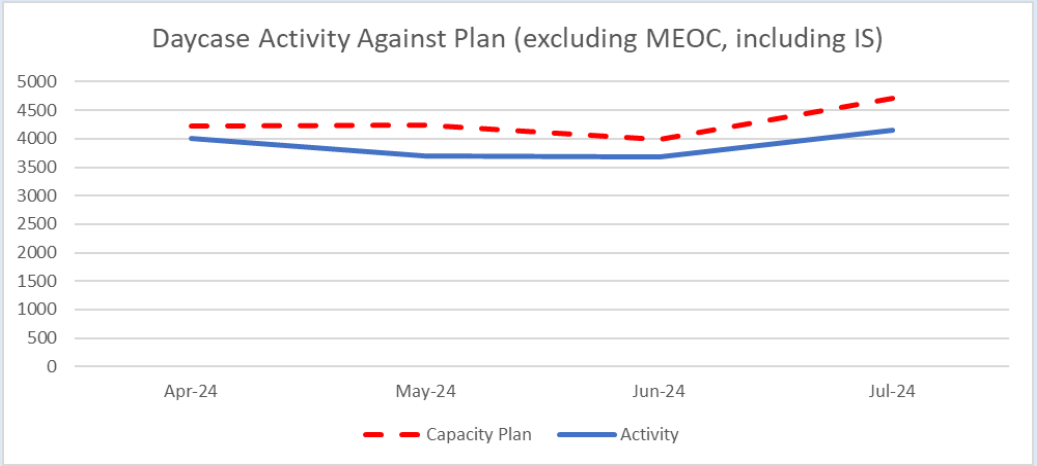


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Daycase Activity Against Plan

Summary of challenges & risks	In July 2024, the Trust delivered 87.8% of plan for day case activity (excluding MEOC activity).
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ophthalmology and T&O are the key challenges, with workforce gaps impacting delivery of day case activity. An elective recovery plan is being developed with both specialties, this includes a rota / workforce review for T&O and short term plan for Ophthalmology until two new Consultants start in post. The Theatres improvement programme continues to focus on utilisation of all core capacity, reducing on the day cancellations and increasing utilisation to 85%.
Action timescales and assurance group or committee	An elective recovery plan is being developed for the remainder of 24/25. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

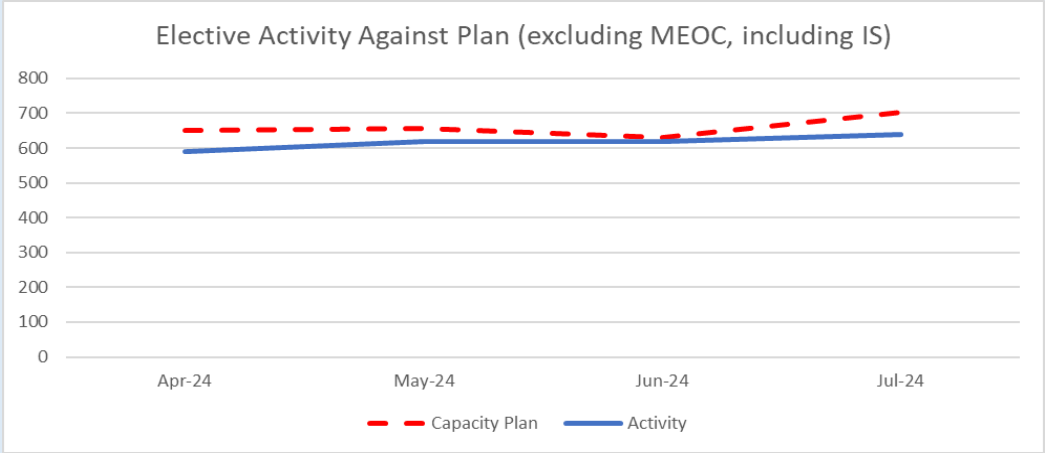


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Elective Activity Against Plan

Summary of challenges & risks	In July 2024, the Trust delivered 90.7% of plan for elective activity (excluding MEOC activity).
Actions to address risks, issues and emerging concerns relating to performance and forecast	The Theatres improvement programme continues to focus on utilisation of all core capacity, reducing on the day cancellations and increasing utilisation to 85%.
Action timescales and assurance group or committee	An elective recovery plan is being developed for the remainder of 24/25. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

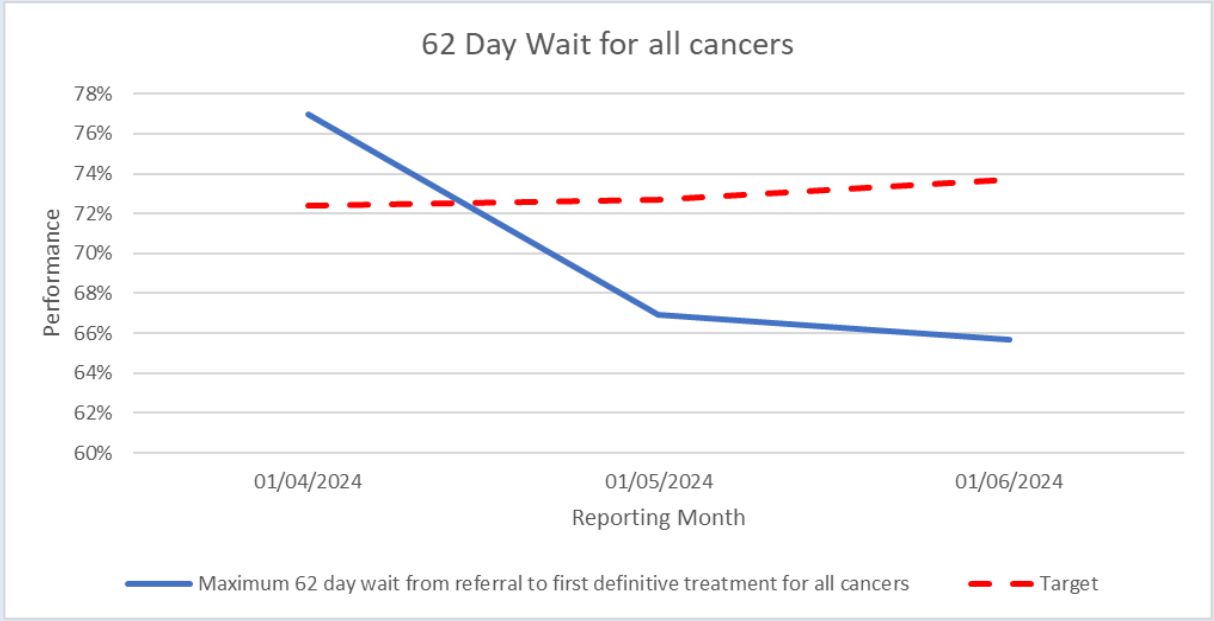


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Cancer 62 day Wait for All Cancers

Summary of challenges & risks	Performance in June 2024 was 65.7% against the national standard of 70%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Additional Urology capacity is funded through cancer alliance for 2024/25. Additional capacity for Dermatology Outpatients and Gynaecology Theatres has been agreed from September. Implementation of robotic surgery. Development of a Trust Cancer Access Policy
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3436 Timely access to cancer services

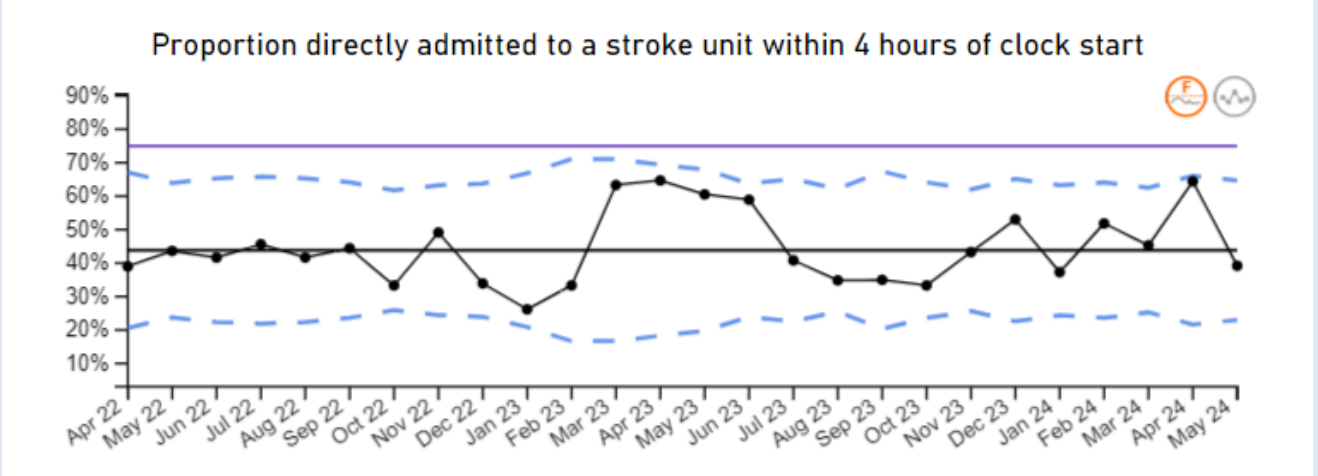


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Stroke - Proportion directly admitted to a stroke unit within 4 hours of clock start

Summary of challenges & risks	Performance at 39.2% in May 2024 against the national standard of 75%. The key drivers of under performance are late diagnosis and stroke inpatient capacity.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Collaborative working with Emergency Medicine to review the stroke triage process to reduce late diagnosis Collaborative working with ambulance service providers ensure patients with suspected stroke are conveyed the appropriate site. Collaborative working with ambulance service providers to explore options for providing real time advice to ambulance service providers and direct admission to the stroke unit, where clinically appropriate
Action timescales and assurance group or committee	An improvement trajectory is to be agreed with the Division Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3495 Failure to deliver the stroke key performance indicators

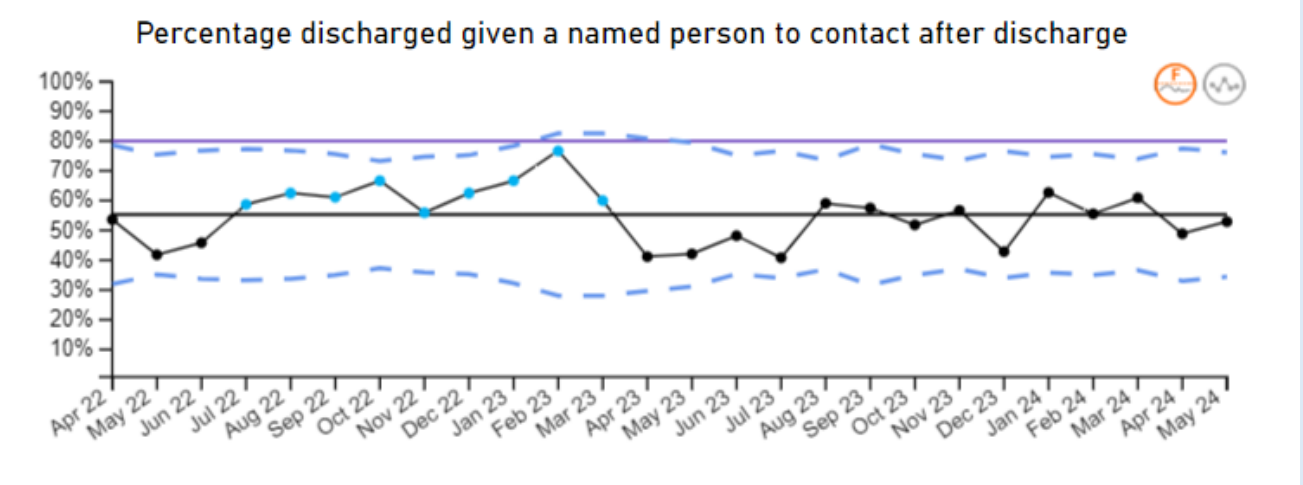


Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

Stroke - Percentage given a named contact on discharge

Summary of challenges & risks	In May 2024, performance was 52.9% against the national standard of 80%. This is due to an identified reporting error which has now been rectified. The divisional team have provided assurance that patients are given the information, however the current performance reflect the failure to record this is the patient records.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Awareness raising with clinical team Investigate option to add as a preselection (requires IT support to amend nerve centre) Explore standardised format for discharge letters
Action timescales and assurance group or committee	An improvement trajectory is to be agreed with the Division Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3495 Failure to deliver the stroke key performance indicators



Source DBTH_IQPR_Dashboard_V9.8_July_2024_SPC

Assurance report

YTD distance from financial plan I&E

Summary of challenges & risks	The Trust's reported deficit in month 4 was £2.5m, which was £0.4m adverse to budget. The Trust's reported deficit YTD at month 4 was £16.0m, which was £2.5m adverse to budget. Excluding MEOC and CDC, the Trust's core deficit in month 4 was £2.8m, which was £0.5m adverse to budget. The Trust's core deficit YTD at month 4 was £16.5m, which was £2.9m adverse to budget. The Trust's core YTD position is mainly driven by ERF underperformance against plan (£3.3m), pay being overspent (£1.7m), which was partly offset with an underspend against Independent Sector usage (£1.2m) and one-off benefits (£1.0m).
Actions to address risks, issues and emerging concerns relating to performance and forecast	See actions on pay spend assurance and ERF position assurance. MEOC: MEOC Board focusing on improvements in filling the lists and improving productivity and case mix.
Action timescales and assurance group or committee	Ongoing
Risk register	

1. Income and Expenditure vs. Budget

Performance Indicator	Annual budget	Monthly Performance				YTD Performance			
		Budget	Actual	Variance to budget		Budget	Actual	Variance to budget	
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	
Income	(560,488)	(48,328)	(49,717)	(1,389)	F	(187,335)	(187,368)	(32)	F
Pay	366,338	30,864	30,753	(111)	F	123,733	125,429	1,695	A
Non Pay	212,745	18,995	21,040	2,045	A	74,274	75,732	1,458	A
Financing Costs	8,590	716	699	(17)	F	2,863	2,659	(205)	F
(Profit)/Loss on Asset Disposals	0	0	0	0	A	0	0	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement relating to Trust core activity	**27,185**	**2,248**	**2,776**	**528**	**A**	**13,535**	**16,451**	**2,916**	**A**
MEOC	(594)	(49)	(3)	46	A	(197)	92	289	A
CDC	(367)	(67)	(242)	(175)	F	82	(581)	(664)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement (including MEOC & CDC)	**26,224**	**2,132**	**2,531**	**399**	**A**	**13,421**	**15,962**	**2,541**	**A**

Income: Over-achieved F; Under-achieved A

Key

F = Favourable **A** = Adverse

Expenditure: Underspent F; Overspent A

Assurance report

ERF position

Summary of challenges & risks	ERF is £3.3m behind plan YTD at month 4. This is mainly driven by Orthopaedics which is £3.2m behind plan (£1.9m core activity and £1.3m Independent Sector).
Actions to address risks, issues and emerging concerns relating to performance and forecast	Recovery plan required for elective activity, particulary for Orthopaedics. This is with the Operational Teams and the Chief Operating Officer.
Action timescales and assurance group or committee	Operational Teams to provide timescales along with the recovery plan.
Risk register	

ERF position by POD	M4 variance to ERF Target
Daycase	£1,443,680
Elective	£3,173,608
Outpatient First	-£11,518
Outpatient Procedures	-£263,194
A&G / costing adjustment	-£1,021,691
Total	**£3,320,885**

Assurance report

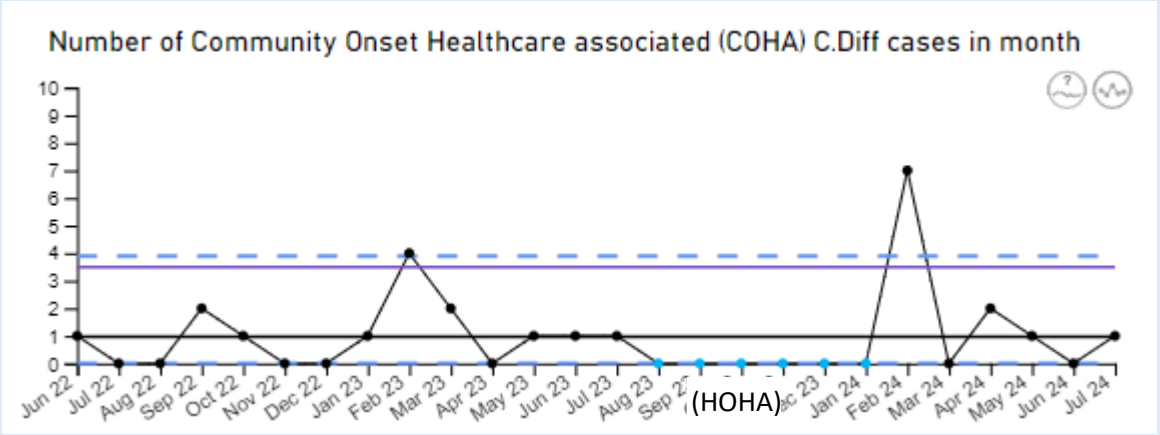
Pay spend against plan

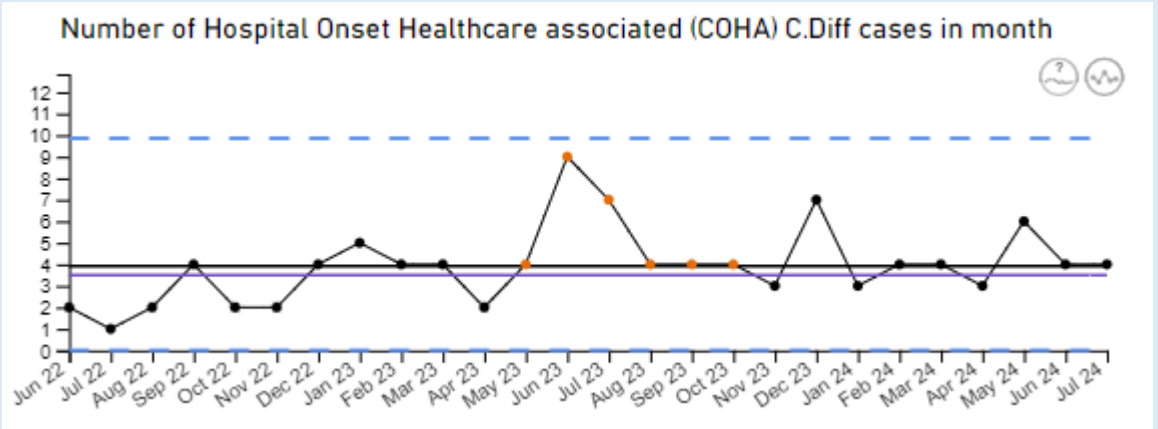
Summary of challenges & risks	The Trust's core position (excluding MEOC & CDC), on pay expenditure is £1.7m adverse to budget. This is mainly driven by overspends on Medical and Dental and Nursing staff in the Division of Medicine and Division of Urgent and Emergency Care and overspends on Medical and Dental staff in the Division of Women and Children.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Medical and Dental staff: Medical Director review of rotas in the Division of Urgent and Emergency Care. Divisional Directors review of Medical and Dental spend at Confirm & Challenge meetings. Medical Director input into agency spend CIP workstreams. Nursing and Midwifery staff: Escalation beds opened in the early part of the year which have now got enhanced prototols over opeing approvals. Patients have more complexity requiring enhanced care driving the bank spend. Divisional Nurse review of Nursing and Midwifery spend at Confirm & Challenge meetings. Director of Nursing input into the agency spend CIP workstreams. Allied Health Professionals: workforce plan being led by the Director of Nursing, commencing in August.
Action timescales and assurance group or committee	Ongoing
Risk register	

Assurance report

Number of Hospital/Community Onset Healthcare associated (HOHA/COHA) C.Diff cases in month

Summary of challenges & risks	The combined number of Hospital Onset Healthcare associated (HOHA) and Community Onset Healthcare associated (HOHA) C.Diff cases in month was 5 in July 2024
Actions to address risks, issues and emerging concerns relating to performance and forecast	We still await confirmation of the 2024/2025 trajectories from NHS England, however continue to benchmark ourselves nationally. A Qi project commenced the 18th April 2024 to review the recurrent themes. Key actions were identified to form part of the Qi project which included: • IPC team increased ward attendance during a pilot • A knowledge survey for clinical staff to complete to form the basis of a newly created education packages. • Exploring digital documentation approaches. • Developing a joint protocol with primary care prescribers and secondary care prescribers on the use of PPIs.
Action timescales and assurance group or committee	Ongoing programme with regular touch points. Monitor as part of infection control operational group and Infection control strategic group.
Risk register	Logged as risk ID - 3517

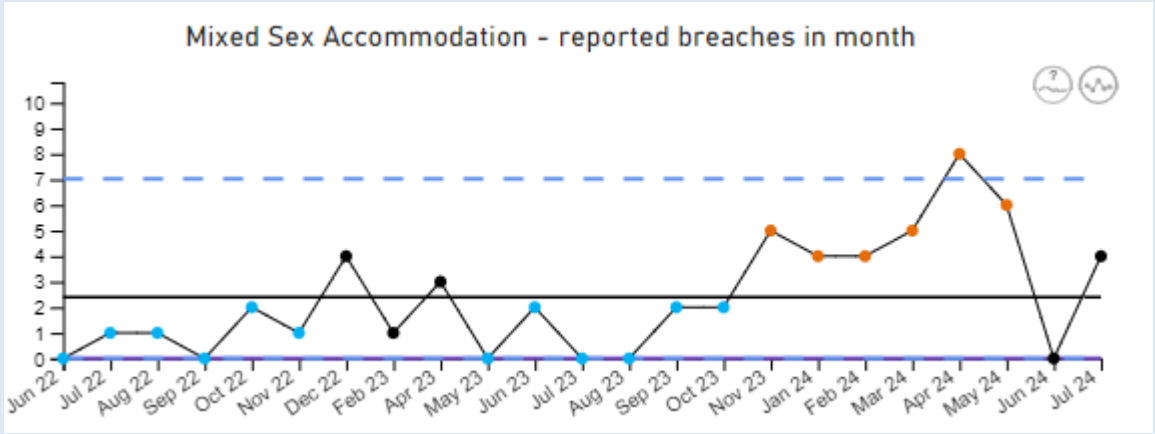




Assurance report

Mixed Sex Accommodation - nationally reported breaches in month

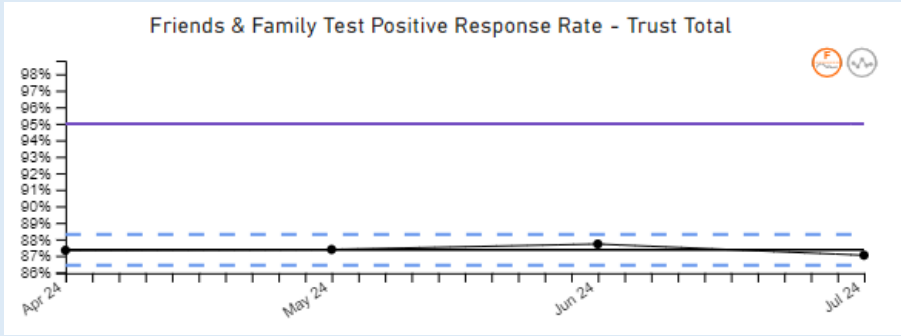
Summary of challenges & risks	There were 4 mixed sex accommodation breaches in July 2024.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Patients for critical care step down are discussed in each of the three times daily operational flow meetings. Intensive Care (where possible) utilise side rooms to avoid breaching.
Action timescales and assurance group or committee	Ongoing.
Risk register	N/A

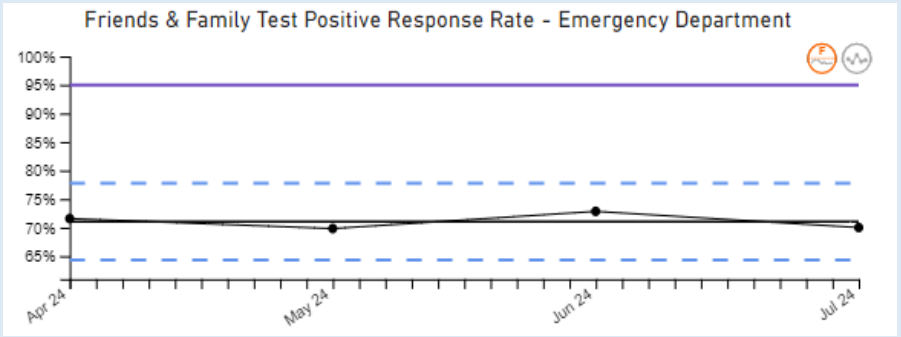


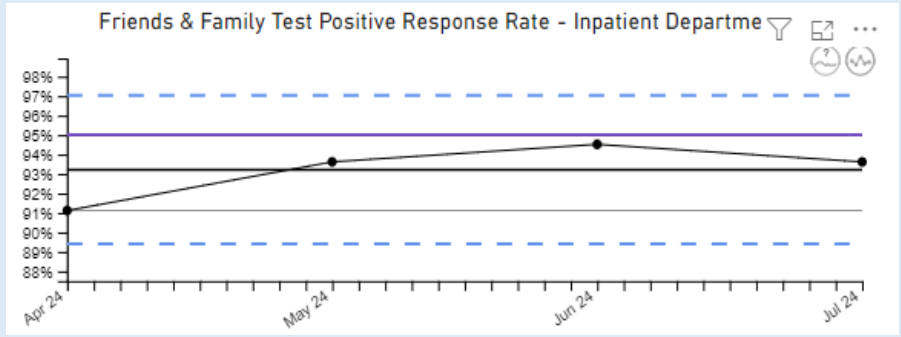
Assurance report

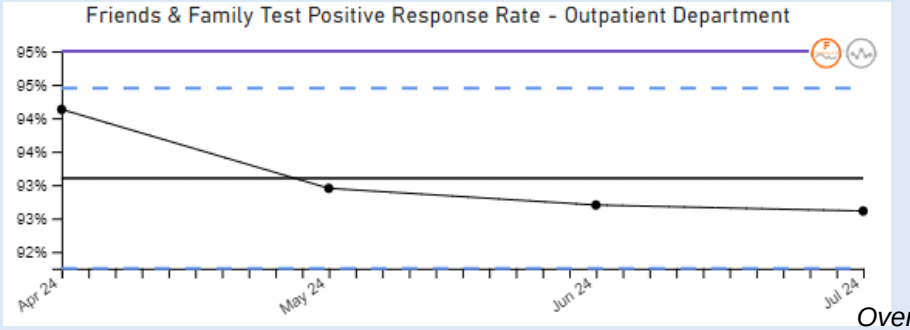
Friends & Family Positive Response Rates

Summary of challenges & risks	Friends and family positive response rates fell below the standard of 95% in July 2024 in: ED – 70.01% Inpatient – 93.62% Outpatient – 92.61% Trust – 87.03%
Actions to address risks, issues and emerging concerns relating to performance and forecast	The main theme from the negative proportion of friends and family test feedback Trust wide was communication. There is work - ongoing with the education team to consider introducing advanced communications skills training for nursing staff. FFT compliance/feedback now reviewed at care excellence meeting and reviewed on Matrons one to one You said, we did, - boards available in all areas to highlight areas of improvements and for staff visibility.
Action timescales and assurance group or committee	Ongoing actions. Patient experience and involvement group
Risk register	N/A





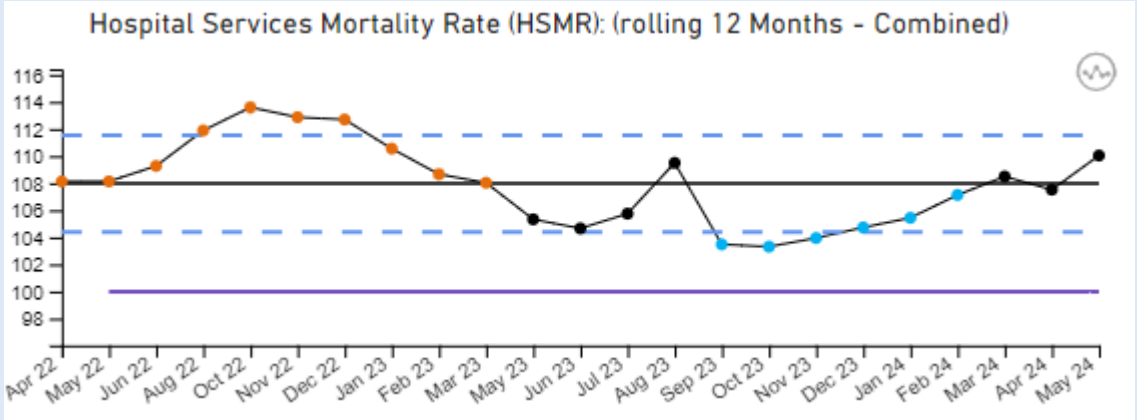


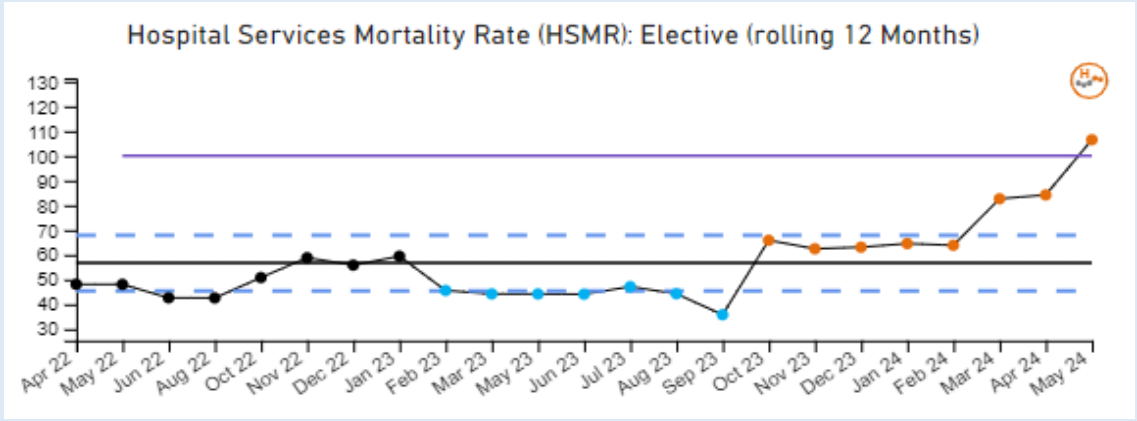


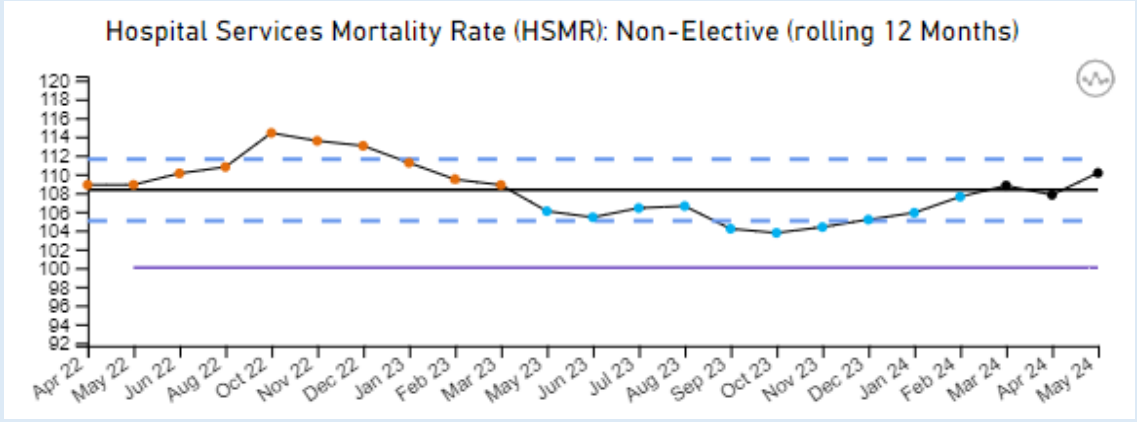
Assurance report

Hospital Services Mortality Rate (HSMR)

Summary of challenges & risks	The Trusts elective HSMR rolling 12-month rate is 106.52 against a target of 100 for May 2024. The Trusts non-elective HSMR rolling 12-month rate is 110.13 against a target of 100 for May 2024. The Trusts combined HSMR rolling 12-month rate is 110.04 against a target of 100 for May 2024.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Unfortunately HSMR has taken an unexpected turn upwards This is mainly driven by fluid and electrolyte balance as a diagnosis. We are looking at this as a driver. Ongoing SJR review into Pneumonia which is another driver. We can also see that our depth of coding is outside the national average which will have an impact. There is work going on with the 360 degree audit looking at coding as well as an external consultancy Maxwell Stanley who have reviewed our coding and we are contracting to help us improve it
Action timescales and assurance group or committee	This is a 3-6 month turn around time for improvement
Risk register	



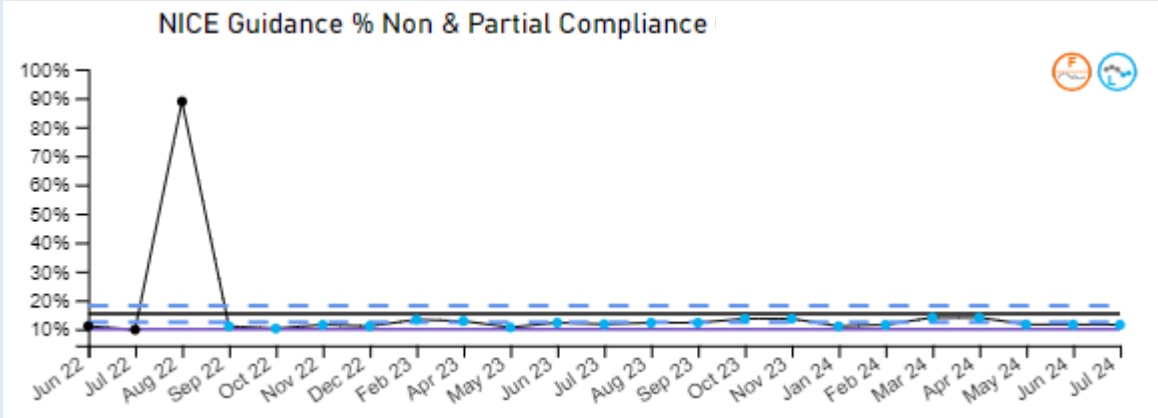




Assurance report

NICE Guidance % Non & Partial Compliance

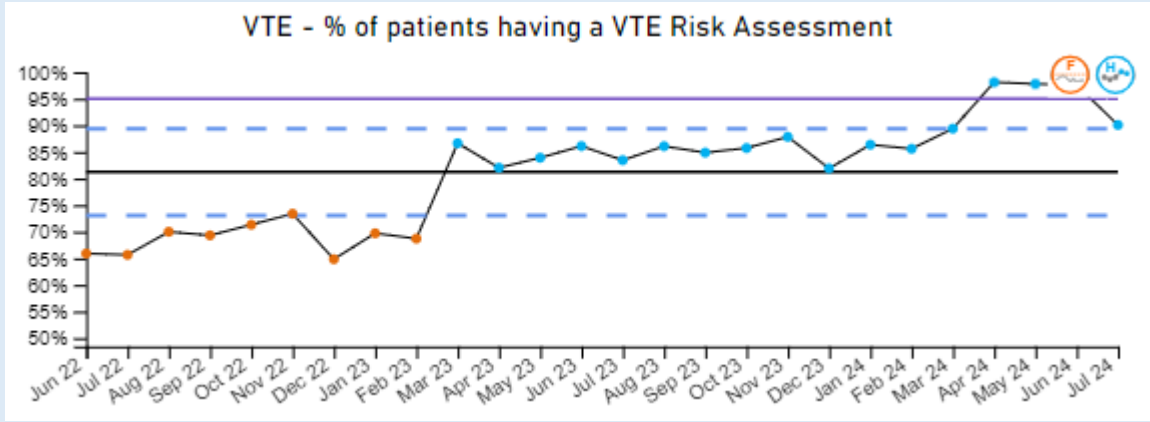
Summary of challenges & risks	NICE Guidance % Non & Partial Compliance for July 2024 was 11.5% against a standard of 10%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	We are very close to achieving the standard here. More work is ongoing through the Audit team and effective committee to address the outstanding compliance items
Action timescales and assurance group or committee	Aiming to achieve target by next board meeting
Risk register	



Assurance report

VTE - % of patients having a VTE Risk Assessment

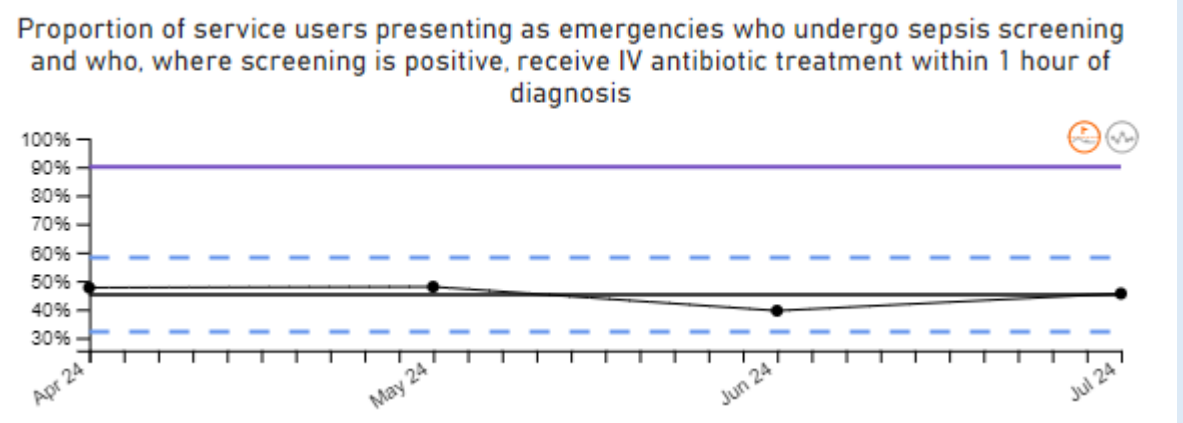
Summary of challenges & risks	In July 2024 90.08% of patients had a VTE risk assessment against a standard of 95%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	You can see the step change in performance in March this year which represents our change to using an electronic form from paper and mandating that this is filled before prescriptions are written. There are a few ongoing issues this leaves us within the elective services where at times the form is done on paper and not electronically which can then slow prescribing down later. We have met the divisions and are working to correct this
Action timescales and assurance group or committee	Monitor to see if July's data is a blip as no changes have been made to account for the one off dip.
Risk register	Improving metric expected to comply with the target

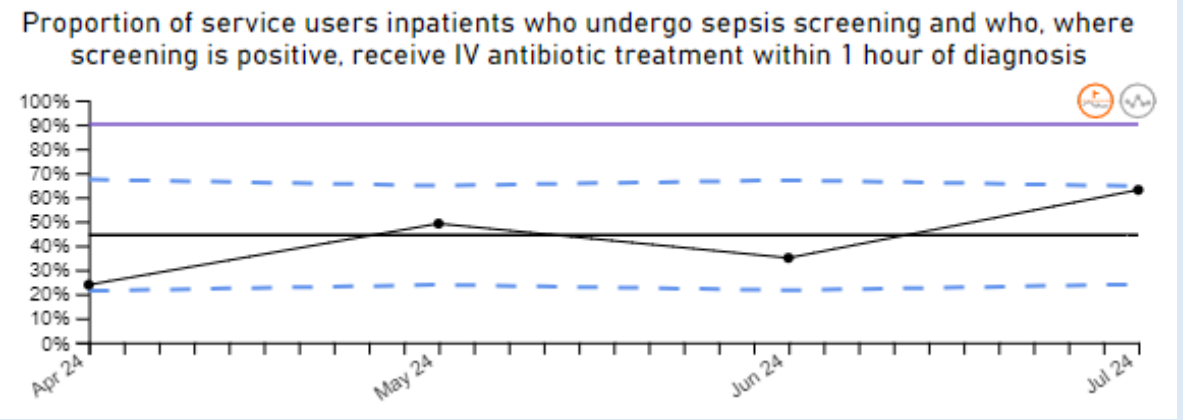


Assurance report

Proportion of service users who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis

Summary of challenges & risks	The proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 45.52% compared to a target of 90% The proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 62.96% compared to a target of 90%
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sepsis action group has ongoing work to address this. There is monitoring and feedback through a dashboard. We have recently added sepsis nurses to our team to improve compliance. We are exploring sepsis prescribing bundles on Wellsky that include fluid prescriptions. We do need to recognise that the sepsis screening is sensitive but not specific so that many of the patients identified are then stepped back from IV antibiotics quickly. We are working to refine the metric in regard to this
Action timescales and assurance group or committee	Sepsis HSMR is now below 100 showing good improvement in outcomes.
Risk register	

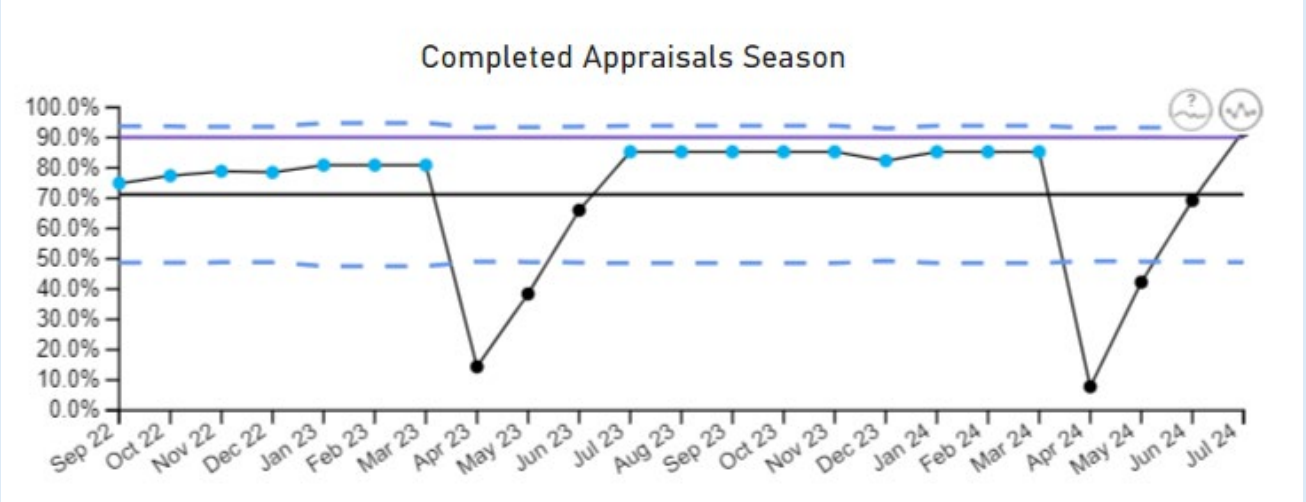




Assurance report

Completed Appraisals

Summary of challenges & risks	The 2024 Appraisal season completion rate was 93.52% against a target of 90%. This is the highest completion rate achieved at the Trust.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Throughout the session, 1 April – 31 July, completion rates were monitored regularly including comparison with 2023 position. Senior leaders were asked to ensure plans were in place within their divisions/directorate and escalate any concerns to the Chief People Officer. People Business Partnering team monitored data and offering focused support to areas. Survey undertaken on quality of appraisals, initial data presented at Trust Leadership Team in June.
Action timescales and assurance group or committee	Appraisal season 1 April – 31 July 2024 Detailed breakdown by division/directorate presented to Trust Leadership Team at the June and July meetings. Appraisal season report to be presented to Trust Leadership Team in September and People Committee in October. Performance Review Meetings CQC action plan Trust Leadership Team People Committee
Risk register	N/A

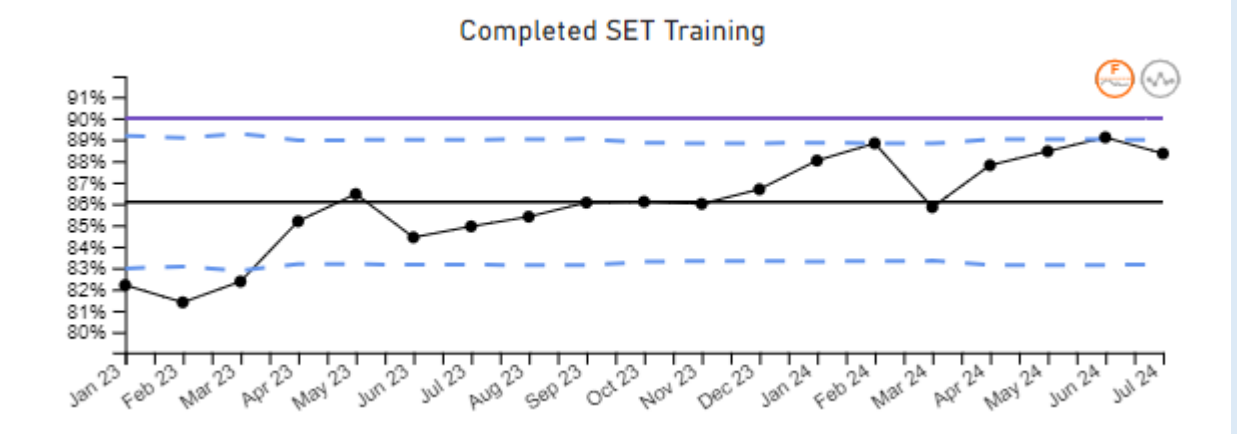


Source *DBTH_IQPR_Dashboard_V9.8_July_2024_SPC*

Assurance report

Completed SET Training

Summary of challenges & risks	In July the Trust had a SET completion rate of 88.35% against a target of 90%
Actions to address risks, issues and emerging concerns relating to performance and forecast	Managers asked to use ESR self-serve to review compliance, ensure position numbers are correct as these determine training requirements and to support individuals accessing SET. There has been a focus on SET during appraisal season which has supported compliance. Qii project on utilisation of training places on face-to-face sessions, as these are more challenging in terms of capacity. Self-booking introduced for a topic with intention to expand further. Work to review the NHS England reform objectives on mandatory training is on track.
Action timescales and assurance group or committee	Trend of improving compliance in 2024. Detailed breakdown by division/directorate presented to Trust Leadership Team at May and July meetings. Performance Review Meetings CQC action plan Workforce & Education Committee Trust Leadership Team People Committee
Risk register	Managers asked to use ESR self-serve to review compliance, ensure position numbers are correct as these determine training requirements and to support individuals accessing SET. There has been a focus on SET during appraisal season which has supported compliance. Qii project on utilisation of training places on face-to-face sessions, as these are more challenging in terms of capacity. Self-booking introduced for a topic with intention to expand further. Work to review the NHS England reform objectives on mandatory training is on track.

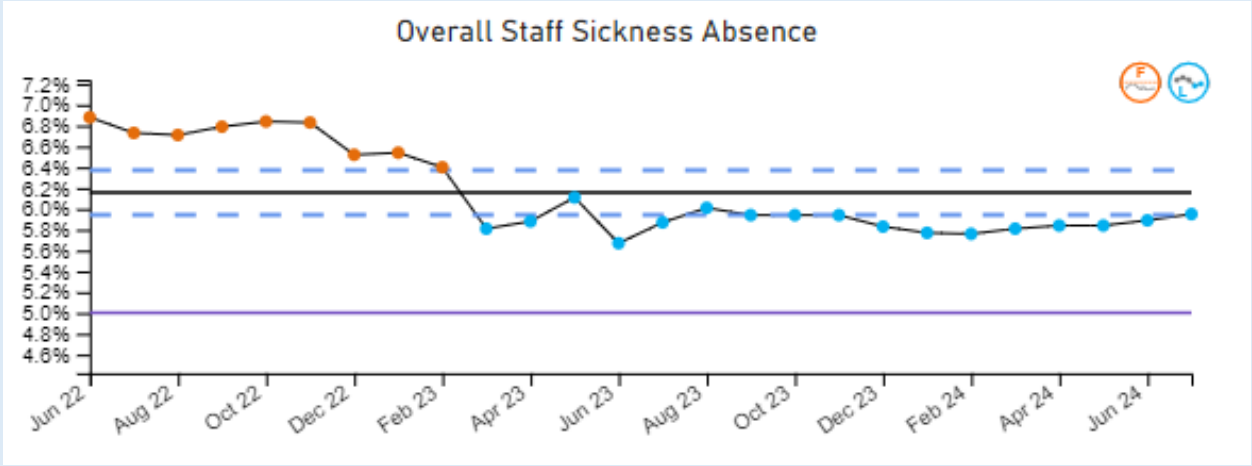


Source *DBTH_IQPR_Dashboard_V9.8_July_2024_SPC*

Assurance report

Overall Sickness Absence

Summary of challenges & risks	For July 2024, the Trust sickness rate is 5.95% against a target for 5%. The overall trend has been a reduction in sickness absence since 2022/23, where the rate was consistently above 6%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sickness absence targets set at division/directorate level, with focused targets for each department/ward. People Business Partnering team providing ongoing support to managers. Also working more closely with Occupational Health to provide support. Impact of new sickness absence policy to be reviewed
Action timescales and assurance group or committee	Performance Review Meetings Workforce Workstream reports to Efficiency & Effectiveness Committee Trust Leadership Team People Committee
Risk register	N/A

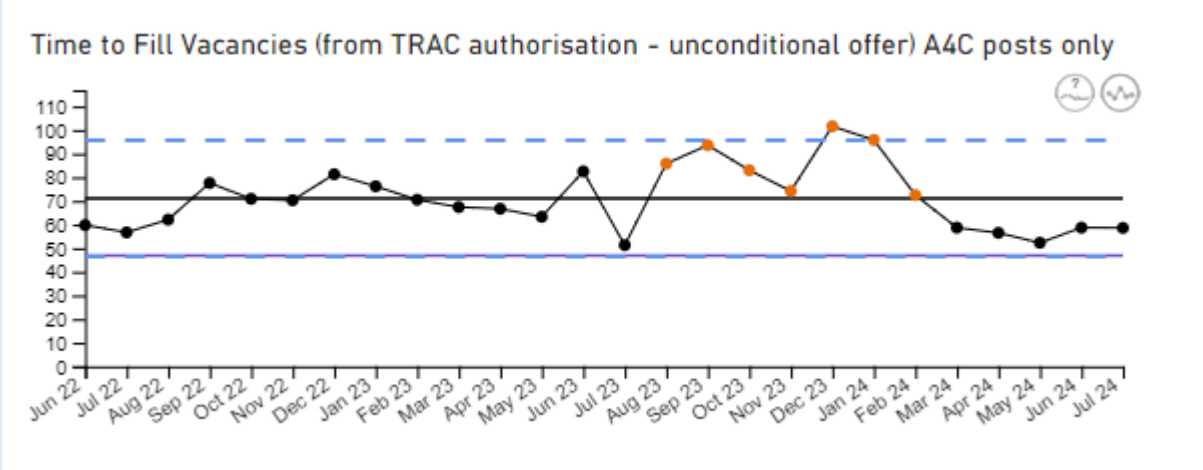


Source *DBTH_IQPR_Dashboard_V9.8_July_2024_SPC*

Assurance report

Time to Fill Vacancies

Summary of challenges & risks	The Trusts time to hire has come down from previous highs but is still at 59 days for July 2024 above the target of 47.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Collaborative work with South Yorkshire recruitment leads to identify good practice and any opportunities. Inclusive recruitment practices action plan in place, to improve experiences of the process.
Action timescales and assurance group or committee	Performance Review Meetings Trust Leadership Team People Committee
Risk register	N/A To note – it has been recognised the current mixed model of centralised and devolved recruitment impacts on ability to achieve time to hire KPIs



Source *DBTH_IQPR_Dashboard_V9.8_July_2024_SPC*

Future IQPR Developments

- SPC Charts in IQPR:
  - Responding to feedback, optimisation, residual presentation issues. November 2024.

- Making Data Count Board Session, 8th October 2024
  - Agree triggers for assurance statements

- Process automation:
  - Summary of metrics
  - Identify variation
  - IQPR output report

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2409 - D2 FINANCIAL POSITION & FINANCIAL PLAN UPDATE

Discussion Item | Jon Sargeant, Chief Financial Officer | 10:55

10 minutes

REFERENCES

Only PDFs are attached

D2 - Financial Position & Plan Update - Month 4.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**D2**
Report Title:	**Financial Position & Plan Update**		
Sponsor:	Jon Sargeant, Chief Financial Officer		
Author:	Rodney Muskett, Deputy Director of Finance Finance Team		
Appendices:			

Report Summary

The Trust's reported deficit in month 4 was £2.5m, which was £0.4m adverse to budget. The Trust's reported deficit YTD at month 4 was £16.0m, which was £2.5m adverse to budget.

Excluding MEOC and CDC, the Trust's core deficit in month 4 was £2.8m, which was £0.5m adverse to budget. The Trust's core deficit YTD at month 4 was £16.5m, which was £2.9m adverse to budget. The Trust's core YTD position is mainly driven by ERF underperformance against plan (£3.3m), pay being overspent (£1.7m), which was partly offset with an underspend against Independent Sector usage (£1.2m) and one-off benefits (£1.0m).

The Trust group income position in month 4 was £42.3m, £1.8m favourable to plan and £167.3m year to date and £5.0m adverse to plan.

The Trusts core clinical income (excluding MEOC and CDC) was £163.5m, £2.2m adverse to plan. However, within this the ERF is behind plan year to date £3.3m mainly relating to T&O performance which was off set £1.2m by independent sector underspends.

The Trust's core position (excluding MEOC & CDC), on pay expenditure is £1.7m adverse to budget. This is mainly driven by overspends on Medical and Dental and Nursing staff in the Division of Medicine and Division of Urgent and Emergency Care and overspends on Medical and Dental staff in the Division of Women and Children.

The Trust's core position (excluding MEOC and CDC), on non-pay expenditure is £1.5m adverse to budget. £4.0m of this variance is offset with income, therefore the underlying non-pay variance is £2.6m favourable to budget. This is mainly driven by an underspend on Independent Sector of £1.2m, which is offsetting some of the underachievement of ERF, an underspend on utilities of £0.7m and one-off benefits of £1.0m, offset by an overspend on drugs of £0.5m.

Capital

Year to date capital spend excluding donated assets/charitable funds is £5,424k, compared to a year to date budget of £5,125k therefore showing an overperformance of £299k. YTD capital spend for charitable funds is £2,469k which relates to the Da Vinci Robot and the Stroke Rehab Robot. Therefore, the YTD total capital spend is £7,893k. The committee should note the risk to the planned programme relating to the cash support requirement to under pin the programme which is not clear in the new NHSE regime the ICB is now under.

Cash

Cash in the ledger has gone down by £2m to £14m. This is despite the Trust receiving £2.2m of revenue PDC support and £1.3m of capital PDC support. The reduction is as a result of £4.7m of capital payments in month, despite the Trust receiving the quarterly Education income in month.

CIPs (Cost Improvement Programme)

In month, the Trust has delivered £1.0m of savings versus the plan submitted to NHSE of £1.3m and therefore is £0.3m adverse to plan. YTD, the Trust has delivered £3.1m of savings versus the plan submitted to NHSE of £3.1m and therefore is on plan.

Trust Forecast and recovery actions

The Trust has undertaken a reforecast for the full financial year which indicates that without stronger financial controls and an increase in income the Trust's financial target is in jeopardy. Following a board discussion a number of enhanced actions have been agreed which will implemented in the next few weeks. These actions are expected to be sufficient to deliver the Trust's financial plan for the year. Work is underway to communicate this in detail to the organisation.

It is worth noting that the Trust's financial controls have been externally assessed by Deloitte LLP for the ICB (along with all ICS organisations) and were found to be rated as strong, with some opportunity to be further enhanced particularly in the area of sickness management and medical staffing. These areas are part of the work programme that will also look at partial vacancy freezes in some areas and further scrutiny on all temporary staffing spending.

Recommendation:	The Board is asked to note • The Trust's deficit in month 4 (July 2024) was £2.5m, which was £0.4m adverse to budget. The Trust's deficit YTD in month 4 was £16.0m, which was £2.5m adverse to budget. • Excluding MEOC and CDC, the Trust's core deficit in month 4 (July 2024) was £2.8m, which was £0.5m adverse to budget. The Trust's core deficit YTD at month 4 was £16.5m, which was £2.9m adverse to budget.			
Action Required: Mark relevant action/s in **bold**	~~Approval~~	**Review and discussion**	~~Take assurance~~	~~Information only~~

Healthier together – delivering exceptional care for all				
Relationship to strategic priorities: Mark in **bold** the relevant SPs this report provides assurance for	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	*We work together to enhance our services with clear goals for our communities.*	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes /No/ **NA**		Yes /No/ **NA**	

Implications			
Relationship to Board assurance framework: Indicate here if the report links to any		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
		BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague

relevant strategic risk on the Board Assurance Framework			experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
		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
		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
	X	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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal/ Regulation:	Identify if the purpose of the report is linked to a legal requirement (e.g. Health and Social Care Act / HSE) or regulatory requirements (e.g. CQC). **If so, indicate impact.**		
Resources:	Please indicate any impact on resources.		
Assurance Route			
Previously considered by:			
Date:			
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 4 – July 2024

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M04 July 2024

1. Income and Expenditure vs. Budget

Performance Indicator	Annual budget	Monthly Performance				YTD Performance			
		Budget	Actual	Variance to budget		Budget	Actual	Variance to budget	
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	
Income	(560,488)	(48,328)	(49,717)	(1,389)	F	(187,335)	(187,368)	(32)	F
Pay	366,338	30,864	30,753	(111)	F	123,733	125,429	1,695	A
Non Pay	212,745	18,995	21,040	2,045	A	74,274	75,732	1,458	A
Financing Costs	8,590	716	699	(17)	F	2,863	2,659	(205)	F
(Profit)/Loss on Asset Disposals	0	0	0	0	A	0	0	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement relating to Trust core activity	**27,185**	**2,248**	**2,776**	**528**	**A**	**13,535**	**16,451**	**2,916**	**A**
MEOC	(594)	(49)	(3)	46	A	(197)	92	289	A
CDC	(367)	(67)	(242)	(175)	F	82	(581)	(664)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement (including MEOC & CDC)	**26,224**	**2,132**	**2,531**	**399**	**A**	**13,421**	**15,962**	**2,541**	**A**

Income: Over-achieved F | Under-achieved A

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

Expenditure: Underspent F | Overspent A

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual Plan
	Plan	Actual		Plan	Actual		
	£'000	£'000		£'000	£'000		£'000
Drugs	38	0	A	38	0	A	500
Income (Other Operating Income)	51	170	F	197	182	A	992
Income (Patient Care Activities)	189	(19)	A	530	61	A	3,351
Non-Pay	248	205	A	641	722	F	5,288
Pay	21	41	F	83	119	F	250
Pay (Skill Mix)	422	417	A	907	1,030	F	5,350
Pay (WTE Reductions)	369	215	A	699	950	F	5,469
Total CIP	**1,338**	**1,028**	A	**3,096**	**3,064**	A	**21,200**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**297,018**	**297,764**	**746**
Current Assets	56,341	57,705	**1,364**
Current Liabilities	-87,604	-86,932	**672**
Non Current liabilities	-14,317	-14,295	**22**
Total Assets Employed	**251,438**	**254,242**	**2,804**
Total Tax Payers Equity	**-251,438**	**-254,242**	**-2,804**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan
	Plan	Actual	Plan	Actual	
	£'000	£'000	£'000	£'000	£'000
Cash Balance		14,096		14,096	1,900
Capital Expenditure	974	2,099	5,125	5,424	38,531

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,660.76	6,073.64	358.17	87.36	6,519.17
Previous Month	6,636.14	6,132.29	338.46	101.54	6,572.29
Movement	24.62	-58.65	19.71	-14.18	-53.12

1. Month 4 Financial Position Highlights

The Trust's reported deficit in month 4 was £2.5m, which was £0.4m adverse to budget. The Trust's reported deficit YTD at month 4 was £16.0m, which was £2.5m adverse to budget. Excluding MEOC and CDC, the Trust's core deficit in month 4 was £2.8m, which was £0.5m adverse to budget. The Trust's core deficit YTD at month 4 was £16.5m, which was £2.9m adverse to budget. The Trust's core YTD position is mainly driven by ERF underperformance against plan (£3.3m), pay being overspent (£1.7m), which was partly offset with an underspend against Independent Sector usage (£1.2m) and one-off benefits (£1.0m).

The Trust group income position in month 4 was £42.3m, £1.8m favourable to plan and £167.3m year to date and £5.0m adverse to plan. The Trusts core clinical income (excluding MEOC and CDC) was £163.5m, £2.2m adverse to plan. However, within this the ERF is behind plan year to date £3.3m mainly relating to T&O performance which was off set £1.2m by independent sector underspends.

The Trust's core position (excluding MEOC & CDC), on pay expenditure is £1.7m adverse to budget. This is mainly driven by overspends on Medical and Dental and Nursing staff in the Division of Medicine and Division of Urgent and Emergency Care and overspends on Medical and Dental staff in the Division of Women and Children.

The Trust's core position (excluding MEOC and CDC), on non-pay expenditure is £1.5m adverse to budget. £4.0m of this variance is offset with income, therefore the underlying non-pay variance is £2.6m favourable to budget. This is mainly driven by an underspend on Independent Sector of £1.2m, which is offsetting some of the underachievement of ERF, an underspend on utilities of £0.7m and one-off benefits of £1.0m, offset by an overspend on drugs of £0.5m.

This position can be seen in the table below, that shows despite under-performance in activity numbers at both the CDC and MEOC they jointly provide a small surplus against the Trust's core overspend.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust						
M04 July 2024						
1. Income and Expenditure vs. Budget						
Performance Indicator	Monthly Performance			YTD Performance		
	Actual	Variance to budget		Actual	Variance to budget	
	£'000	£'000		£'000	£'000	
Trust						
Income	(49,717)	(1,389)	F	(187,368)	(32)	F
Pay	30,753	(111)	F	125,429	1,695	A
Non Pay	21,040	2,045	A	75,732	1,458	A
Financing Costs	699	(17)	F	2,659	(205)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**2,776**	**528**	**A**	**16,451**	**2,916**	**A**
CDC						
Income	(591)	(115)	F	(2,053)	401	A
Pay	126	(11)	F	540	(281)	F
Non Pay	223	(49)	F	932	(784)	F
Financing Costs	0	0	A	0	0	A
(Profit)/Loss on Asset Disposals	0	0	A	0	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**(242)**	**(175)**	**F**	**(581)**	**(664)**	**F**
MEOC						
Income	(433)	772	A	(1,769)	2,369	A
Pay	222	(180)	F	781	(825)	F
Non Pay	208	(546)	F	1,081	(1,255)	F
Financing Costs	0	0	A	0	0	A
(Profit)/Loss on Asset Disposals	0	0	A	0	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**(3)**	**46**	**A**	**92**	**289**	**A**
Total						
Income	(50,740)	(732)	F	(191,190)	2,738	A
Pay	31,101	(301)	F	126,749	589	A
Non Pay	21,471	1,450	A	77,744	(581)	F
Financing Costs	699	(17)	F	2,659	(205)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**2,531**	**399**	**A**	**15,962**	**2,541**	**A**

Income				Key	Expenditure			
Over-achieved	F	Under-achieved	A	F = Favourable A = Adverse	Underspent	F	Overspent	A

Capital

Year to date capital spend excluding donated assets/charitable funds is £5,424k, compared to a year to date budget of £5,125k therefore showing an overperformance of £299k. YTD capital spend for charitable funds is £2,469k which relates to the Da Vinci Robot and the Stroke Rehab Robot. Therefore, the YTD total capital spend is £7,893k. The committee should note the risk to the planned programme relating to the

cash support requirement to under pin the programme which is not clear in the new NHSE regime the ICB is now under.

Cash

Cash in the ledger has gone down by £2m to £14m. This is despite the Trust receiving £2.2m of revenue PDC support and £1.3m of capital PDC support. The reduction is as a result of £4.7m of capital payments in month, despite the Trust receiving the quarterly Education income in month.

CIPs (Cost Improvement Programme)

In month, the Trust has delivered £1.0m of savings versus the plan submitted to NHSE of £1.3m and therefore is £0.3m adverse to plan. YTD, the Trust has delivered £3.1m of savings versus the plan submitted to NHSE of £3.1m and therefore is on plan.

Trust Forecast and recovery actions

The Trust has undertaken a reforecast for the full financial year which indicates that without stronger financial controls and an increase in income the Trust's financial target is in jeopardy. Following a board discussion a number of enhanced actions have been agreed which will implemented in the next few weeks. These actions are expected to be sufficient to deliver the Trust's financial plan for the year. Work is underway to communicate this in detail to the organisation.

It is worth noting that the Trust's financial controls have been externally assessed by Deloitte LLP for the ICB (along with all ICS organisations) and were found to be rated as strong, with some opportunity to be further enhanced particularly in sickness management and medical staffing. These areas are part of the work programme that will also look at partial vacancy freezes in some areas and further scrutiny on all temporary staffing spending. In addition, the COO has been asked to produce a recovery plan to ensure that the Trusts ERF target is hit. Finally, the Trust will concentrate on fewer CIP schemes to ensure delivery of its CIP plan. Amongst all this activity the Trust Board agreed that patient safety will be maintained and that QEC will be advised of impacts of schemes to provide assurance that this is the case.

Recommendations

The Board is asked to note:

- The Trust's deficit in month 4 (July 2024) was £2.5m, which was £0.4m adverse to budget. The Trust's deficit YTD in month 4 was £16.0m, which was £2.5m adverse to budget.
- Excluding MEOC and CDC, the Trust's core deficit in month 4 (July 2024) was £2.8m, which was £0.5m adverse to budget. The Trust's core deficit YTD at month 4 was £16.5m, which was £2.9m adverse to budget.
- The Trust is moving to tighten financial controls and bring its elective work back into line with plan. These actions are necessary to deliver the Trusts financial plan for the year.

Jon Sargeant
CFO
23 August 24

2409 - D3 HEALTHCARE SUPPORT WORKER BAND 2/3 PROJECT

Information Item | Zoe Lintin, Chief People Officer | 11:05

10 minutes

REFERENCES

Only PDFs are attached

D3 - Healthcare Support Worker Band 2 - 3 Project.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	**3 September 2024**	**Agenda Reference:**	**D3**
Report Title:	**Healthcare Support Worker Band 2/3 Project**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Anthony Jones, Deputy Director of People & OD		
Appendices:	N/A		

Report Summary

This paper provides a short summary and background regarding the work which has been undertaken by the project team to review the Trust Band 2 and Band 3 Healthcare Support Worker roles in line with the review of the national Agenda for Change (AFC) profiles. This work commenced nationally in 2019 and concluded in 2021, and in the absence of national guidance discussions on the application of the changed profiles have taken place at different times in different Trusts with some starting this work in 2019 and others starting in later years.

An updated position in relation to the Healthcare Support Worker Band 2/3 project is also provided specifically in relation to the decisions taken at the confidential Board of Directors meeting on 2 July and a meeting of the Board on 14 August 2024 regarding the implementation date from which any changes to individual roles would take effect.

The paper outlines developments since the original decision on 2 July 2024 which would have resulted in inequity for our colleagues in terms of the DBTH position in comparison with other South Yorkshire acute trusts and the negative impact on employee relations. Therefore, further discussions were held with ICB colleagues and internal Staff Side colleagues.

Following these discussions a decision was taken at the meeting of the Board held on 14 August 2024 to review the effective implementation date from the initial decision of 1 June 2022 to 1 August 2021, bringing DBTH in line with the majority of the local trusts and the majority collective position previously outlined by the relevant unions involved.

Recommendation:	The Board is asked to note the decision made on the 14 August 2024 to agree an implementation (back pay) date of 1 August 2021 for the Healthcare Support Worker project.

Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	**Information only**

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	*We work together to enhance our services with clear goals for our communities.*	***We are efficient and spend public money wisely.***
	South Yorkshire ICS		**NHS Nottingham & Nottinghamshire ICS**	

We believe this paper is aligned to the strategic direction of:	**Yes**		**Yes**
Implications			
Relationship to Board assurance framework:		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
	X	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
		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
		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
	X	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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:			
Resources:	Financial impact is detailed in the paper		
Assurance Route			
Previously considered by:			Executive Team Board of Directors
Date:	Executive team - various dates Board of Directors - 2 July 2024 & 14 August 2024		
Any outcomes/next steps	Decisions made on implementation date, as described in the paper.		
Previously circulated reports to supplement this paper:			

1. Background

In July 2019 a national review of the Band 2 and Band 3 Agenda for Change (AFC) nursing profiles was undertaken by the central Job Evaluation Group. This review resulted in the development of newly defined national profiles for both band 2 and band 3 Healthcare Assistant roles. National profiles are used in support of the Agenda for Change job evaluation process. Each role within the NHS is linked to an appropriate national profile which determines the levels of accountability, responsibility, autonomy, skills and experience required which in turn informs the banding and salary level for each position.

The revised band 2 national profile job statement states that the role is involved in providing personal care to patients whilst the band 3 national profile statement details that the role is involved in carrying out a range of delegated clinical health procedures and duties.

In response to the national review the Trust commenced a piece of work reviewing the job descriptions for nursing support colleagues on both band 2 and 3 job descriptions, as potentially they would no longer be in line with the new national profiles and no longer reflect the expected duties of the roles required within DBTH. All trusts have been carrying out similar exercises, commencing at different times since 2019. Project work commenced at DBTH in late summer 2023, reviewing roles within the Trust potentially impacted by the national changes and significant progress has been made.

This paper sets out the decisions taken by the Board in relation to the effective implementation date for this project, for formal ratification.

2. Board deliberations

The Board considered and discussed the ongoing Healthcare Support Worker Band 2/3 project at the confidential session of the Board meeting held on 2 July 2024, including determining the effective date of implementation. This is a key point as it will be the date from which those individuals who have evidently been operating at the band 3 level and are required to do so, and currently in receipt of band 2 pay, will be moved to a substantive band 3 post. This is also the date from which back pay would apply for each identified individual. The Board discussion at this time supported the implementation date being 1 June 2022, the date at which the issue was formally raised with the Trust and therefore in line with the usual procedure in respect of these matters.

Discussions were also undertaken with the Trust's Staff Side Chair to understand the collective union position in relation to an effective implementation date and union representatives were canvassed with regards to their individual positions. The majority of unions, with the exception of two, identified 1 August 2021 as the date from which any back pay would be calculated for eligible colleagues.

Following the Board meeting on 2 July, some local Trusts formalised their position with regards to the effective implementation date, confirming an effective implementation date of 1 August 2021, resulting in DBTH being an outlier within the ICB. The emerging national picture indicates that the date of 1 August 2021 is also being increasingly adopted by trusts nationally. Therefore, the 1 June 2022 date resulted in the Trust being an outlier in terms of implementation date resulting in inequity for our colleagues as well as having a strong negative impact on employee relations and partnership working relationships with unions.

Discussions were held with ICB colleagues and positive informal conversations were held with internal Staff Side colleagues. In light of these developments, a paper was presented to the confidential meeting of the Board held on 14 August 2024 proposing to agree an implementation date of 1 August 2021 in line with Acute Federation partners, the majority union view and the emerging national picture. The Board agreed to review the previous decision and confirmed support for an effective implementation date of 1 August 2021.

This has since been communicated to internal Staff Side colleagues and regional officers of the relevant unions. Throughout the project, open meetings, one-to-one meetings and communication has been shared with the individuals in scope within this project through a multi-disciplinary working group. The next phase of the project is now underway including communicating more specific information with the individuals involved.

3. Projected Costing Information

Based upon the work undertaken by the project group the projected cost of back pay is estimated to be £1,375,067 which creates a cost pressure to the 2024/25 financial plan of £730,567.

4. Conclusion and Recommendation

Following the discussion and agreement at the 14 August 2024 confidential Board meeting, the Board is asked to note the reasons for its decision to support an effective implementation date of 1 August 2021 for the Healthcare Support Worker project.

BREAK 11:10 - 11:20

?

2409 - D4 RESEARCH & INNOVATION BI-ANNUAL REPORT

Discussion Item

Zoe Lintin, Chief People Officer, Prof Sam Debbage, Director of Education & Resear

10 minutes

REFERENCES

Only PDFs are attached

D4 - Research & Innovation Bi-annual Report.pdf

D4 - Appendix Research & Innovation Presentation.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**D4**
Report Title:	Research and Innovation Update – bi-annual report		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Sam Debbage, Director of Education and Research Jane Fearnside, Head of Research		
Appendices:	Research and Innovation Update presentation		

Report Summary				
Purpose of the report & Executive Summary The presentation provides an update on the research and innovation activity across DBTH aligned to deliverables in year 0 and areas of growth, development and opportunity for year 1 of the Research and Innovation Strategy (2023 to 2028).				
Recommendation:	The Board is asked to note the work to date and take assurance that the R&I Strategy continues to be delivered in accordance with agreed milestones and quality indicators.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	Information only

Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications			
Relationship to Board assurance framework:		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
	X	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
		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
	X	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
		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

		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
	X	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:			
Resources:	Business plan is being drafted to support ongoing delivery of the Research and Innovation Strategy		
Assurance Route			
Previously considered by:		People Committee	
Date:	20 June 2024		
Any outcomes/next steps	Committee assured, bi-annual update to be presented at Board in September 2024		
Previously circulated reports to supplement this paper:			

Research and Innovation update

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

- University Teaching Hospital status
- Delivery of Year 0 of R&I Strategy
- Growth of place-based R&I activity
- Working across the system
- Emerging opportunities for R&I growth

Key achievements

Clinical academics

- **Growth of our clinical academic pipeline**
  - Prof. of Maternal & Infant Health
  - Senior Clinical Lecturer in Public Health
  - 3 x post-doctoral fellows
  - National Institute of Health and Care Research (NIHR) Senior Clinical Practitioner Award
- **Bespoke training & development implemented**
  - 2nd cohort of Chief Nurse Interns
  - Launch of the Research Academy
  - Formal innovation training, provided by the University of Lincoln

Industry partnerships

- **Growth in commercial research**
  - Human Tissue Authority License awarded to support ambitions to deliver different types of studies
  - Over £30K in commercial research incentives achieved
- **Collaborations with Small to Medium Enterprises (SMEs)**
  - NHS partner on a study for reducing carbon emissions in pressure ulcer care pathways
- **Real-world evaluations**
  - Rewire – stroke rehabilitation
  - Peezy – urine sample collection

R & I activity

- **Achieving our ambition**
  - Increase in Research Capability Funding (RCF) from £25K to £40K
  - Increase in funding application submissions
  - Agreement in principle of DBTH to host research in line with our capabilities
- R&I infrastructure
  - New infrastructure models currently being tested (secondments, fixed term contracts)
  - External funding applications submitted and awarded
- Growth in strategic priority areas
  - Stroke research
  - Maternal and women's health

Research governance:

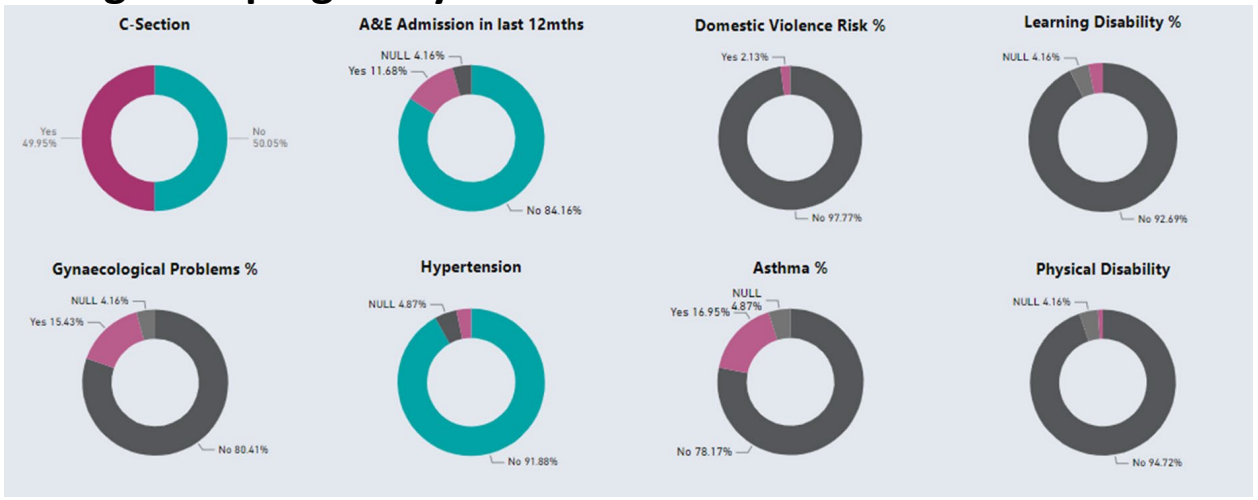
- Sponsorship capabilities
- Regulatory compliance
- Clinical research facility

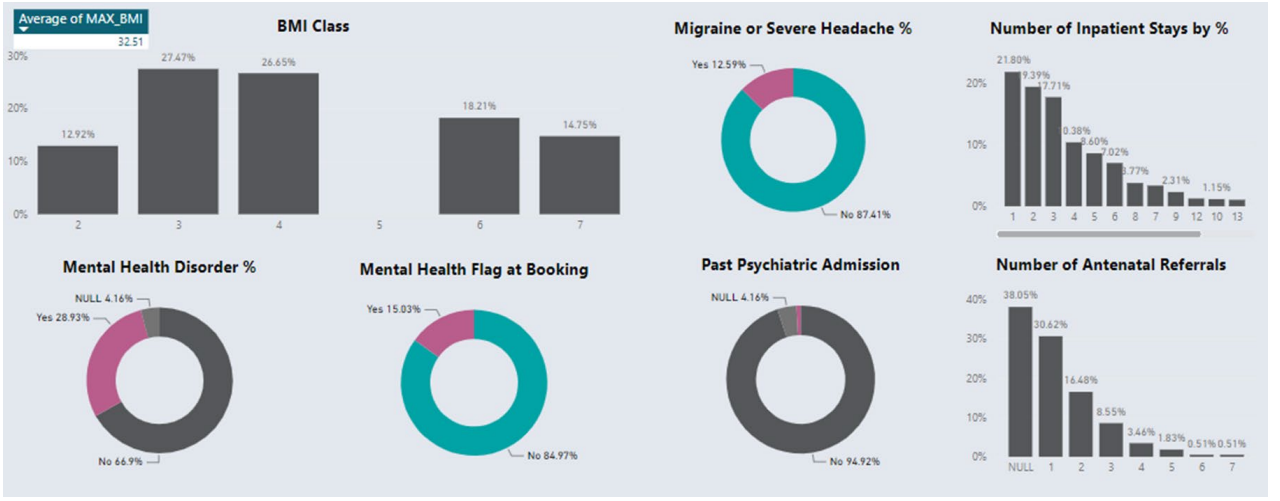
Areas of focus

BaBi-D – the story so far

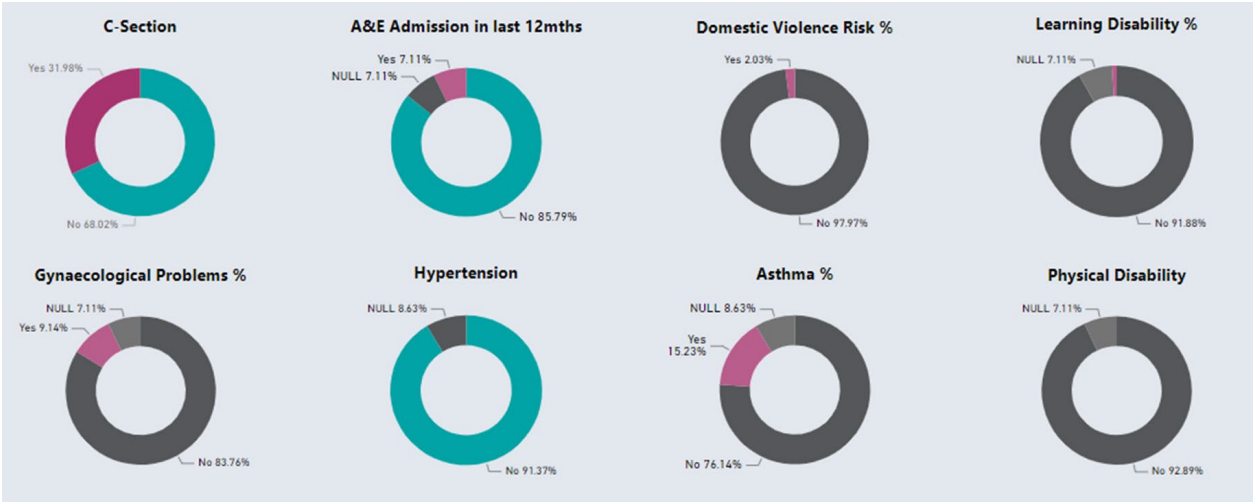
1461 consented pregnant people, 1269 babies: High risk pregnancy: 83.33%

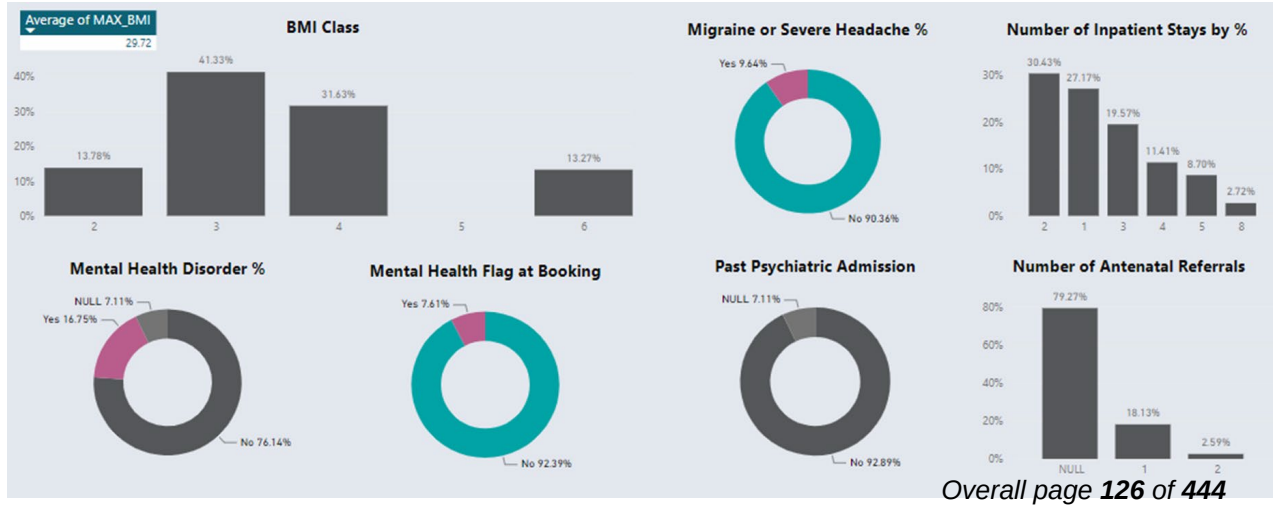
Is high risk pregnancy



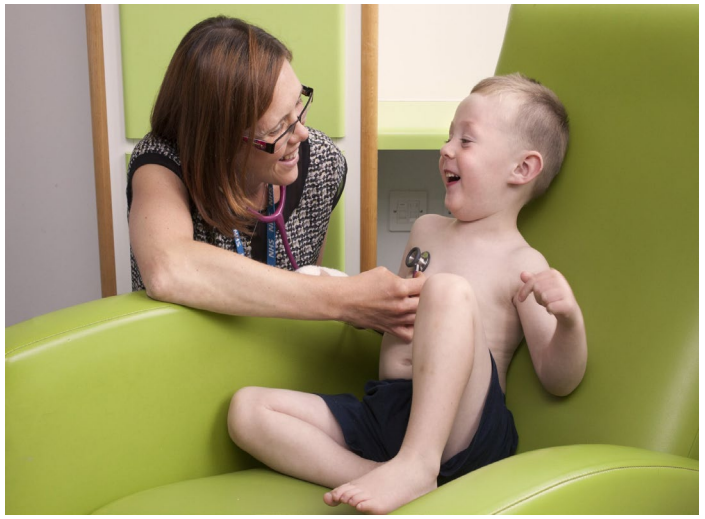


Is NOT high risk pregnancy





"Children are 50% of the population but 100% of the future" *Professor Paul Dimitri, Professor of Child Health, Sheffield Children's Hospital*



- Conference aims: To better understand and address the complexities and issues surrounding maternal and child health by identifying practical solutions.
- Outputs will include:
  - A research and innovation pipeline that addresses the unmet need of patients, our community and the NHS
  - Involvement from our underserved communities to drive R&I that really matters to them
  - Opportunities to transform DBTH services and use R&I to support service need
  - Greater exposure of opportunities across the region and an opportunity to share learning and best practice

Thank you, any questions?

2409 - D5 PATIENT EXPERIENCE ANNUAL REPORT

Discussion Item | Karen Jessop, Chief Nurse | 11:30

5 minutes

REFERENCES

Only PDFs are attached

- D5 - Patient Experience Annual Report.pdf
- D5 - Patient Experience Annual Report 2023-2024.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**D5**
Report Title:	**Patient Experience Annual Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Grace Mhora, Head of Patient Engagement, Experience and Involvement		
Appendices:	n/a		

Report Summary

This annual report provides a review of our patient experience data collected through the Friends and Family Test (FFT), National Surveys as well as themes from PALS enquiries, complaints, website communications and engagement events. It also features work undertaken and presented to our patient experience and involvement committee.

Key points:

- In the 2023/2024 financial year, 620 complaints were reported to the Trust. This was a 16.1% reduction from 2022/2023 financial year when the total complaints reported were 739.
- There were 122 patient feedback submissions to patient opinion in 2023/2024. Each opinion is responded to and feedback provided to the relevant service for action/information.
- As part of a drive to improve response rates, in January 2024, the Trust changed the way in which we collect our FFT feedback. The Trust were able to procure the services of Iwantgreatcare for a "pilot" period of 12 months, to support the data collection and analytics of the friends and family test survey. This has increased the options for patients to feedback to include text messages alongside paper forms and QR codes it has improved our response rate.
- The Trust has led twelve engagement events throughout 2023/24
- On average, there are 170 volunteers. This was an increase from the previous year when the Trust had an average of 157 volunteers
- Following a successful NHS Charities Bid the Trust were able to commission the People Focused Group as the Trust's engagement partners over a twelve-month period
- Objectives for 2024/ 2025 are included within the report.

Recommendation:	Trust Board is asked to take assurance from the annual patient experience report.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*

We believe this paper is aligned to the strategic direction of:	South Yorkshire ICS	NHS Nottingham & Nottinghamshire ICS
	Yes /~~No/ NA~~	**Yes /~~No/ NA~~**

Implications			
Relationship to Board assurance framework:	**x**	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
		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
		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
		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
		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
	x	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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **~~YES~~/NO**		
Legal/ Regulation:	Health and Social Care Act and regulatory requirements (CQC). Could result in regulatory action if not achieved.		
Resources:	Nil		

Assurance Route	
Previously considered by:	Patient Experience and Involvement Group
Date:	June 2024.
Any outcomes/next steps	Approved.
Previously circulated reports to supplement this paper:	N/A

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

DBTH Patient Experience Annual Report 2023/24

dbth.nhs.uk/dbth-patient-experience-annual-report-2023-24

There are a number of sections within this document. Using the links below, or to the side, you can skip to specific sections.

If you need this page in another language, please head to: https://translate.google.co.uk. For more accessibility options and information, please visit: https://www.dbth.nhs.uk/a-z/accessibility/

Introduction

Our vision as a Trust is: “Healthier together – delivering exceptional care for all.”

This is further complemented by our priority statements, values and the DBTH Way.

An image explaining the Trust's vision and priority statements, the full explanation can be viewed here.

This annual report provides a review of our patient experience data collected through the Friends and Family Test (FFT), National Surveys as well as themes from PALS enquiries, complaints, website communications and engagement events. It also features work undertaken and presented to our patient experience and involvement committee.

Activity

As an organisation, we have built upon the achievements and performance of the previous years, improving in some aspects of care, whilst upholding standards in others. We have also maintained a focus upon good financial performance, with an eye on capital developments and sustainability.

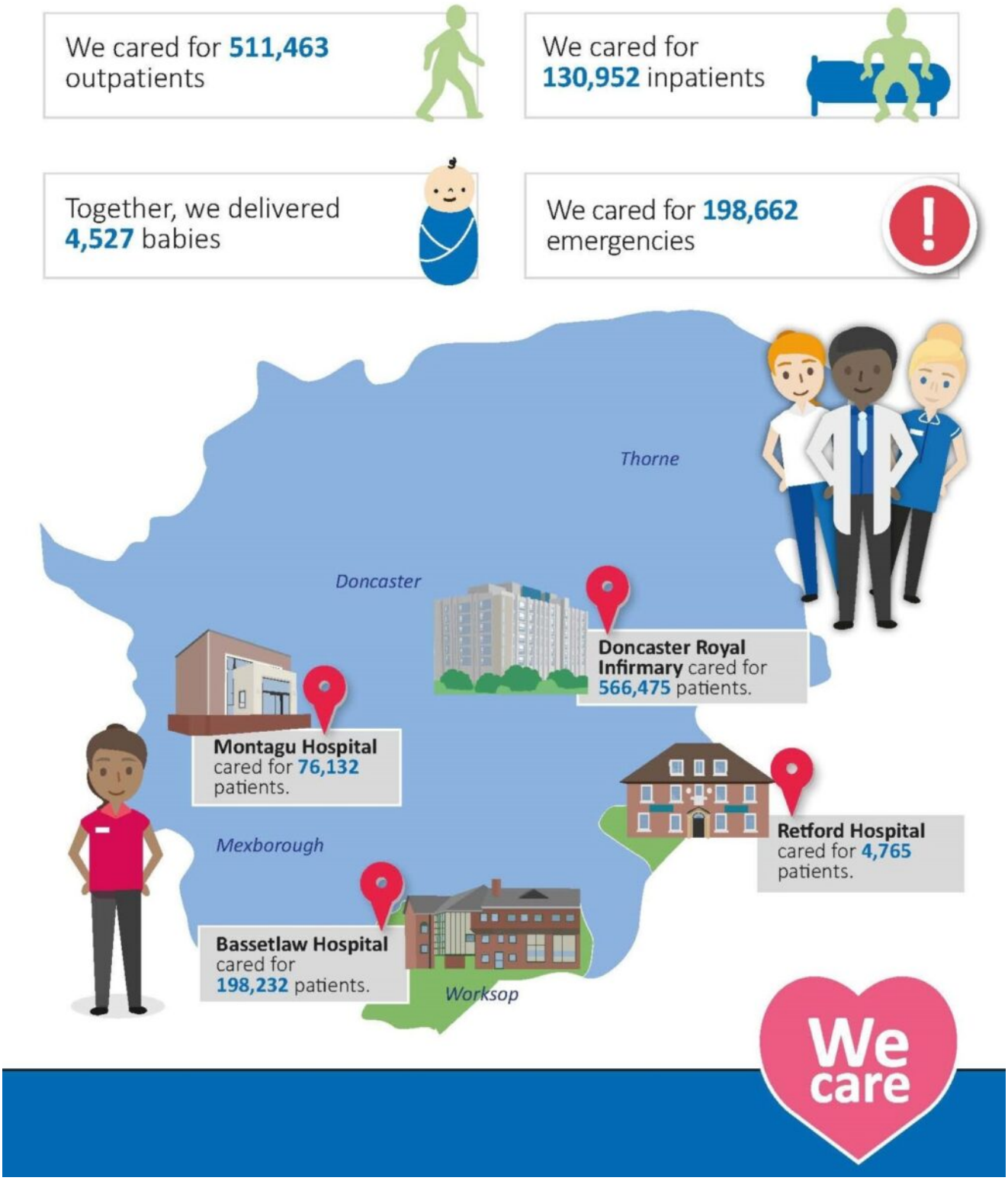
Our activity in 2023/24:

- We cared for 511,463 inpatients.
- We cared for 130,952 outpatients.
- We cared for 198,662 emergencies.
- We delivered 4,572 babies.

In comparison with 2022/23:

- We cared for 15,150 more inpatients.
- We cared for 29,041 more outpatients.
- We cared for 4,631 more emergencies.

- We delivered 66 fewer babies.



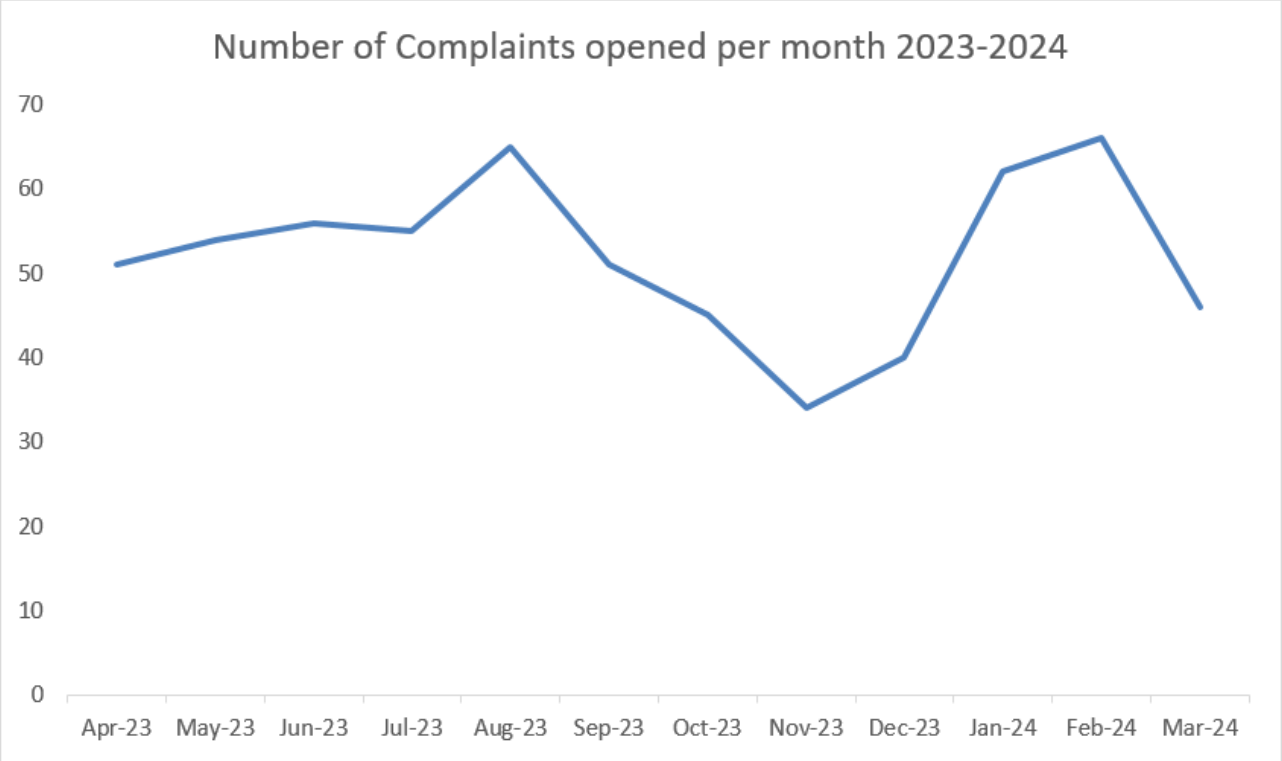
Experience

In this section:

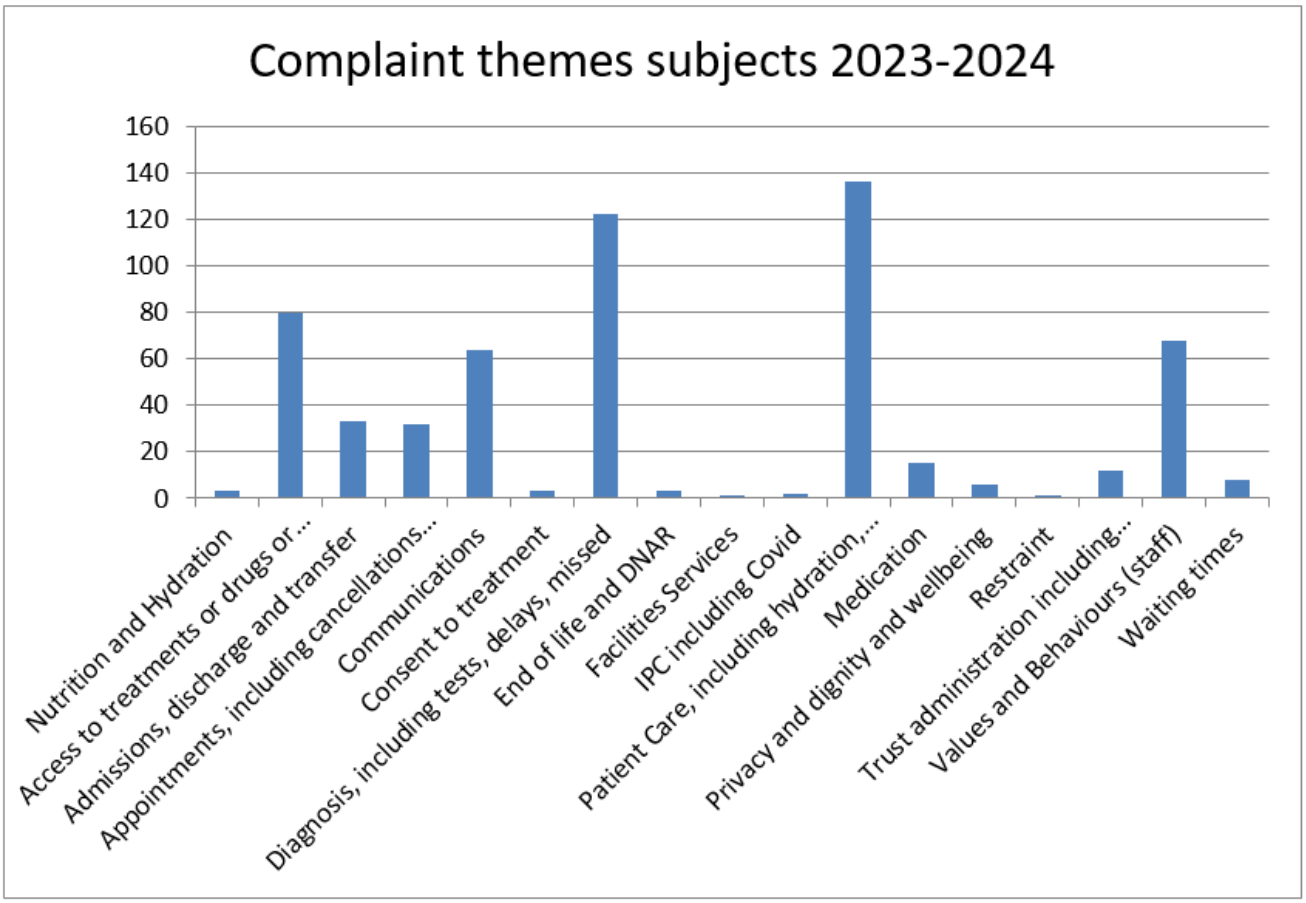
Complaints

In the 2023/2024 financial year, 620 complaints were reported to the Trust. This was a 16.1% reduction from 2022/2023 financial year when the total complaints reported were 739.

The table below outlines the monthly reporting of complaints.



The table below outlines the key themes from complaints reported throughout the year.



The top theme in complaints was related to Patient Care, including hydration and nutrition with 136 complaints reported. The second most frequent theme was Diagnosis, including tests, delays, missed which had a total of 122 complaints reported.

The third most frequently reported complaint theme was Access to treatments, or drugs or equipment or appliances with 80 complaints received.

Top Themes: examples of complaints received.	
Theme	
Patient Care, including hydration and nutrition	Fracture not healing within the expected time.
	End of life care.
Diagnosis, including tests, delays, missed	Delayed diagnosis of Fracture
	Delayed diagnosis of Eye ulcer.
Access to treatments, or drugs or equipment or appliances	Waiting for hearing aid.
	Waiting for splints.

Complaints

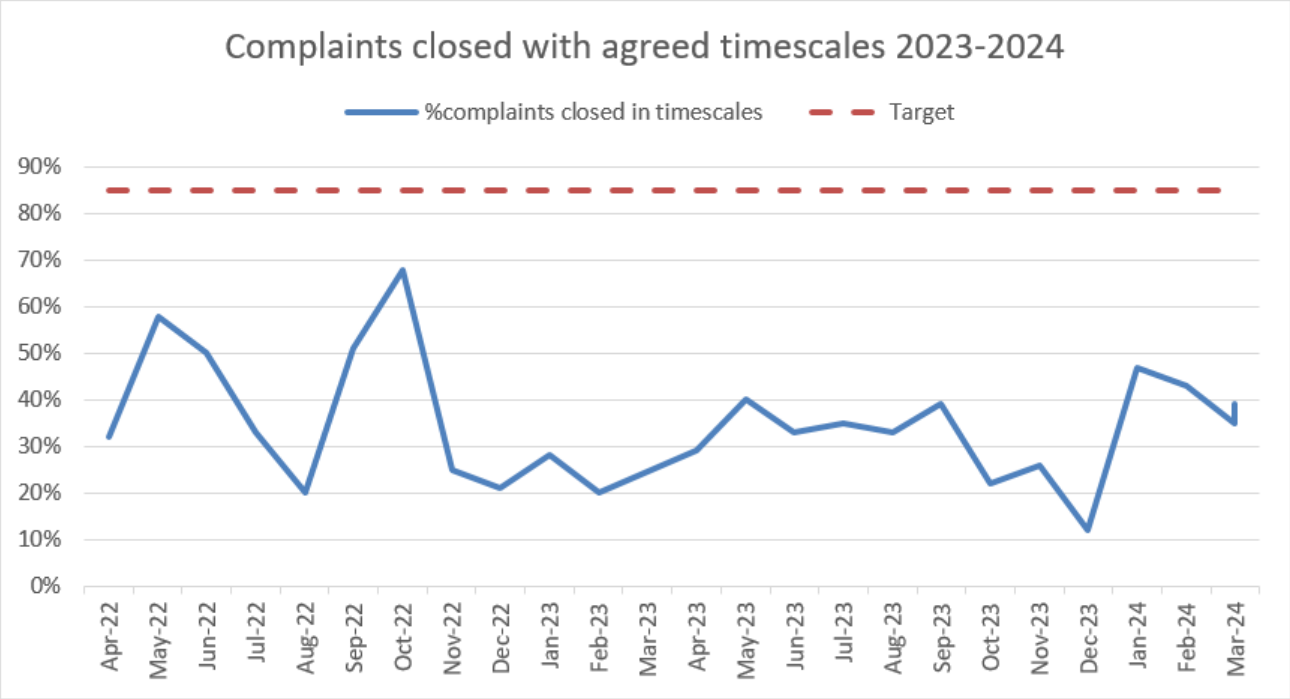
Acknowledgement within three days: Local and national guidance requires that all complaints are acknowledged within 3 working days. The Trust sets itself a 95% compliance target in this area. The Trust has met this target throughout the year.

Complaints closed within agreed timescales: Meeting the proportion of complaints closed within the agreed timeframe has been challenging throughout the year.

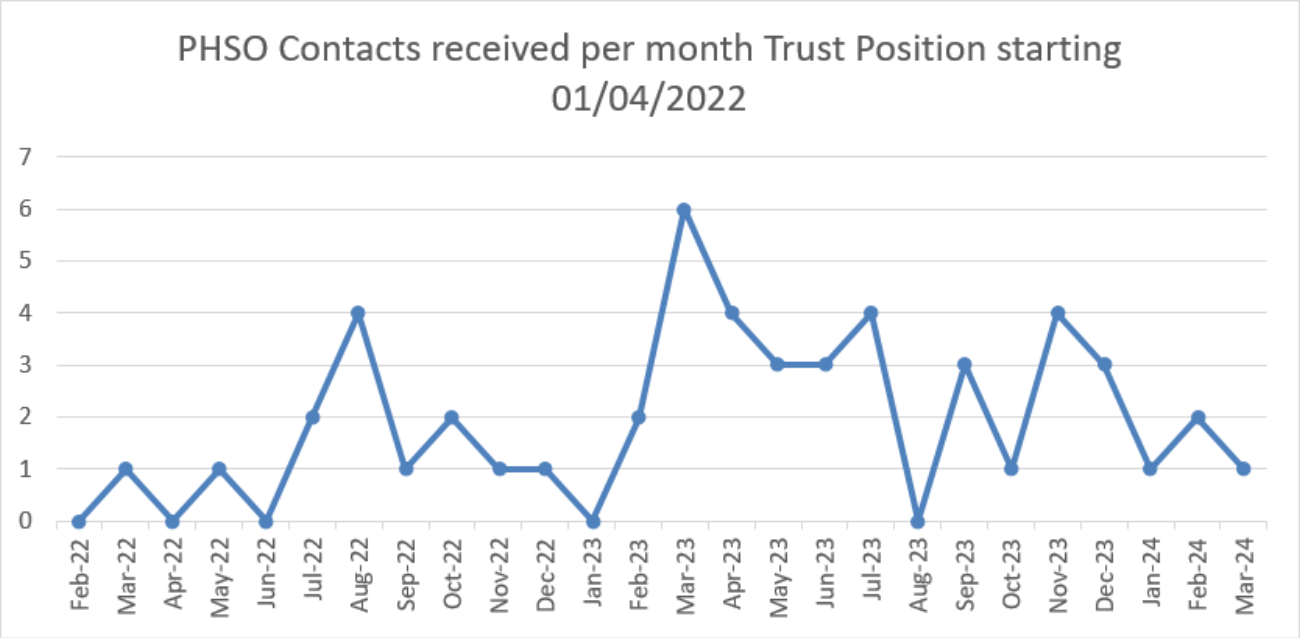
A concerted effort was made during 2023/24 to recover the number of overdue complaints at the beginning of the financial year, which was 120. This reduced to 14 complaints overdue at the end of March 2024. During 2023/2024 work has been undertaken with the Divisions to improve complaints management processes and recruitment to key posts. This engagement work has supported the revision of the complaints policy to comply with the Parliamentary Health Service Ombudsman (PHSO) standards.

The closure of complaints within the agreed timeframe has remained below the set target throughout the year.

The table below provides the 2023/2024 ongoing position on the closure of complaints within the agreed timescales, which has remained below the Trust threshold of 85% throughout the 2023/2024 financial year. It should be acknowledged that, due to small numbers, caution should be taken when interpreting the data.



Parliamentary and Health Service Ombudsman (PHSO): The number of PHSO contacts reduced from the previous year, with an average of two requests for information made per month.

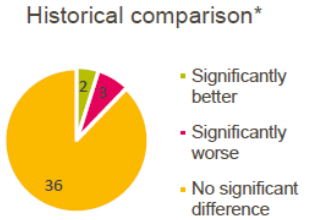


Inpatient Survey

The Trust participated in a number of Picker Surveys through the year.

1250	1156	40%	40%	33%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (463)	Average response rate for similar organisations	Your previous response rate

80%	Q46. Rated overall experience as 7/10 or more
98%	Q45. Treated with respect and dignity overall
97%	Q17. Had confidence and trust in the doctors



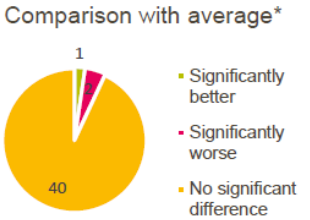
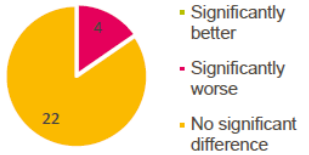


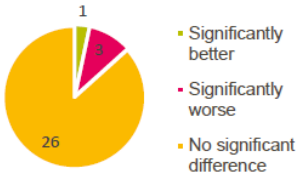
*Chart shows the number of questions that are better, worse, or show no significant difference

Urgent and Emergency Care results

580	575	17%	21%	28%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (99)	Average response rate for similar organisations	Your previous response rate

83%	Q41. Rated experience as 7/10 or more	Historical comparison*	Comparison with average*
96%	Q40. Treated with respect and dignity		
96%	Q17. Had confidence and trust in the health professionals		





Children and Young People's Patient Experience Survey

This survey is scheduled to be conducted in 2024.

Maternity Survey results

385	383	41%	42%	27%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (156)	Average response rate for similar organisations	Your previous response rate

97%	C21. Treated with kindness and compassion during labour and birth	Historical comparison*	Comparison with average*
94%	C18. Had confidence and trust in staff (during labour and birth)		
88%	C20. Felt midwives or doctor aware of medical history (during labour and birth)		

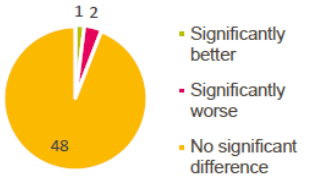


*Chart shows the number of questions that are better, worse, or show no significant difference

Action Plans were developed following all the CQC survey results and were monitored by the Patient Experience and Involvement Committee.

Patient opinion

There were 122 patient feedback submissions to patient opinion in 2023/2024. Each opinion is responded to and feedback provided to the relevant service for action/information.

Example of positive feedback:

> “Every bed was full and staff were constantly back and forth. I genuinely expected a longer wait but the staff were amazing. If one person couldn’t answer a question or worry, it was less than 5 minutes before someone else did. I had to go to 2 separate imaging departments and was taken promptly by very kind and reassuring staff. I also had to wait for a consultant from a separate department and they arrived very quickly despite being based elsewhere in the hospital.
>
> I was well informed and was very well cared for. It was clear that all staff showed care and compassion to all those around me. It is hard being in a hospital bay but simply hearing the staff and how kind and caring they were made the experience much better than I thought when the ambulance was initially called.”

Example of positive feedback:

> “The NHS has been marvellous however from all the community care I have received from the nurses. I’ve had nurses out for ulcers and falls team out previously and they have been so kind and caring.”

Friends and Family Test

The Friends and Family Test (FFT) is a national survey designed to give the public an easy way to provide feedback on their experience.

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

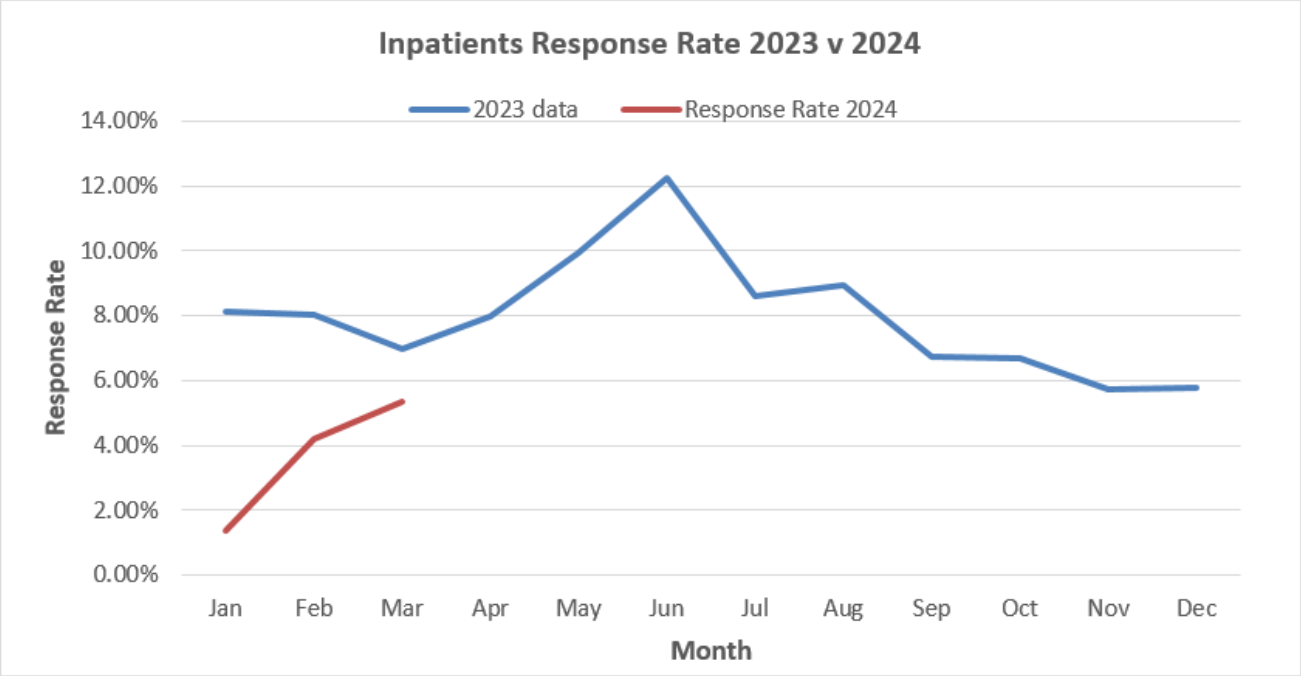
Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

The FFT is made up a single mandatory default question followed by at least one open free-text question, so that people can tell us what they want us to know in their own words. The number of responses received for the friends and family test survey can be used as a sense of how effectively we have implemented the friends and family test survey as well as allowing us to review if are consistent with other settings in the proportion of responses received.

As part of a drive to improve response rates, in January 2024, the Trust changed the way in which we collect our FFT feedback.

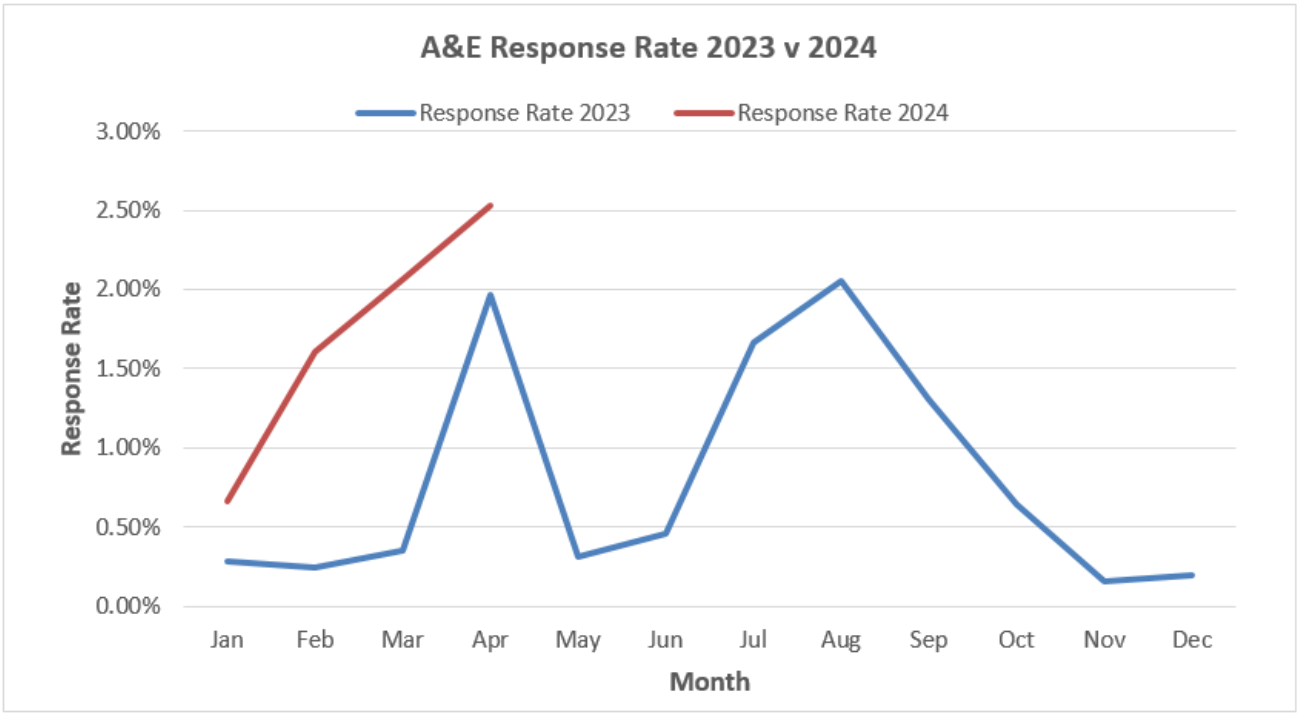
The Trust were able to procure the services of Iwantgreatcare for a “pilot” period of 12 months, to support the data collection and analytics of the friends and family test survey. This would increase the options for patients to feedback to include text messages alongside paper forms and QR codes with the aim of improving the response rate. Iwantgreatcare also allows patients to complete the survey in other languages providing an inclusive way for feedback. Following the launch initially, there was aninitial reduction in the overall response rate.

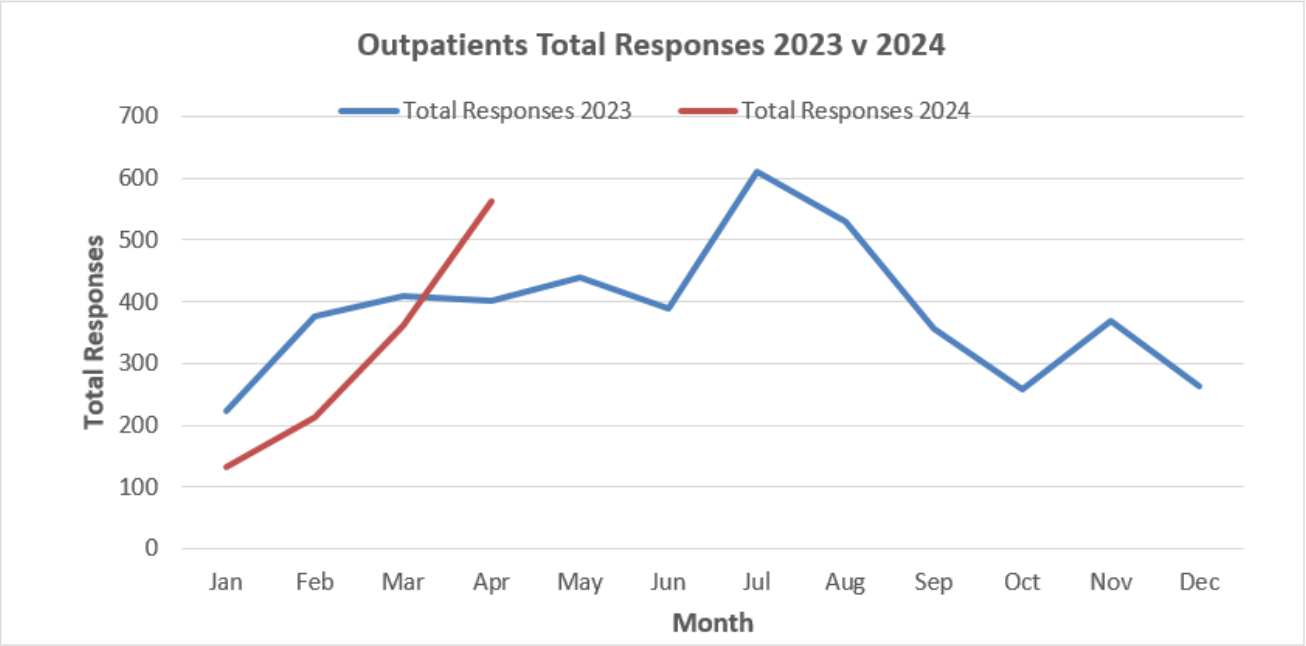
Engagement with staff has identified that some ward staff had stopped giving patients the paper forms, assuming the survey was now electronic only. Regular ward visits are being undertaken to capture the majority of staff and ensure they are aware of the changes to the survey. The overall trend shows increasing responses month on month. It is anticipated the number of responses will continue to increase throughout the year.



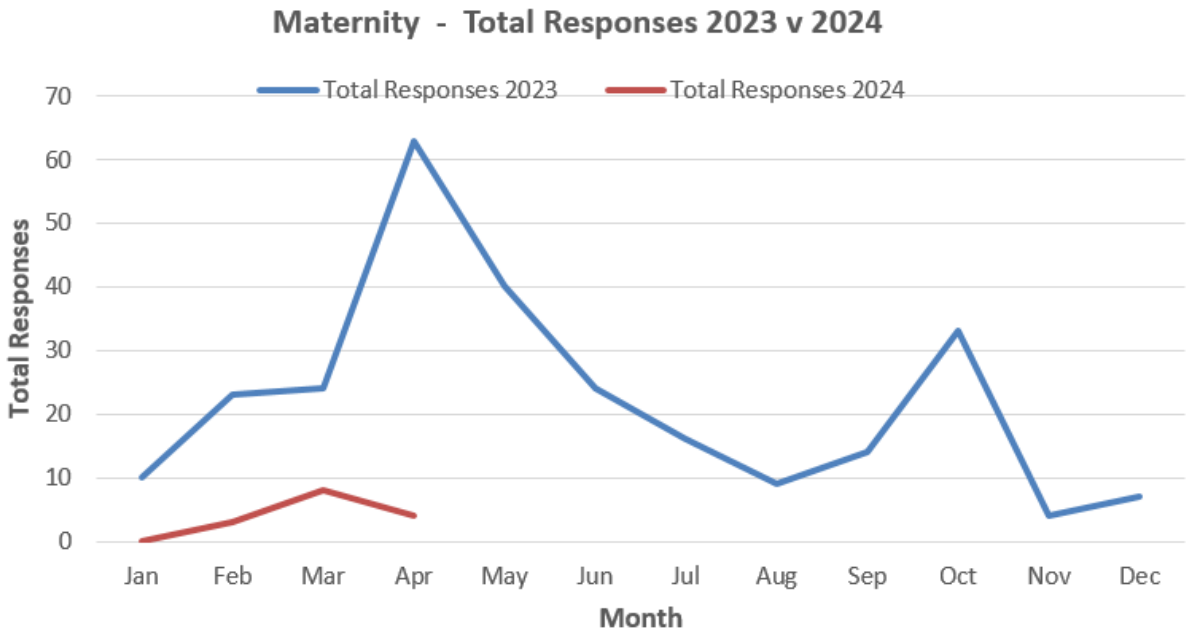
The overall the Trust Inpatient response rate has maintained below 10%. This is significantly below the average Inpatient response rates of other Trusts and there is work ongoing in the Trust to improve this by providing additional means to provide feedback to include text messages. Other work include:

- Nominating a member of staff to offer FFT forms to patients daily.
- Changes to the text messages to allow ease in completing the survey including sending patients a direct link to feedback on the department they were in so they are not having to look through the messages.





Please note the outpatient response rate in per count instead of proportion as the footfall for these areas was not being recorded for the period in order to calculate a proportion.



It should be noted, that following the transfer of the FFT survey to include SMS messages, there was a request from Maternity to exclude those patients who were undergoing safeguarding procedures. Data was not sent to Iwantgreatcare to commence SMS messages in Maternity until a process was agreed.

Accessible Information Standard

From 1 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standards (AIS). AIS aims to set out a specific, consistent approach in identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

The Accessible Information Standards working group was re-established during 2023 and meets regularly to work towards getting the Trust fully compliant with the standard. As part of their work they have established:

- The Trust's main Patient Access systems have the ability to create flags on the system.
- The question regarding communication needs should be routinely asked as part of nursing assessment.
- The communications department has developed posters for patients aimed at ensuring they are aware that they can request information in other formats from the staff. There are also posters that have been developed for staff to increase the awareness of staff on the Accessible Information Standard and shared by the Trusts communications team.
- The Accessible Information Standard Group is also involving local community groups including the deaf community and partially sighted society.
- The Trust has co-developed a draft Accessible Information and Community Policy with community groups which will replace the Trusts Translation Policy.
- As part of the feedback received, the Trust has procured a variety of translation services in order to meet patient communication needs, including video relay messaging, face to face British Sign Language (BSL) interpreting service, face to face language interpreters, telephone interpreters, translation of documents into other languages as well as other formats such as Braille.
- The Trust has begun a review of its letter templates based on patient feedback.
- In December 2022 NHS England published guidance on the national reasonable adjustments flag and work is ongoing in the Trust to enable compliance with the requirements.

Engagement and involvement

The Trust has participated in twelve engagement events throughout 2023/24

Public/Community Engagement Piece of Work (Completed in the Last Year)	Groups Engaged With for Their Views	Insights Gained	Actions Taken
Feedback on Trust Leadership framework.	Community groups engagement via Health-watch	There was great praise for the first page of the document and the ‘we care values’; there was also some feedback regarding some of the wording that could have been improved.	Feedback shared with lead and Leadership framework has since been launched.

Engagement event attended the People focused Group	Community voluntary sector Group. Feedback from patients who community warden visited.	One stated they were admitted late and they were not given food the next day as she was not there when she ordered. One lady said ‘you are doing a good job’.	Sodexo have actions in place to ensure patients who are admitted late are accounted for in the meals.
Engagement event – Doncaster race course.	Community event	As part of being visible in the community, the Trust attended local community events and had a stand at Doncaster racecourse during their family day. We obtained feedback from patients regarding what matters to them post-hospital stay. Feedback regarding Ambulatory Care Unit: staff were friendly, it was clean, no long wait times, and everything was well explained. Feedback related to the Maternity service: staff were friendly, approachable, and gave good advice. Fracture Clinic: long waiting times. Cataract eye surgery: very friendly.	This feedback was given to the responsible teams.
Engagement event – Partially sighted society	Local Voluntary Sector group.	The partially sighted society fed back on our communications and how we can improve patient access to our letters.	Partially Sighted Society invited to Accessible Information Standards working group. Accessible information standard policy has been drafted with feedback from the group.

Review of eliminating mixed sex accommodation policy.	Feedback from community groups through health watch. Feedback also obtained from staff LGBT Forum.	Feedback on policy language and terms.	Revised policy now been ratified.
Development of Patient Safety Incident response framework patient leaflet.	Feedback obtained from community groups through health watch, also received from the deaf community.	Feedback asked if the language could be changed and there was also a request for BSL video from the deaf community.	The leaflet language was changed to make it easier to understand. A BSL video was also developed for the leaflet and published on the patient safety page.
Feedback on the Nursing and Allied Health Professionals Strategy.	Obtained feedback from community groups on the Nursing and Allied Health Professionals Strategy.	Feedback on the presentation and understandability of the document for members of the public.	Amendments made to the final document based on the feedback.
Focus Group – Deaf community	Focus group feedback on the trust.	Feedback regarding letters only having a telephone number for contact, request for video relay messaging, request for review of interpreting service. A request also made for calling screens in outpatients. There was also feedback regarding the Trust's Audiology Department.	Changes made to the information at the back of our trust letters to also include an email address contact. The trust now has a video relay messaging service available. A request for patient calling systems has been added to the specification of our patient kiosks when they are reviewed.

Community Event – Bassetlaw multicultural event	Community engagement event	Feedback from attendees was positive, especially around the use of simple language to make it easier for patients to understand.	Information shared with teams.
Community Veterans focus group	Community engagement event	They provided feedback regarding the importance of identifying if patients are Veterans, giving examples such as the Royal British Legion funding hearing aids for Veterans. One gave their view stating ‘don’t ask don’t care’. They explained the impact of Post-Traumatic Stress Disorder and that when staff do not understand their condition, they can easily trigger them. They felt more comfortable with services run by ex-Veterans as they understood them.	The Trust has reaccredited as a Veterans aware hospital. The Trust has also changed its documentation for nursing to have a mandatory question asking if a patient is currently serving or has served in the British Armed Forces and another asking if a patient is a close family member of somebody who is serving or has served in the British Armed Forces.
Community event – Senior citizens fair	Community engagement event	The majority of the feedback was positive with only one person feeding back about staff attitude which can be improved.	This was shared with Divisional Nurses in the Patient Experience and Involvement Committee.
Community engagement event Parkinson’s up	Community engagement event	There was some feedback regarding Audiology waiting times. There was also feedback regarding essential medications for Parkinson’s and the timeliness of its administration.	There is an Audiology Quality improvement project which is currently ongoing. The Divisional Nurse for Medicine is leading a working group on improving the timely administration of essential medicine.

Volunteers

Volunteers are integral in enhancing the quality of care to patients at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT).

There are a wide range of roles undertaken by our dedicated volunteers; escorting patients around the hospital, ward volunteers, clinic volunteers, library volunteers and A&E Volunteers. We are in the process of developing new roles for the Dietetics Department and Pharmacy.

On average, there are 170 volunteers. This was an increase from the previous year when the Trust had an average of 157 volunteers.

During 2023/2024 the Trust recruited 19 volunteers. To support our recruitment process we are engaging with communications to utilise the Trusts social media platforms and we advertise our positions on the BCVS (Bassetlaw Community and Voluntary Service) website.

The Trust also participated in the South Yorkshire Volunteering for Health Bid, as well as the Nottinghamshire Volunteering for Health Bid. The South Yorkshire bid aims to create meaningful volunteering experiences for people in under-represented groups, strengthening Place and system level cross sector volunteering opportunities.

The Nottinghamshire Volunteering for Health Bid focused on a BCVS recruiting volunteers for Bassetlaw site hospital. We are currently awaiting the outcome for both bids.

Work also began on the development of a Trust database to manage volunteers and record hours as well as demographic data. This will support a more strategic recruitment as we will it will focus our recruitment of volunteers in those groups that are underrepresented.

Innovation

Following a successful NHS Charities Bid the Trust were able to commission the People Focused Group as the Trust's engagement partners over a twelve-month period. As part of this project, peer supporters will be spending time in the following areas:

- The Emergency Department at DRI
- the Emergency Department at Bassetlaw Hospital
- St Leger Ward DRI St Leger Ward 9 (Orthopaedics)
- Mallard DRI Mallard Ward (Gresley Unit) – Dementia
- SEND Therapies DRI
- Audiology Sandringham Road Centre
- Montagu Hospital Audiology
- Bassetlaw Hospital Audiology

- Ward 26 DRI Ward 26 (Surgical Unit)
- Elective Orthopaedic Mexborough Elective Orthopaedic Centre
- Mexborough Community Diagnostic Centre

Peer supporters will get to know patients and the Trust services providing a unique community led view of each area. They will also be the link to ensuring the patients' voice is central to receiving excellent care across the Trust.

The Peers have also participated in the Trust Care Accreditation Audit undertaking care questions for the Audit. This provided patient opinion on services as well as getting unique insights on feedback patients gave to the peers on their experiences of care. The People focused group are also assisting the Trust in recruiting to its citizens panel through its wide network of patient groups. The aims is that by the time the twelve month pilot has ended the Trust will have a functional Citizens' Panel and Readers' Panel.

The project and peer engagement will be evaluated following the 12-month period.

The next 12-month and beyond

Our plans for the next 12-months are as a follows:

- Provide a wide variety of ways for patients to feedback to us.

- Hold community engagement events and work with Healthwatch and voluntary sector organisations in the community to gain insight and feedback from the community including those groups who are seldom heard or affected by health inequalities.
- Embed and Audit Carers Charter/Contract.
- Embed and Audit the John's campaign principles.
- Review our complaint handling process for opportunities to provide swifter resolution for people when they raise concerns.
- Review patient experience reporting and escalation procedures to ensure Chief Nurse and Board have oversight of patient experience.
- Establish a patient forum and engagement panel.
- Achieve compliance with Accessible Information Standard.
- As part of the Patient Safety Incident Response Framework Introduce of Family Liaison Officers
- Introduce "relative ward rounds" across inpatient areas.
- Embed, patient involvement and co-design into our organisations Policies, Procedures and Governance. Integrating the patient, family and carer voice within our everyday business.
- (Improve how we) Celebrate success stories when we've engaged with patients/families to change services and feedback on changes is positive. ('You said we did') and demonstrate and share learning where things haven't gone so well.

Proposed Developments for the Volunteer Services for 2024/2025

- Develop a Volunteer Strategy.
- Work more closely with other organisations and educational bodies to develop volunteer roles aligning evolving healthcare roles.
- Increase the current level of volunteer activity reflecting the diverse local population.
- Maintain and continue to raise the profile of the value of voluntary services within the Trust and the community.

Content out of date? Information wrong or not clear enough? Report this page.

2409 - D6 BOARD ASSURANCE FRAMEWORK & TRUST RISK REGISTER

Discussion Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance & Execut

20 minutes

REFERENCES

Only PDFs are attached

- D6 - Board Assurance Framework & Trust Risk Register.pdf
- D6 - Appendix 1 BAF.pdf
- D6 - Appendix 2 Trust Risk Report.pdf
- D6 - Appendix 1 BAF.xlsx

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**D6**
Report Title:	**Board Assurance Framework (BAF)**		
Sponsor:	Zara Jones, Deputy Chief Executive Officer		
Author:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance		
Appendices:	Appendix 1 - BAF (risk 1-7) Appendix 2 - Trust Risk Register 15+		

Report Summary

Purpose of the report & Executive Summary

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of our Strategic Priorities, People, Patients, Partnerships and Pounds. The BAF sets out the 'three lines of defence' or key controls which are in place to support delivery of those priorities and to mitigate risk. It provides an assurance map, aligned with the business undertaken through our Committees, which the Board can draw upon when considering the effectiveness of those controls. Where gaps in controls or assurance are identified, action plans are in place, which either provide additional assurance or reduce the likelihood or consequence of the risk identified towards the target.

The Board Assurance Framework is enclosed in appendix 1 for Board review and assurance. The BAF will continue to develop in line with the developing strategy and identified milestones. A review of the highest risks and their impact on this will be reviewed via the Board Development session in December 2024.

There are a number of key observations to draw out from the updated BAF:

- There is one BAF risk with a score of 20 (extreme). Risk 4 which links to identified estates risks, which impact patient care and efficient use of public money. While this remains high due to the age of the estate, there is significant assurance around the mitigations in place to maintain critical infrastructure. This is reviewed at Finance and Performance committee.
- BAF risk 1 and 5 both have a score of 16. Risk 1, *'We deliver safe, exceptional, person-centered care'* is monitored through the Quality and Effectiveness committee. There has been a recent change to the operational clinical governance structure which will be reviewed as this becomes embedded. Risk 5 *'We are efficient and spend public money wisely'* is reviewed through the finance and performance committee. There has been a raft of measures to address the current overspend within the Trust which are mirrored at system level. Board have been kept updated on current issues and taken assurance on the mitigations in place.

The top 3 risk themes on the Trust Risk Register remain as:

- Workforce
- Finance
- 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.

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 for 24/25.

Recommendation:	The Board is asked to note the updated BAF strategic risks for 2024/25 (appendix 1) & updated Trust Risk Register (TRR15+)			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	**Information only**
Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications			
Relationship to Board assurance framework:	**x**	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
	X	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
	x	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
	X	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
	x	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
	x	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
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES**		
Legal/ Regulation:	The Well led framework requires Boards to have an effective Board Assurance Framework in place and regularly reviewed within its governance arrangements		

Resources:		
Assurance Route		
Previously considered by:		Delegated Committees of the Board
Date:	Finance and Performance, 25 July 2024 People Committee, 20 June 2024 Quality and Effectiveness Committee 6 August 2024	
Any outcomes/next steps		The BAF will be reviewed as part of the Board Development Session in December 2024
Previously circulated reports to supplement this paper:		N/A

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision is:

Healthier together – delivering exceptional care for all.

Our four strategic priorities are:

BOARD ASSURANCE FRAMEWORK

September 2024

BOARD ASSURANCE FRAMEWORK SUMMARY

Sep-24

Strategic Priorites	BAF Ref	BAF Executive Owner	Strategic Risk IF	Strategic Risk THEN	Oversight Committee	Target for March 24	Apr-24	May-24	Jun-24	Jul-24	Aug-23	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Current LxC	Current	Target Score
PATIENTS	BAF 1	Chief Nurse	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	QEC	12	16	16	16	16	16	16							4 (L) x 4 (C)	16	12
PEOPLE	BAF 2	Chief People Officer	If DBTH is unable to recruit, motivate, retain and develop sufficiently skilled workforce to deliver services	Then 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	9	12	12	12	12	12	12							4 (L) x 3 (C)	12	12
PATIENTS	BAF 3	Chief Operating Officer	If Demand for services at DBTH exceeds capacity	Then this could impacts on safety, effectiveness, experience of patients and meeting national and local quality standards	F&P	9	12	12	12	12	12	12							4 (L) x 3(C)	12	9
PATIENTS/ POUNDS	BAF 4	Chief Financial Officer	If DBTH's estate is not fit for purpose	Then DBTH cannot deliver services and this impacts on experience for patients and colleagues	F&P	20	20	20	20	20	20	20							5 (L) x 4 (C)	20	20
POUNDS	BAF 5	Chief Financial Officer	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	F&P	12	16	16	16	16	16	16							4 (L) x 4 (C)	16	12
PARTNERSHIP	BAF 6	Dep CEO	If DBTH does not effectively engage and collaborate with its partners and communities will miss opportunities to address strategic risks which require partnership solutions	Then DBTH fails to meet its' duty to collaborate and deliver integrated care for benefit of people of Doncaster and Bassetlaw	QEC	6	6	6	6	6	6	6							2 (L) x 3 (C)	6	6
PEOPLE / PATIENTS	BAF 7	Chief Financial Officer	If DBTH does not deliver continual quality improvement, research, transformation &innovation	Then the Organisation won't be sustainable in long term (? People strategy - could sit in people?)	F&P	6	6	6	6	6	6	6							2 (L) x 3 (C)	6	6

Board Assurance Framework 2023/24

Links to Strategic Ambitions

Patients

Strategic Objective

We deliver safe, exceptional, person-centred care

BAF 1 Executive Owner

Karen Jessop
Chief Nurse

Strategic Risk

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

Current Risk Score

16

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

Risk of a lack of learning from incidents, risks,complaints inquests and deaths
Risk of inconsistent standards of care leading to impact on quality of care and nurse sensitive indicators, such as HAPUs, Hospital
Identified risk in compliance with Mental capacity act and deprivation of liberty safeguards
Identified gaps following analysis of Safeguarding compliance with National Safeguarding accountability and assurance
Failure to deliver on the clinical audit action plan
Potential review of submission for Clinical Negligency Scheme for Trusts (Yr 5)
outcome of CQC inspection
Skill mix ratios (RN/HCA) in clinical lower than recommended national levels (links to Baf risk2)

Overseeing Committee

Quality & Effectiveness Committee (QEC)

6th August 2024

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 24)	4	4	16
Target Risk (Plan for Mar 25)	3	4	12

Risk Appetite

Quality - (Cautious) - Our Preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the the possibility of improved outcomes and appropriate controls are in place **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) Approved by Trust Board of Directors	Strategy delivery plan and update to QEC provided for start of Q1 (2)	Partial Assurance
	Quality steering Group (2)	Full Assurance
	Safeguarding, IPC and Patient experience Annual reports	Full Assurance
	Approved NMAHPS Quality Strategy with SROs for each theme (2)	Significant assurance
	Actions for 360 assurance MCA audit now complete.	Significant assurance
	Biannual establishment review reporting for Nursing and Midwifery to People Committee (2)	Full Assurance
2) Chief Nurse Quality Oversight framework	Chief Nuse Quality and Safety Report to QEC (2)	Full Assurance
	Picker Patient surveys UEC and Maternity (3)	Significant Assurance
	CQC Quarterly engagement meetings (3)	Significant Assurance
	Chief Nurse Executive Group (2)	Significant Assurance
	Patient Experience and Involvement Committee (2)	Significant Assurance
	Completion of Care Excellence accreditation reviews (2)	Full Assurance
	Rapid Quality Reviews for key events in place (2)	Significant Assurance
	Progress reporting on completed CQC actions to QEC (2)	Significant Assurance
3) Maternity services has executive level oversight: CN Board level Safety Champion	Maternity and Neonatal Safety & Quality Cttee (2)	Significant Assurance
	Children & Young People's Committee (2)	Significant Assurance
	Maternity and Neonatal report to Board Bi Monthly (2)	Full Assurance
	Bi Monthly ED and NED safety champion visits & mtg	Full Assurance
	Receipt of confirmation of Year 5 CNST Compliance	Full Assurance
	Humber LMNS review of still birth report (3)	Full Assurance
	LMNS CNST Check and Challenge Meeting year 6 (3)	Full Assurance
4) Clinical Goverance processes in place and established	Effectiveness Committee in place (2)	Significant Assurance
	Divisional Governance meetings (1)	Partial Assurance
	Mortality Governance and Data Assurance Group (1)	Partial Assurance
	Audit and Effectiveness Committee (2)	Partial Assurance
	Internal audit Report Clinical Audit (3)	Partial Assurance
	Learning from deaths Quarterly report (2)	Partial Assurance
	Internal audit report Mental Capacity Act (3)	Partial Assurance
	Medical Examiner external review (3)	Full Assurance
5) Risk Management Board established and working effectively	Risk Management Board monthly meeting (2)	Full Assurance
	Internal audit Report - Divisional Risk Management (3)	Significant Assurance
5) Patient Safety Incident Response Framework	Learning from Patient Safety Events panels established in	Signficant Assurance
	Trust Executive Patient Safety Oversight Group established (2)	Signficant Assurance
	Development of Trust wide safety improvement plans	Partial Assurance
	Patient Safety Committee (2)	Signficant Assurance
	Bi Monthly reporting to QEC on learning responses	Signficant Assurance

Significant gaps in current controls

Areas where further assurance against controls is required

	Evaluate the new committee structure when embedded - Proposed Q4
	Clinical Coding - depth of coding is poor

Key actions to close gaps

	Lead	Target Date	Progress
Evaluation of new Clinical Governance Structure (proposed Q4)	EMD and CN	Quarter 4	Meetings all established, structure shared at QEC, evaluation to be planned
Clinical Audit	EMD	Quarter 4	Plan progressing as outlined in December 2023 meeting
Formal establishment review of AHP workforce (link with risk2)	CN	Quarter 3	Started review August 2024
360 internal audit commissioned re: clinical coding	EMD	Quarter 3	Awaiting final 360 report to agree actions
Maxwell Stanley consultancy reviewing coding	EMD	Quarter 4	Pilot completed, work to be commissioned
Development of Trust wide safety improvement plans	CN	Quarter 3	Commenced linked to priorities as per PSIRP, plan to approve in PSC
Continued recruitment to Safeguarding team as per approved Business	CN	Quarter 3 & 4	Post being recruited to as per plan agreed with CFO and CN
Continued progression of the Quality Dashboard	CN & CFO	Quarter 3 & 4	Progress stalled at the beginning of the year due to personnel gaps/changes, progress now recommenced with phase 2 almost complete and Phase 3 underway

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
3449				Increasing incidence of Hospital acquired pressure ulcers - category 4

3197	4	4	16	Safeguarding Compliance
3296				Skill mix of RN:HCA not at agreed national recommendations
3246	5	3	15	Mental Capacity Act and Deprivation of Liberty Safeguards

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective
People	We are supportive, positive and welcoming

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 and the nationally identified need to increase training numbers

National context of continuing industrial action

Introduction of NHS Long Term Workforce Plan (LTWP), which is aligned with our People Strategy. Further details to be confirmed nationally on the LTWP including funding

National context including 24/25 operational and financial planning guidance, which has a focus on restricted workforce growth in the short term. In this context, and despite significant assurance on the implementation of the DBTH People Strategy and positive movement on key People indicators, the People Committee agreed at its meeting on 16.04.24 that the risk score remains at 12

RA box below - it was agreed at a previous PC to change the target score to 12 for 2024 recognising the external factors impacting on this - there will be a minute on this

Overseeing Committee

People Committee

Date of last Committee review

PC - 16 April 2024 / September 2024 Board please can you check the PC date

Risk Assessment	Consequenc	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	3	4	**12**
Current Risk Assessment	3	4	**12**
Target Risk	3	4	**12**

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 undertaken Q4 - Significant Assurance (3)	Assured
		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
		Internal 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 Leadership Team (1)	Assured
		Reports to People Committee (2)	Assured
		Annual staff survey results and learner surveys - further significant improvements seen in 2023 staff survey results (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, Workforce Race Equality Standard/Workforce Disability Equality Standard (3)	Assured
5	Provision of quality education, learning and development	Workforce & Education Committee (1)	Assured
		Reports to Trust Leadership Team (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Education quality visits and outcome reports - positive feedback in NHSE report Q4 23/24 (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 developed and rolled out Q4 23/24, Talent management tools developed in Q3, piloted in Q4 and launched late March 2024 to align with 2024 appraisal season. Appraisal season 90% compliance target exceeded in 2024 (currently 92%, pending final data entry upload)
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. Renewed focus in Q4 to increase amount of data being collated centrally, to be reported at WEC once sufficient data gathered

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 regularly and assurance report presented at every People Committee, next meeting is 22 October 2024. Plans on track, actions completed. Review of first year of strategy presented at PC on 20 June 2024, Committee assured.
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	Successful launch of DBTH Way completed. Embedding work continues including faciliated sessions with leadership groups e.g. Clinical Directors, incorporated into appraisal season form, inclusion in new job description and person specification templates, incorporated with Star Awards. Update presented to PC on 9 Jan as part of Engagement & Leadership report. Committee assured.
2	Implementation of strategic workforce planning tool and embedding of deep dive and focus workshops	Zoe Lintin/Anthony Jones	Mar-24	Implementation phase of strategic workforce planning tool from KPMG completed. Use of the tool considered for business as usual activites and incorporated within business planning process for 2024/25. Update & demo of the tool presented to PC on 9 Jan, Workforce Supply & Demand papers at every PC meeting, committee assured. Work ongoing to determine best use of the tool in changing national context in relation to workforce growth
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 presented to PC on 9 Jan, actions are on track with no escalations - Committee assured. EDI annual report presented to PC on 16 April, copmmittee assured.

1, 5	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 reports presented at every People Committee meeting, committee assured. Education Quality Framework developed, approved and launched in Nov, aligned with the Quality Strategy. Positive feedback received from NHS England education quality visit and report.

Links to Operational Risks

Ref	Consequen	Likelihood	Risk Score	Risk Title
19 PEO1	4	3	12	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work
16	4	3	12	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills
				Agreed at Risk Management Board on 15.07.24 to reduce risk 16 to risk score of 12

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective
Patients	We deliver safe, exceptional person-centred care

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**	12

Key Issues that could impact on ability to manage the strategic risk	Overseeing Committee
Increased waiting list size and increased waiting times for elective care following the pandemic Sustained high demand for urgent and emergency care Lack of capacity (physical capacity and workforce capacity)to meet the demand and clear the elective backlog Underutilisation of clinical capacity High bed occupancy and discharge delays have a detrimental impact on patient flow out of the ED	Finance & Performance Committee **Date of last Committee review** Jul-24

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-25**)	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	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 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
5. Operational Governance arrangements to maintain oversight of activity delivery vs plan, delivery of the access standards / improvement trajectories, delivery of the operational planning guidance improvements	Monthly Divisional Performance Review Meetings (1) Weekly COO oversight of 65 / 78 week forecast (1) Weekly theatre booking / scheduling meetings (1) Divisional PTL meetings and Grip & Control meetings (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance(2) Monthly Access Standards report to F&P (2) Monthly Elective Activity 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)	Partial Assurance - with improvements required
6. Elective Care Improvement Programme to ensure the fundamentals of good elective care management and governance are in place across the Trust	Monthly SRO oversight through the Programme Board (1) Project groups in place, with Deputy CEO leadership (1) DQ Steering Group (1)	Partial Assurance - with improvements required

Significant gaps in current controls	Areas where further assurance against controls is required
Senior operational oversight of the activity delivery vs plan (forward look)	
Standardised Corporate PTLs for RTT and Cancer, in line with best practice	
Specialty specific length of stay action plans	
Senior operational oversight of BAU patient flow metrics	

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Recovery plans to delivery the activity plan for 24/25	COO	Aug-24	In progress - Divisions developing
2	Corporate PTL meeting refresh for RTT and Cancer	COO	Q2	Revised ToR to be drafted and meetings launched
3	Divisional action plan to deliver LoS improvements	COO	Aug-24	in progress - Divisions of Medicine and Surgery developing
4	Weekly oversight of activity vs plan (forward look)	COO	Aug-24	To be established with Deputy COO oversight
5	Weekly Patient Flow meeting to provide oversight of BAU actions	COO	Aug-24	To be established with Deputy COO oversight

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
3434	4	3	12	Timely access to diagnostic services
3435	4	3	12	Timely access to elective care
3436	4	3	12	Timely access to cancer services
3437	4	4	16	Timely access to emergency care

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective
Patients / Pounds	We deliver safe, exceptional, person-centred care We are efficient and spend public money wisely

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

18/01/2024 / May 2024 Board

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	16
Current Risk Assessment	4	5	20
Target Risk	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. Top up insurance now in place.	Reports to Audit and Risk Committee (via H&S Report) (2)	Significant Assurance - with minor improvement opportunities
		Reports to Finance & Performance Committee (2)	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. Funding identified for the staffing in the final quarter of 2024/25.	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.	Board Report (2)	Partial Assurance - with improvements required
	DCC case signed off by DHSC with NHSE sign off imminent (August 2024) works started in discussion with DHSC team. East Ward Block SOC work starting for completion in July 2025 Doncaster CEO priorities project to look to move some services to other sites to alllow closure of poorest estate at DRI	Board report (2) F&P Paper (2)	Partial Assurance - with improvements required Partial Assurance - with improvements required 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
	Work on the Doncaster CEO Priorities to include moving services to other locations in Doncaster, plus review of step up/step down facilities and provision of new car parking and accomodation	JS	ongoing	Project commissioned by place CEO's with budget identified. Project team being assembled and governance structure being setup.
3	SOC for East Ward Block	JS	Jul-25	Paper to FP, project team being pulled together.
3	Staffing to be recruited in for final quarter of 24/25 for PPm in response to the granger report.	JS	Nov/Dec 2024	Funding in budget for 2024/25
2	Site Development plan for DRI and BDGH being prodcued	JS	Jan-25	inititated

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 estat upgraded in line with curre
1214	Increased Risk to Life and P of Fire Compartmentation
1277	Increased Risk of Fire and S Compartmentation
1246	Risk of Failure of Critical Ve and Operating Standard No
1807	1807 Risk of Critical Lift Fail

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective
Pounds	We are efficient and spend public money wisely

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 £26.2m with an assumed CIP delivery of £22.1m. The ICS is under siginificant pressure relating to its finances as there remains £48m of unidentified CIP being held within the ICB budget. The ICB is under pressure to deliver a plan to close this gap, this inevitably will mean that system partners are requested to deliver more savings. At the end of first quarter of 24/25 DBTH's run rate would suggest a deficit of c£50m at yearend, missing the plan by £23.8m The ICS has commissioned a drivers of the deficit report from Deloittes for all partners in the system and the DBTH report from last year has been refreshed. This report is consistent with the prior years report, and suggeststst that the short run opportunities for DBTH are less than this years CIP target.

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 24/25 has been to deliver above pre-pandemic levels of activity within resources allocated whilst providing safe and sustainable services. 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. Currently the Trust is not delivering these productivity gains, through either the BAU operational processes or the The Theatres and Outpatient efficiency workstreams.

5) Non-pay expenditure continues to grow despite the low activity numbers. Key areas of growth in expenditure are drugs and clinical supplies.

6) Temporary Staffing Spend - agency spend remains above pre-pandemic levels. Further work in this area is required to reduce temporary staffing usage, in light of an increase in substantive staffing

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

25/07/2024 / Confidential Board 14th August

Risk Assessment	Consequence	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	16
Current Risk Assessment	4	4	16
Target Risk	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 - 24/25	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 in September (due to YE accounts) Board in Nov	FULL Assurance
		Deloittes review of financial controls July 2024	Significant Assurance - with minor improvement opportunities
		Reports to Audit and Risk Committee	Significant Assurance - with minor improvement opportunities
		Reports to Finance and Performance Committee	Significant Assurance - with minor improvement opportunities
2	Commissioning of drivers of underlying financial deficit.	Refreshed report received Aug 2024.	Assured
			Significant Assurance - with minor improvement opportunities
3	Budget Setting and Business Planning	Board and F&P sign off of plan (April 2024)	Significant Assurance - with minor improvement opportunities
		Internal Audit - Business Planning	Significant Assurance - with minor improvement opportunities
4	Internal and external audit programme including counter fraud	Internal Audit - HFMA 22/23 Review	Partial Assurance - with improvements required
		Internal Audit - Temporary Staffing	Significant Assurance - with minor
		Counter Fraud reports to ARC	Significant Assurance - with minor
		External Audit - 22/23	Significant Assurance - with minor improvement opportunities
5	24/25 financial forecast prepared for F&P	Report to FP July 2025 And Board seminar	Partial Assurance - with improvements required
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	Significant Assurance - with minor improvement opportunities
7	Development and Delivery of CIP plan	Reports to Finance and Performance Committee	
		Implementation of the Efficiency and Effectiveness Committee reporting into FP and CEO chaired	

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
Temporary staffing controls	Enhanced grip and control meetings plus executive attendance at meetings
Elective underperformance against ERF targets	COO to produce a recovery plan with monitoring through execs and FP

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
Partnerships	We work together to enhance our services with clear goals for our communities

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

Key issues	Overseeing Committee
Lack of a clear partnership strategy for DBTH aligned to its other Trust strategies (to enable their delivery) Failure to develop effective partnerships and achieve agreed outcomes DBTH aligned to 2 different ICS's causing complexity and inefficient working for DBTH	To be reviewed with proposal to have different elements across applicable committees (has been F&P to date)
	Date of last Committee review
	April 2024 / May 2024 Board

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	3	2	**6**
Current Risk Assessment	3	2	**6**
Target Risk	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	Ffeedback to Trust through committees and Board / CEO and Chair reports (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, reports 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 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)	Significant Assurance - with minor improvement opportunities
4	Additional Executive capacity created (new DCE post) for partnership working with a particular focus on Nottinghamshire ICS relationships	Embedded support and input in the Notts Provider and ICS/ICB leadership forums. Work commenced on Acute Fed Clinical Services review. Strategy Directors PPG workplan to develop clear strategy and roadmap will help DBTH articulation of partnership priorities, alongside outputs of clinical services.	Significant Assurance - with minor improvement opportunities
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	This has progressed since the last update with links made between our operational and strategic partnership risks. Overall strategy work continues as described above with commitment to develop a Trust Strategy with clear partnership intentions in 2024/25.

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	Ongoing	Lists have been created but need linking across to relevant work objectives once we are clearer on key areas of focus for the year ahead
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	Progress and focus on initially refreshing Trust Strategy. Vision and priorities developed. Emphasis on partnership within this in terms of our revised vision and priorities.

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
				9 risks on our TRR have been linked to an overarching partnership risk. Reported to the risk management board monthly.

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective
People / Patients	We are supportive, positive and welcoming We deliver safe, exceptional Person-centred care

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	May 2024 Board

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	3	2	**6**
Current Risk Assessment	3	2	**6**
Target Risk	3	4	**6**

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. Self assessment refresh for 24/25 due Q3, plans in palce to undertake with original multidisciplinary team to ensure consistency	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. Both strategies now apporved - complete	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) People Committee (2) Teaching Hospital Board (2)	Assured COMPLETE
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. Qii Strategy approved and launched May 2024, aligned to new trust 4 P's. Complete	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) New strategy to TEG November 23	Assured COMPLETE
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. Follow up workshop now being planned for Q3 with Deputy CEO, aligned to results of staff survey and NHSE Impact guidance.	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. Launched and being trialied	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. COMPLETE
3	Develop a 5 year detailed business case from April 2024	Sam Debbage/ Jane Fearnside	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 incorporated in report to F&P Feb 24
5	Board Training programme to be developed	Kirsty Edmondson-Jones/Rob Mason	Oct-23	First session commenced October - Second session Q3, 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 – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Trust Risk Register

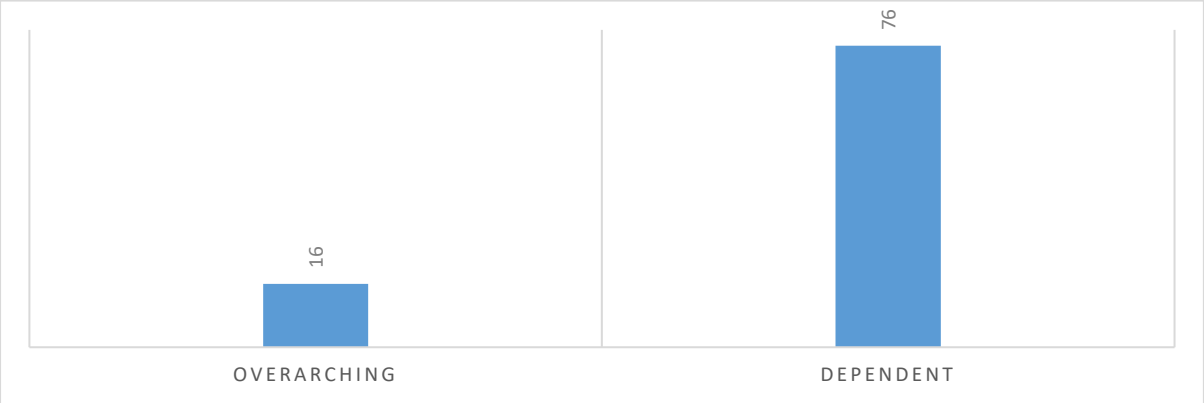
The Trust Risk Register is compiled of Overarching Operational Risks linked with the Trust Strategic Risk and the 15+ stand-alone risks and notates the dependent risks. Dependent risks are available on the linked records field of the Overarching risk. See **Appendix 1** for the Trust Risk Register details. For detailed mitigating control and actions please access 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



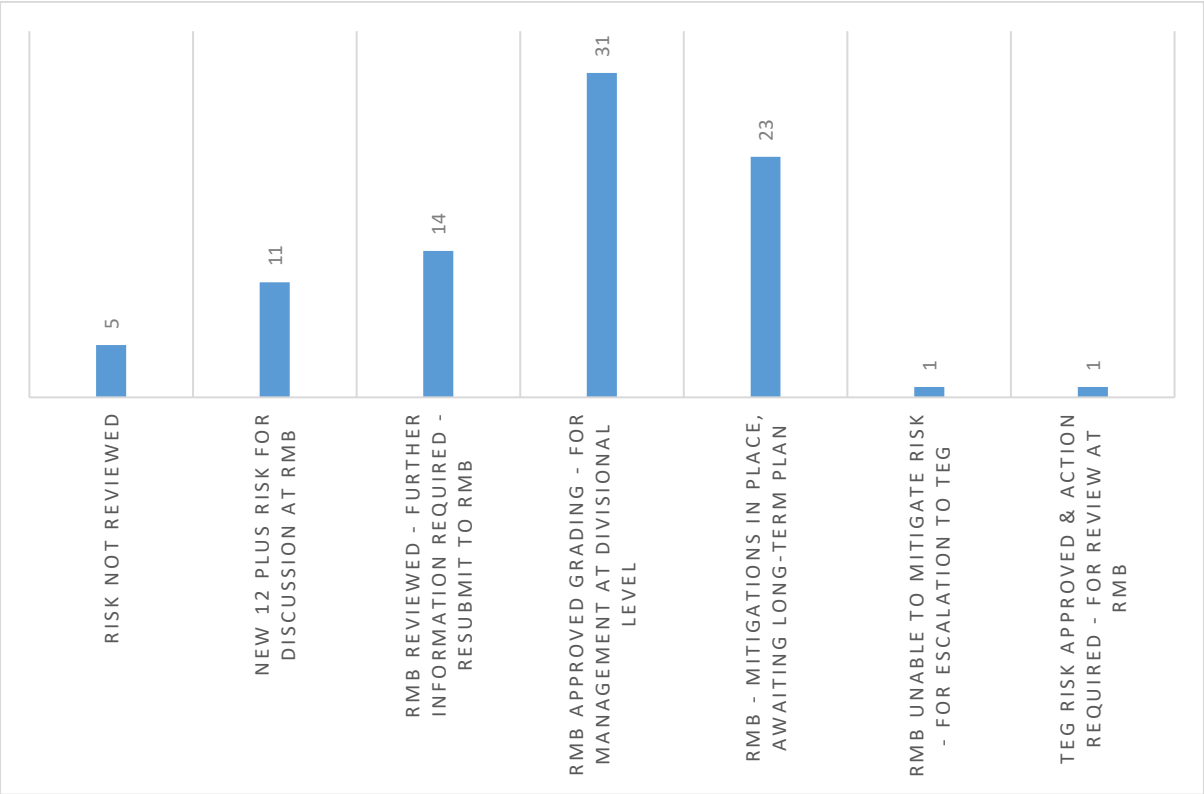
There are 16 overarching risks with 76 dependent risks.

[SIX OF THE OVERARCHING RISKS, LINKING TO THE BOARD ASSURANCE FRAMEWORK (BAF), SIT BELOW THE EXTREME THRESHOLD FOR THE TRUST RISK REGISTER (TRR), BUT ARE INCLUDED IN THE TRR IN APPENDIX 1]

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risks by RMB Status (15+ Risks only)



There are 86 Risks rated as Extreme (15+); an increase of two since last month.

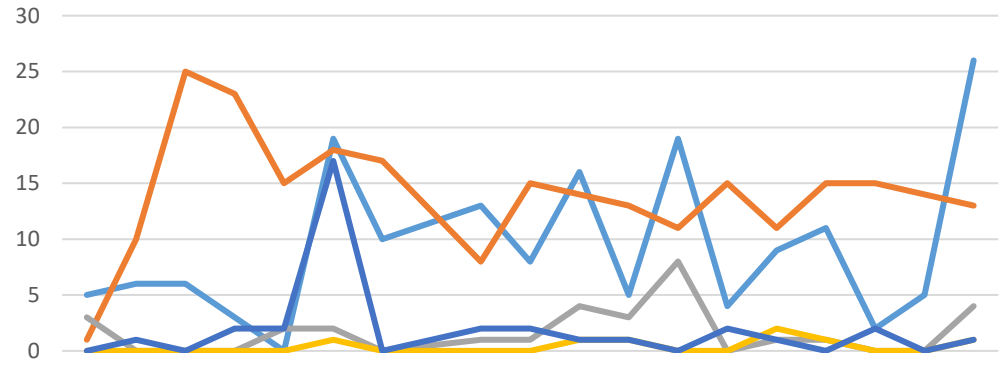
There are five new 15+ risks included in this total. Since the last report, three Extreme risks have been closed.

All 15+ Risks on Datix have been discussed at RMB, and new 12+ risks are scheduled for discussion at a future RMB, once it has been discussed at Divisional / Directorat4e Governance.

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Cumulative RMB Status (12+ Risks discussed)



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
New	5	6	6	3	0	19	10	13	8	16	5	19	4	9	11	2	5	26
Review	1	10	25	23	15	18	17	8	15	14	13	11	15	11	15	15	14	13
Downgraded	3	0	0	0	2	2	0	1	1	4	3	8	0	1	1	0	0	4
Archived	0	0	0	0	0	1	0	0	0	1	1	0	0	2	1	0	0	1
Escalation to TLG	0	1	0	2	2	17	0	2	2	1	1	0	2	1	0	2	0	1

[DATA FOR THIS REPORT IS ACCURATE AT THE TIME OF WRITING. THE STATUS OF REVIEWED RISKS AND ANY ESCALATIONS WILL BE UPDATED FOLLOWING RMB TO ENSURE AN ACCURATE REPRESENTATION OF DISCUSSION FOR OVERSIGHT COMMITTEES]

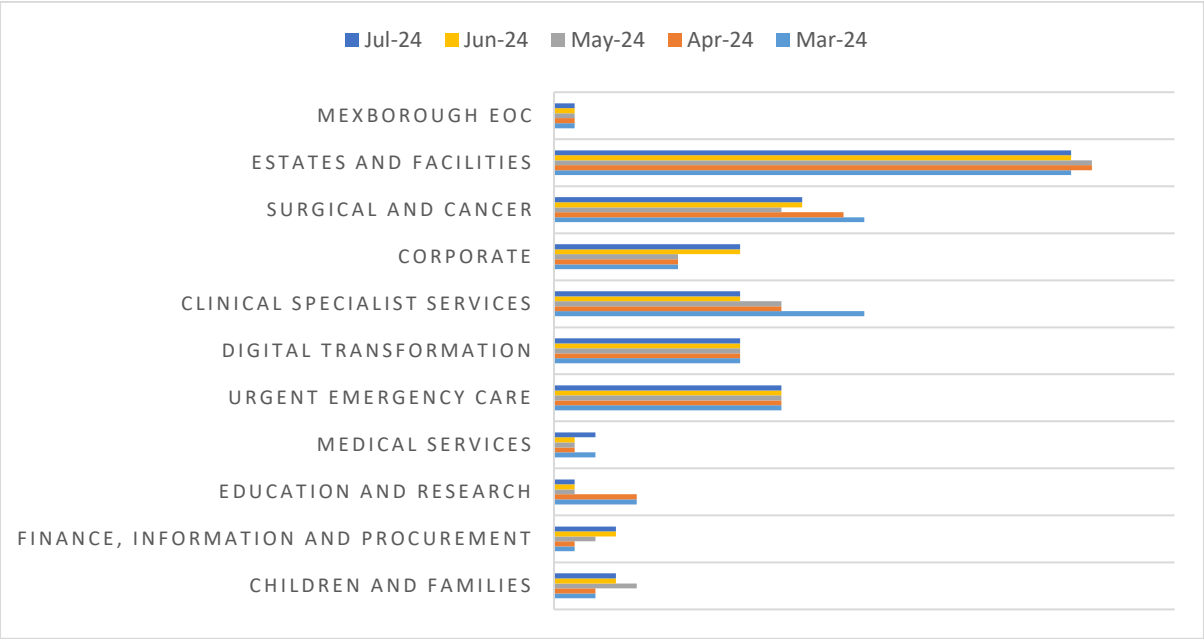
June saw five new risks discussed, and all five were approved for onward management at Divisional / Directorate level. A further 14 risks were reviewed and progress on the risks and any actions were discussed and logged. There were no escalations to TLT this month.

July has 26 risks scheduled for discussion of which one was archived and four downgraded. An additional 13 risk were reviewed and one risk was escalated to TLT (Bleeps).

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

15+ Risks per Corporate and Division over time



There is an increase of 1 risk in Medicine.

Overdue Risks on Trust Risk Register

There are no overdue risks on the Trust Risk Register.

Action Plan Status on Trust Risk Register

There are 16 Risks on the Trust Risk Register; all risks have actions in place. The 16 risks have 44 actions of which 23 (52.3%) have been completed, with 21 active actions; there are seven of the active actions that are overdue (33% of the active actions). The owners of the actions are regularly prompted to review and update their actions.

Action Plan Status on 15+ Risks

There are 86 Extreme Risks within DBTH, with 16 of these risks having a new status that are scheduled for discussion at RMB, leaving 70 active approved risks. Of the 70 approved risks, five risks do not have an action plan in place to further mitigate the risk (7.1%).

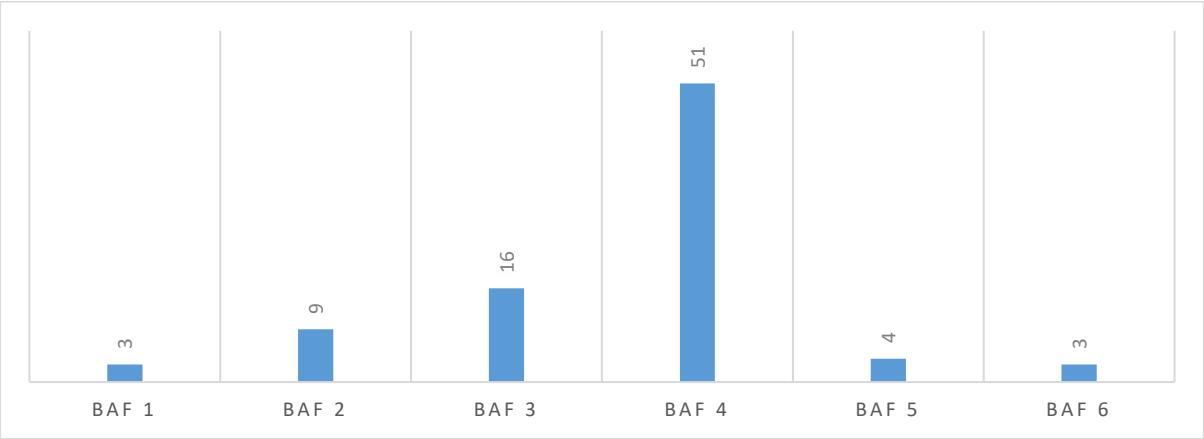
The 65 risks (with actions) have 137 Action plans between them; 84 actions are active (61.3%) and 53 with actions completed (38.75%). Of the active actions, 22 are overdue (26.2% of the active actions). The owners of the actions are regularly prompted to review and update their actions.

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

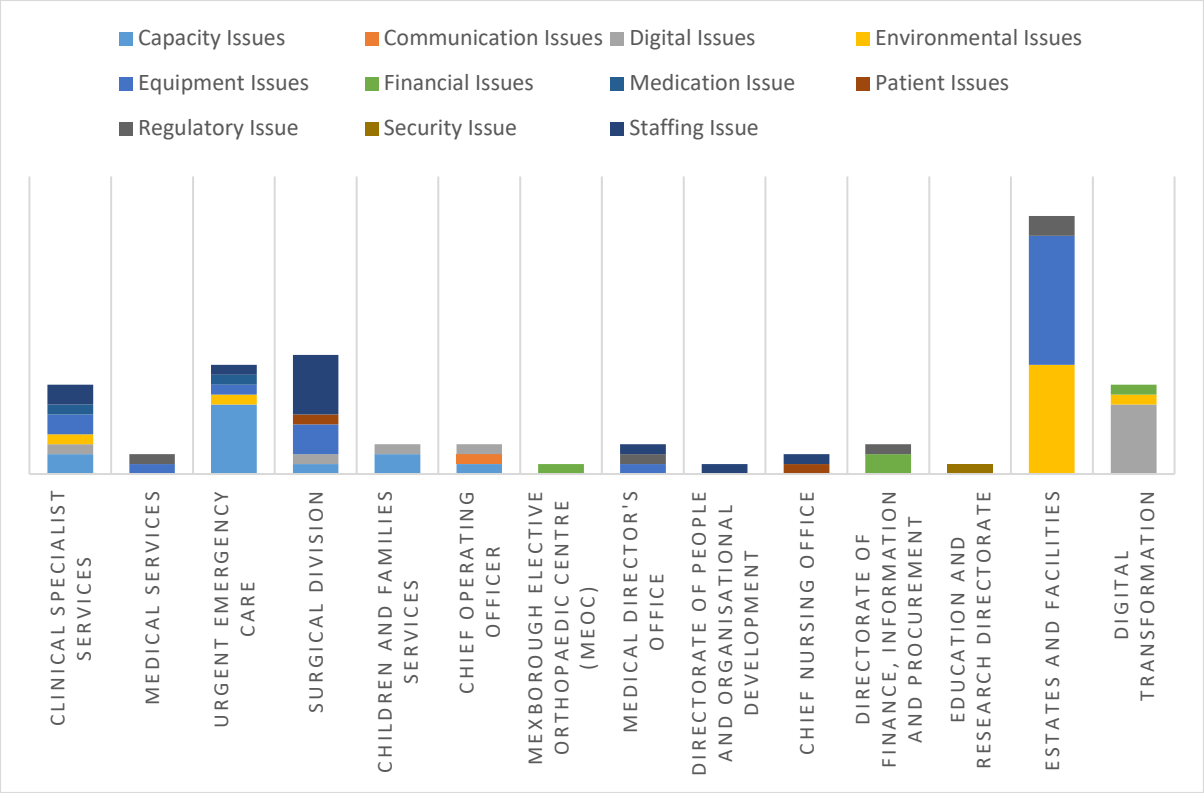
15+ Risk relationship with BAF Risks

Work has been completed to align each of the 15+ Risks to one of the Strategic Risks within the Board Assurance Framework.



59% of the 15+ risks are related to BAF 4, the DBTH Estate which includes Estate Infrastructure, Digital Infrastructure and Equipment, 19% pertaining to BAF 3, Capacity, and Workforce BAF 2 has 10% of the risks.

Risk Themes

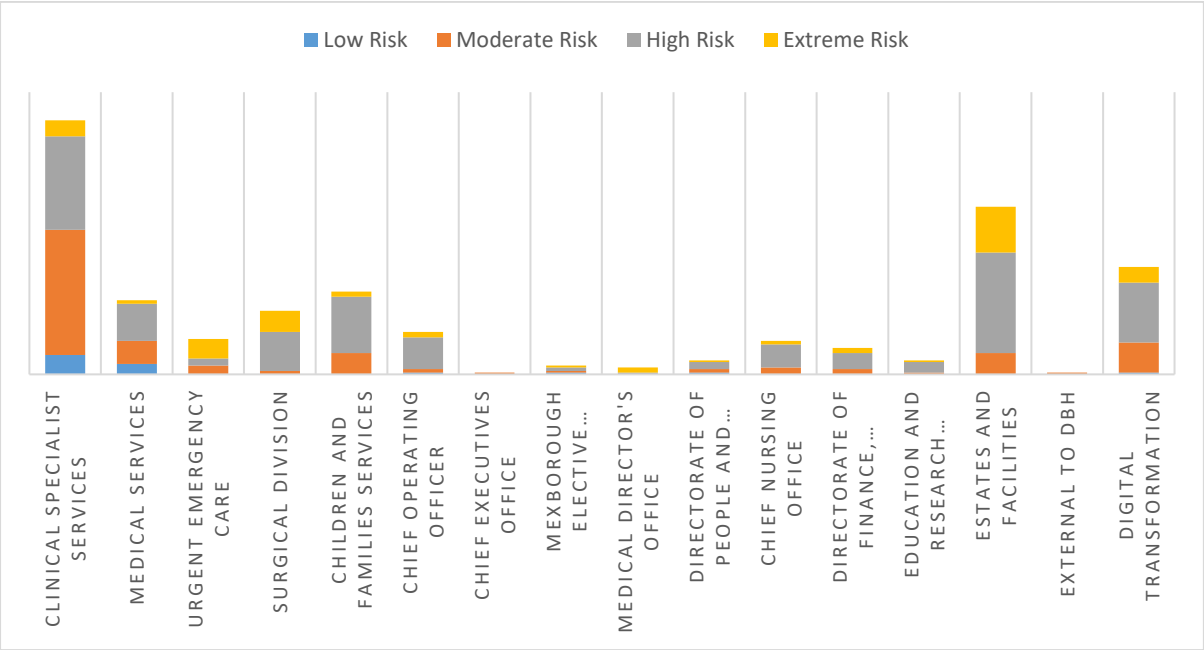


The greatest number of risk issues link to equipment, with 24.4% of the risk profile. Environmental issues has risen to the second highest category with 16.3% and Capacity issues rising to the third highest category with 15.1%. Staffing issues has dropped to fourth highest with 14.0% and Digital issues remaining in fifth highest with 12.8% each.

Trust Risk Report – July 2024

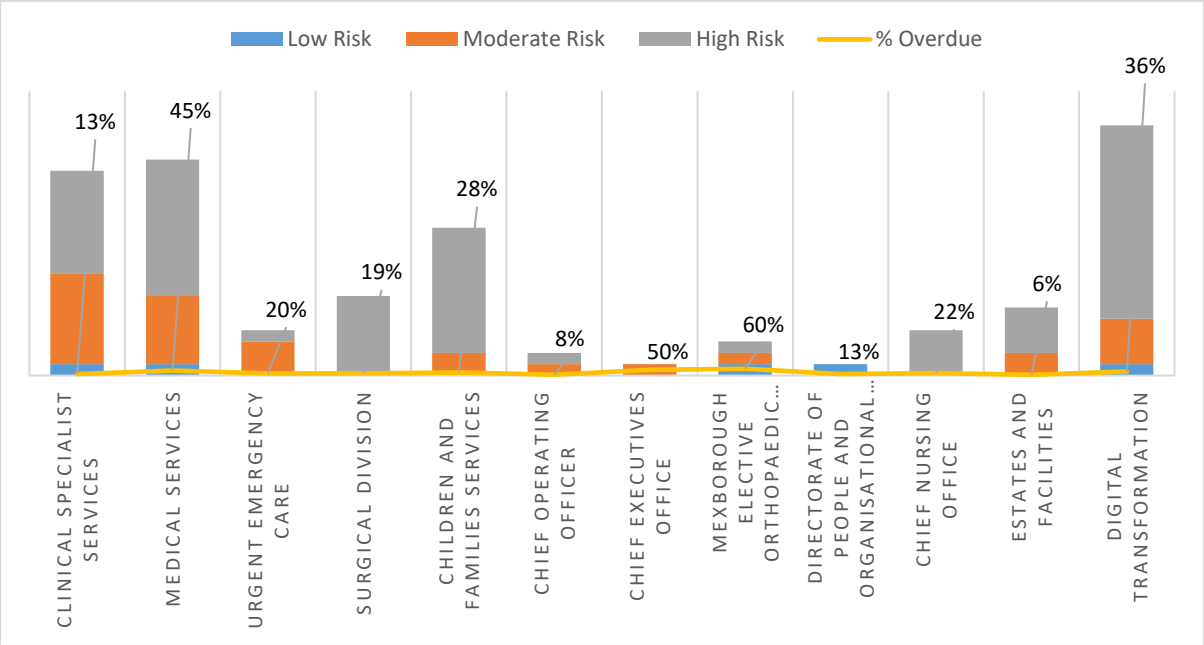
Summary of data pulled from Datix Risk Management System 10th July 2024.

Complete Trust Risk Profile



Overall, there are 530 risks on Datix (4 fewer than June), of which there are 21 low risks, 147 Moderate risks, 276 High Risks and 86 Extreme Risks.

Overall, there are 100 overdue risks across the Trust, 18.8% of all risks. The Divisional split for these risks by risk level is below. The percentage on the chart is the percentage of overdue risks per division and not the total number of risks. [Divisions or Directorates not appearing on the chart have no overdue risks]



Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
11	Sargeant, Jonathan	Failure to achieve compliance with financial performance and achieve financial plan	Kept on TRR but strategic risk on BAF. 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.	19/07 2024	16	Extreme Risk	8	Overarching	Extreme 3439 High 3017, 3170, 3179 Moderate 3174, 3175	BAF 5	15992	Review of financial controls including authorised signatory list	30/06 2023	03/01 2024
											15993	Complete an analysis of the drivers of deficit with Deloites	30/06 2023	03/01 2024
12	Timms, Howard	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation	Asset Capture Complete Estates Business Case being finalised to support additional staffing requirements and compliance with SFG20	30/09 2024	20	Extreme Risk	10	Overarching	Extreme 1078, 1082, 1083, 1095, 1096, 1097, 1208, 1209, 1246, 1264, 1274, 1277, 1782, 2335, 2863, 2868, 3506 High 1204, 1234, 1268, 1781, 1786, 2144, 2565, 2805, 2867, 3190, 3478 Moderate 147, 2878,	BAF 4	1914	Maintain CSR 3 or above	31/03 2020	10/10 2016
											6207	Development of Estates condition operational risk and investment requrements – short term Estates Strategy.	31/03 2017	12/08 2017
											16159	Complete Asset capture at all sites and produce Estates maintenance business case in accordance with the seven point plan	13/12 2023	12/12 2023
											17817	Ongoing Estates Planning and Strategy Development	31/03 2025	

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
16	Lintin, Zoe	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	A schedule of Deep Dive workshops arranged throughout 2023/24 and will continue into 2024/25. Introduction of focused planning sessions for areas struggling to support Deep Dive approach.	20/12 2024	16	Extreme Risk	12	Overarching	Extreme 26, 2465, 2768, 2781, 2865, 2948, 3006, 3010, 3043, 3120, 3127, 3159, 3197, 3200, 3212, 3213, 3219, 3244, 3250, 3257, 3259, 3265, 3266, 3267, 3311, 3322, 3323, 3342, 3345, 3426, 3423, 3450, 3467 High 441, 1047, 1228, 2427, 2715, 2745, 2749, 2872, 2880, 3001, 3023, 3067, 3143, 3152, 3183, 3187, 3192, 3211, 3240, 3245, 3333, 3329, 3376, 3441, 3496 ***For remaining dependant risks see Datix***	BAF 2	1920	P&OD workforce action plan	31/05 2016	13/09 2018
											15995	development of trust-wide multiyear strategic workforce plan	31/03 2024	
											15996	reintroduction of deep dive workforce planning workshops in specialty areas	31/08 2023	29/09 2023

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
1412	Timms, Howard	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	Works in progress as part of 23/24 Capital Programme	30/09 2024	15	Extreme Risk	10	Overarching	Extreme 1077, 1214, 1216, 1221, 1225, 1786, 2941, High 1197, 1218, 1219, 3479 Moderate 147,	BAF 4	16703	6 facet survey review - Trust wide	19/02 2024	
											16704	Review critical infrastructure risks on E&F risk register	20/05 2024	
											16705	Investment in Critical Infrastructure included within the Capital programme	13/03 2025	
1807	Hutchinson, James	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	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.	31/10 2024	15	Extreme Risk	8	Overarching	Extreme 1224, 1239, 2682, High 885, 1240, 2798, 3154 Moderate 2608, 2681, 3360,	BAF 4	10218	Maintain CSR 3 or above	31/03 2020	10/10 2016
											10219	Development of Estates condition operational risk and investment requrements – short term Estates Strategy.	31/03 2017	12/08 2017
											16158	Lift replacement and upgrade forms part of the overall Trust Capital plan	13/06 2024	

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
3209	Smith, Denise	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	Recruitment for Data Quality Team ongoing 10 filled, 2 outstanding. Source group extended further past March. PPMS significant amount of data cleansing, clinical engagement though the Business Manager. Pilot sites identified and roll out programme planned.	09/09 2024	20	Extreme Risk	6	Overarching	Extreme 3051, High 3094 Moderate 2568	BAF 1	15703	Move from Surgical to Corporate Risk	20/03 2023	09/03 2023
											15704	Please add current mitigations to the Risk	20/03 2023	12/01 2024
											15705	Send out Comms	20/03 2023	12/01 2024
											15706	Expand report to include clinic / consultant level data	19/06 2023	12/01 2024
											15707	Identification of patients in other buckets for tracker	17/04 2023	12/01 2024
											17455	Round table discussion	29/03 2024	14/03 2024
3348	Mallaband, Nicholas	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	Senior divisional managers are responsible for identifying division priorities for the replacement of medical devices and the requirement for the procurement of new/extra medical equipment. 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.	14/10 2024	20	Extreme Risk	10	Overarching	Extreme 2819, 3147, 3184, 3237, 3238, 3251, 3320, 3346, 3419, 3420, 3415, 3470, 3473 High 53, 2581, 2935, 3036, 3142, 3146, 3288, 3298, 3308, 3493 Moderate 795, 971, 2372 Low 1012, 2623,	BAF 4	17451	2023/24 Keep and manage a database of all Trust Medical Equipment	29/03 2024	15/01 2024
											17452	2023/24 Notification to users equipment that reaches EoL	29/03 2024	15/01 2024
											17453	2023/24 Development of risk assessment process	29/03 2024	15/01 2024

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
3437	Stubbs, Suzanne	Timely access to emergency care - Demand, Capacity & Flow	Reports into TLT then F&P committee each month, then to Board, to be aware of position and performance.	05/08 2024	16	Extreme Risk	12	Overarching	Extreme 3386, 3398, 3437, 3400, 3401, 3402, 3403, 3405	BAF 3	18259	Operational management Cover	07/10 2024	
											18260	Funding request	07/10 2024	
3454	Mallaband, Nicholas	If there is a deterioration in services we will be unable to deliver high-quality care which may result in regulatory action	Working on staffing mix and have a risk on Datix, including maternity. Re-training staff on the use of incident reporting/ LFPSE implementation. New Risk Folder for environmental risks. Ambient room temps for medication is already on risk register. Drive on Statutory and Mandatory training which includes safeguarding. Appraisal season is commencing. IPC - bare below elbow, cleaning awareness. Reviewing and maintenance of risks. Prioritising patients in ED - risk on Datix. Working towards ePR for records.	14/10 2024	16	Extreme Risk	8	Overarching	Extreme 3246, 3336, 3398 High 3290, 3380, 3457, 3507	BAF 1	18076	CQC Action Plan on Monday .com	31/05 2024	28/05 2024

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
3502	Marriott, ARRAN	Overarching risk for critical care consultant staffing	daytime session for some DCC consultants to cross cover at BDGH, however not sufficient number to provide full cover and support plan for new SOP to transfer a number of level 3 patient from BDGH to DRI, however still needs approval	06/08 2024	20	Extreme Risk	20	Overarching	Extreme 2664, 3244, 3159	BAF 2	18266	Checklist Audit for ICU	31/03 2025	
3409	JONES, ZARA	Failure to gain partnership solutions to deliver services safely for the community	Development of clear strategy for partnership. Contribution to system operational meetings & support to partners. Development of Place plans. 'Every Contact Counts' Delivery of Health Inequalities strategy and prioritisation according to need when delivering health care	29/02 2024	6	Moderate Risk	6	Overarching	Extreme 3296, 2873, 3467 High 2839, 2977, 3056, 3186, 3242, 3305, 3397, 3412	BAF 6	17626	To review partnership risks that are absent from the Risk Register	31/10 2024	
											17627	Partnership Risk Profiling Report	31/05 2024	20/05 2024

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
3384	HOWARD, Dan	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	A prioritised list for capital funding is being worked on, and will be approved by CIG. The delivery plan will be regularly reviewed by the heads of department. 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. SY Federation wide procurement where possible & Sharing of services /support as necessary	07/06 2024	12	High Risk	8	Overarching	Extreme 1410, 1670, 2685, 2717 ,2727, 3184, 3224, 3280, 3282 ,3283, 3284, 3285, 3287, 3375, 3469, 3474 High 1663, 1664, 1674, 1675, 1676, 1677, 1678, 2116, 2135, 2534, 2686, 2691, 2695, 2703, 2720, 2721, 2722, 2726. 2732, 2734, 2735, 2736, 2747, 3056, 3060, 3078, 3111, 3186, 3215, 3225, 3226, 3281, 3286, 3295, 3466 Moderate Risk 1665, 1667, 1671, 2733, 2848, 3160 Low Risk 2378, 2624, 2740, 2755	BAF 4	17918	Create Action Tracker for EOL Services/Systems	17/05 2024	

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
3436	Barnett, Lesley	Timely access to cancer services - Demand, Capacity & Flow	Clinical harms policy in place. Quarterly Clinical Breach review to highlight action required and learning. Weekly Cancer PTL. Cancer panel discussion weekly to drive the pathways with a focus on patient safety and support. Quality and Governance structure and process in place.	26/07 2024	12	High Risk	12	Overarching	Extreme 3296	BAF 3	18094	Awaiting Annual plans	07/06 2024	
											18258	Development of Cancer Access Policy	07/10 2024	
3480	Reay, Jeannette	Failure to Fulfil EPRR Statutory Duties	EPRR Annual Work Plan EPRR Steering Group	12/08 2024	12	High Risk	12	Overarching	High 3482, 3483, 3485, 3486, 3487, 3488, 3489, 3490, 3491, 3492	BAF 1	18159	Add individual EPRR Domain risks	28/06 2024	
											18160	Actions for 2024/25 to be captured in individual EPRR risks	31/03 2025	
3434	VASEY, BEN	Timely access to diagnostic services - Demand, Capacity & Flow	Working in collaboration with key partners to redesign the audiology service model.	07/10 2024	12	High Risk	12	Overarching	Extreme 2750, 3258, 3354, 3444, 3467, 3471, 3481, 3499, 3505 High 2775, 2977, 3032, Moderate 3292 Low	BAF 3	18252	Request mutual aid	07/10 2024	
											18253	Develop Insourcing / Outsourcing proposals	07/10 2024	
											18254	Enhanced senior operational oversight	07/10 2024	

Trust Risk Report – July 2024

Summary of data pulled from Datix Risk Management System 10th July 2024.

Risk ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Dependent Risks	BAF number	Action ID	Description	Due date	Done date
3435	VASEY, BEN	Timely access to elective care - Demand, Capacity & Flow	Senior divisional oversight of the waiting list ensure patients are treated in order of clinical priority. Individual patients tracked by teams, with daily updates and escalations. Prompt response when corneal transplant materials become available. Focussed work to ensure all long-wait patients have a pre-operative assessment as early as possible. Utilisation of capacity for clinically urgent and longest waiting patients. Senior operational oversight of any proposed cancellation of long waiting patients.	07/10 2024	12	High Risk	12	Overarching	High 3101, 3109, 3124	BAF 3	18255	Review of ENT capacity	07/10 2024	
											18256	Management of corneal grafrs	07/10 2024	
											18257	Request NHSE Support	07/10 2024	

2409 - D7 CHAIR'S ASSURANCE LOG - QUALITY & EFFECTIVENESS COMMITTEE

Discussion Item | Emyr Jones, Non-executive Director | 11:55

5 minutes

REFERENCES

Only PDFs are attached

D7 - Chair's Assurance Log - Quality & Effectiveness Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Subject:	Quality & Effectiveness Committee Meeting	**Board Date: September 2024**
Prepared By:	Jo Gander, Committee Chair & Non-executive Director	
Approved By:	Quality & Effectiveness Committee Members	
Presented By:	Jo Gander, Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Quality & Effectiveness Committee meeting held on 6 August 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
None to report	Although the Never Event Exception report received Full Assurance a further paper was requested at October's QEC to provide assurance and information around the broader Trust strategic plans to learn from and avoid a repeat of never events. A request was made that Sub Committee minutes and reports clearly demonstrate that the agreed TORs are being implemented specific areas to be included around Clinical Audit progress and exception reporting. It was recognised in the committee that there are wider governance based actions that will look at Committee Terms of Reference, work plans and structures, and which will further help to clarify and improve transparency around the assurance processes across the Trust.
Significant or Full Assurances to Provide	**Decisions Made**
Full Assurance PSIRF Progress and Outcomes report CQUINS Update report Quarter 4 CQC Action Plan & Update Committee Substructure Plan HAPU4 exception report Never Event Exception report Still Birth report Progress report on Year 1 of the NMAHPS Quality Strategy Mortality report Audit & Effectiveness Update report Audit & Effectiveness Annual Report	Minutes of the QEC Meeting held on 4th June 2024 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.

2409 - D8 CHAIR'S ASSURANCE LOG - CHARITABLE FUNDS COMMITTEE

Discussion Item | Hazel Brand, Non-executive Director | 12:00

10 minutes

REFERENCES

Only PDFs are attached

D8 - Chair's Assurance Log - Charitable Funds Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Special Charitable Funds Committee Meeting	**Board Date: September 2024**
Prepared By:	Hazel Brand, Committee Chair & Non-executive Director	
Approved By:	Charitable Funds Committee Members	
Presented By:	Hazel Brand, Committee Chair & Non-executive Director	
Purpose	The paper summarises the key highlights from the Special Charitable Funds Committee meeting held on Tuesday 16 July 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
• The Fred & Ann Green Legacy provided the DBTH Charity with an income stream that no longer exists as the Legacy is almost spent. This means that charity expenditure is limited during 2024/25 as it is a transition year between the charitable functions being provided by DBTH and transfer to Doncaster & Bassetlaw Healthcare Services on 1 April 2024. Moderate assurance • There are ambitious but reportedly realistic targets for fund-raising during the year. Moderate assurance	Fund-raising/Grant-making draft strategy to be prepared for the September meeting by the incoming Head of Charity, with opportunity for trustees' input
Significant or Full Assurances to Provide	**Decisions Made**
	To approve the paper presented by Mark Olliver, MD, Doncaster & Bassetlaw Healthcare Services, on Charity Operations Update, adopting the KPIs outlined therein

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.

2409 - D9 TRUST GOVERNANCE RE-EVALUATION & RECOMMENDATIONS

Information Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

5 minutes

REFERENCES

Only PDFs are attached

D9 - Trust Governance Re-evaluation & Recommendations.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**D9**
Report Title:	**Trust Governance re-evaluation and recommendations**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen Associate Director Strategy, Partnerships and Governance		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

This report summaries the evaluations of the governance arrangements at Trust level.
Part one focusses on the governance at board and committee levels as per the internal audit findings and the governance review carried out by the Associate Director of Strategy Partnerships and Governance since starting in post in June 2024. This provides a series of combined recommendations for the Board to decide.

Part two focusses on two Council of Governor effectiveness reviews plus survey results which took place between February and July 2024. This provides a series of combined recommendations for the Board to decide.

Recommendations:	**Part 1** • To reinstate face-to-face board meetings at least 3 times a year. • To ensure all committee and board cover sheets are completed in full and the actual template is reviewed in year to support this. • To review risk management processes collectively with the Board Assurance Framework (BAF) including frequency of its review. • To procure an external well-led review for 2025/26. • To review the Terms of Reference of all board committees to include a review of attendee lists. • **Part 2** • To cease the practice of governor observers at board committees • To reinstate at least one face-to-face Council of Governor meeting a year and review the training and development program

Action Required:	**Decision**	**Review and discussion**	~~Take assurance~~	~~Information only~~

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***

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

Implications			
Relationship to Board assurance framework:	**x**	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
		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
		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
		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
	X	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
	x	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
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:	**Regulation / Legal:** Compliance with Provider Licence, Code of Governance, Director duties and NHS Constitution.		
Resources:			

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

Part 1

Introduction

Internal Audit carried out their core audit program on the governance arrangements at Doncaster and Bassetlaw NHS Foundation Trust (DBTH) in Quarter 1 of 2024. There were several recommendations from this, with the main identified risks focussed on the annual committee and board cycle, aligning their Terms of Reference (ToR) to the committee and board work plans together with the frequency and effectiveness of the Board Assurance Framework (BAF) and how this sits within a wider risk management framework across the Trust.

Since starting in post, the Associate Director of Strategy, Partnership and Governance has reviewed the governance internal audit and provided an action plan of longer-term initiatives to address the identified gaps and move towards best practice standards.

The suite of governance documents is interdependent, therefore review and amendment of one will require review and amendment of the remaining documentation. They include Terms of Reference and associated documentation, the Trust Constitution, Scheme of reservation and delegation of powers, standing financial instructions as well as the way in which the Trust operates and utilises these.

Reinstate face to face board meetings at least 3 times a year.
Board effectiveness is reliant on the working relationships between non-executive and executive directors. During the Covid-19 pandemic, MS Teams has proved invaluable for enabling boards and committees to function and maintain business continuity. However, this should not be seen as the default position for all Trust business. Establishing effective board relationships, with new members requires time and effort and the wrap around discussions that happen as part of a face-to-face experience is a contributing factor in this. The Trust recognises there is a balance, and that MS Teams has supported greater public attendance, reduced travel costs, reduced environmental impact and saved time resources. A board meeting in public will still enable all public and governors to attend in person should they wish to, and as in pre-pandemic times, they will need to contact the Trust Board Office to make sure we have sufficient space to enable this. The impact of changes to the board format will be reviewed as part of the annual board effectiveness review in 2025/26.

The recommendation is therefore to reinstate at least 3 face-to-face of the public board meetings a year which will address this balance and will be evaluated in the following year.

Committee and Board cover sheets
All papers to board and Committees should have a coversheet that indicates to the reader what the issues are and what information is included which may be needed to support decision-making. The coversheet is a critical link to wider trust governance, strategic objectives, and risk management. The current sheet has not been in use for a full year, however, audit noted this not always completed and therefore impacts on the quality of information flowing through committees and boards. Moving to best practice, the cover sheet should be a useful tool for the report reader and author and support monitoring of progress of the trust strategy and associated risks.

The recommendation is for the Board to commit to fully implementing the current coversheet, and review this within the year against best practice alternatives to support both report authors and executives to observe its completion.

To review risk management and Board Assurance Framework (BAF)

The Internal Audit and direct conversations with members of the Board recognised the amount of work that has already been achieved in terms of the BAF and the risk management framework. In moving towards best practice there needs to be further work to review the operating standards of the template and how frequently this is reviewed within committees and board. The BAF should be utilised across the Trust and assured at committee that strategic risks are adequately mitigated and actions are making progress. While the current arrangements do this, there is room to make further amendments to support the 'working document' nature that the BAF should represent across all levels of the Trust.

The recommendation is for the Board to review the current BAF template and frequency of its review within its committees and board workplans.

External well-led review for 2025/26

As part of the Code of Governance for NHS Provider Trusts (4.7) all trusts are expected to have an externally well-led review every 3-5 years. This is a specific review that follows the Well-led Framework that came into force in April 2024. Full guidance is still being developed, however as the Trust has not had one in over 3 years, it would be best practice to commission this, following the annual internal well-led review that will take place later in 2024. A procurement exercise will be utilised to commission this as part of the board workplan in 2025. It should be noted that the requirement to comply with external review will create a financial cost pressure in that year, which we can benchmark against the previous review.

The recommendation is to procure an external well-led review in 2025/26, that will be informed by the findings of the internal well-led review completed in 2024/25.

Committee Terms of Reference

The Terms of Reference for board committee meetings are the backbone of corporate governance and support all those involved to understand their roles and responsibilities in the right context, and to ensure the right things are being discussed appropriately. Practical, operational items were outlined with the internal governance report and together with NHS Providers Council of Governors (CoG) Effectiveness report, and a subsequent external CoG effectiveness report there were a series of recommendations around attendance to committee meetings. Attendance should follow NHS Providers and best practice governance standards. This states "effective committees will have a membership large enough to encompass diverse perspectives but small enough to gain the benefits of focused challenge and scrutiny in a safe space (enabling frank and open discussion). The committee should have the correct attendance for specific matters but should leave the room once those matters are concluded. Council of Governor related items are discussed with more detail in Part 2.

The recommendation to review the ToR of board Committees and associated governance documentation (Board Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions), ensuring all operational details captured in the internal audit report are addressed, together with clear roles and responsibilities and review of attendee lists.

Part 2

Introduction

In March 2024, NHS Providers undertook an effectiveness survey of the Council of Governors, this was followed by a further independent governance review in April 2024, which used the findings of that survey to support reflections and recommendations. This was shared with the Council of Governors; a further survey was circulated in June and July 2024. None of the engagement surveys captured 100% of governor feedback, however there were consistent themes throughout. There was a strong focus on understanding and clarification of the statutory role of the Council of Governors in terms of individual and collective responsibilities and the difference in the roles of non-executive directors and governor roles.

Governors have a statutory duty to hold the NEDs to account for the performance of the board. However, the legislation says nothing about what this duty means or how it is to be performed. This can be problematic if governors are not given clear guidance by the trust, leading to councils attempting to duplicate the work of the board, because their role is not clearly differentiated from the role of NEDs. The reviews provided evidence that this clarification was not evident for some governors and recommended governor training and development needs, especially in terms of the governor (Council of Governors) role and responsibilities as well as wider opportunities to engage stakeholders and system collaboration.

Governor Observers at Board Committees

NHS Providers and governance best practice recommend that governors are not invited to observe board committees. There are a number of governance reasons specified by NHS Providers that this recommendation is based on:

- It is the governor role to form a view on the performance of the board of directors and to hold the NEDs to account for *this* performance, so it is the board's performance, not the NEDs performance, with which governors should concern themselves. Governor attendance at committees can be justified as "seeing NEDs in action" however, it is not the role of governors to assess specific NEDs in this context or for themselves to act as secondary NEDs in this forum.
- There is the danger of creating individual 'expert' governors who appear to have knowledge on the work of the board. This can impair the governor's ability to act independently when sitting on the council of governors. This also creates an environment whereby roles and responsibilities between NEDs and governors are confused, and an individual governor is seen as holding a role that is not defined as part of the Council of Governors duties.
- the act of observation alone can impact on outcomes. Where Governors see themselves as having a role in the committee, this can fetter open and frank discussions and prevents the committee operating as a safe space for the board to effectively challenge and fulfil its own delegated duties. This in effect has the outcome of governors being party to a decision which they will ultimately be holding others to account for.

Regardless of governor or membership status, any member of the public has the right to observe the performance of the board through the actual board meeting and scrutiny of the data publicly available. As all committee actions are reported through to the board, this transparency is still maintained.

It is recommended that governor observations at committees are ceased upon board agreement, with the relevant governance documentation amended to reflect this decision as part of the wider governance actions.

Council of Governor Meetings, training, development and partnering opportunities

As outlined in Part 1, there are benefits to the virtual on-line meeting provision of MS Teams. However, this also needs to be weighed against the benefits of meetings in person. The evidence shows there is considerably

more engagement and attendance of governors when meetings and activities are online, however having a minimum of one formal meeting annually is something that governors have requested in all survey responses. This is over and above the training and development sessions, briefing sessions and meet and greet coffee mornings that are often physical events at the various hospital sites throughout the year.

As part of this process, the induction program, training, and development offer of governors and how they can become a more integrated part of the Trust will be reviewed collaboratively. This will include a review of how governors can have a formal role within the wider service visits program.

It is recommended to the board, there is at least one face-to-face official Council of Governors meeting planned into the annual cycle.

The recommendations included in this report are based on best practice and benchmarking across the NHS governance professionals' network and in line with the national governance frameworks and accompanying documentation (Code of Governance for NHS Providers, Provider Licence, Well-led etc.

2409 - E STATUTORY & REGULATORY

2409 - E1 MATERNITY & NEONATAL UPDATE TO INCLUDE MATERNITY & NEONATAL INDEPENDENT SENIOR

Discussion Item | Karen Jessop, Chief Nurse & Danielle Bhanvra, Head of Midwifery | 1

Abbey Harris, Maternity & Neonatal Independent Senior Advocate
20 minutes

REFERENCES

Only PDFs are attached

- E1 - Maternity & Neonatal Update.pdf
- E1 - Appendix 1 - Q1 PMRT Report.pdf
- E1 - Appendix 2 - Neonatal medical staffing action plan.pdf
- E1 - Appendix 3 - Q1 ATAIN report.pdf
- E1 - Appendix 3 - Q1 ATAIN report.xlsx
- E1 - Appendix 4 - Maternity Dashboard July 24.pdf
- E1 - Appendix 4 - Maternity Dashboard July 24.xlsm
- E1 - Background and Glossary of Terms - Maternity.pdf
- E1 - Maternity & Neonatal Independant Senior Advocate Bi-annual Update.pdf
- E1 - SYB MNISA Bi-annual Update.pdf
- E1 - MNISA Presentation.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**E1**
Report Title:	**Maternity & Neonatal Update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse, Paediatrics		
Appendices:	1 - Q1 Perinatal Mortality Report 2 - Neonatal medical Workforce Plan 3 - Q1 ATAIN report 4 - Maternity Dashboard		

Report Summary

Purpose of the report & Executive Summary

The following papers gives an update on the progress against the single delivery plan, maternity self-assessment tool and CNST.

The report covers the review and learning from patient safety events, perinatal mortality reviews and patient safety investigations.

It covers the work related to the improvement of maternity and neonatal services which includes;

- Training compliance for anaesthetic, maternity and neonatal staff
- Saving babies Lives care bundle V3
- Midwifery, Obstetric, neonatal nursing and medical staffing
- Avoiding term admissions to the neonatal unit
- Updates on the neonatal services
- Perinatal metrics
- The triage service

Progress against the work required to achieve full compliance with year 6 CNST standards which includes maternity, neonatal and anaesthetic services.

Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this maternity and neonatal safety report and to record in the Trust Board minutes to provide evidence for the maternity incentive scheme the following:- • Reviewed and approved the Q1 Perinatal Mortality Report • Reviewed and approved Q1 ATAIN • Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce have not been met and approved the neonatal medical workforce action plan to address this. • Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal nursing workforce have not been met

	and approved the neonatal nursing workforce progress update against lasts year's plan. • Board Safety Champions are meeting with the perinatal leadership team bi monthly and any support required of the trust board has been identified and is being implemented. • Progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support being considered and implemented			
Action Required:	**Approval**	Review and discussion	**Take assurance**	Information only

Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes /~~No/ NA~~		**Yes /~~No/ NA~~**	

Implications			
Relationship to Board assurance framework:	**x**	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
	X	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
		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
		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
		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
	x	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
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**			
Legal/ Regulation:	CQC - Regulation 12 Potential high impact *Clinical Negligence Scheme for trusts - High impact*			

Resources:		
Assurance Route		
Previously considered by:		The Maternity and neonatal Safety Quality Committee Divisional Governance Meetings
Date:	Monthly	
Any outcomes/next steps		Support to continue improvements in maternity & neonatal service, and achieve year 6 CNST standards
Previously circulated reports to supplement this paper:		

Bi Monthly Board Report

July 2024

1. Report Overview

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with the Single Delivery plan, which includes Ockenden and progress made in response to any identified concerns at provider level.

2. Perinatal Mortality Rate

The graphs included in Appendix 1, demonstrate how DBTH is performing against the national ambition.

2.1 Stillbirths and late fetal loss > 22 weeks

One still birth in June and two in July.

2.2 Neonatal Deaths

None.

2.3 Perinatal Mortality Review Tool (PMRT) 1.6.2024 to 31.7.2024

Date	Type of Death	Gestation	Antenatal / Intrapartum / Neonatal	Information
May	Stillbirth	27+3	Antenatal	Booked at 22+0. G5 P4 No children in her care. Booked too late for aspirin. BW 900g MG-PSERP review - no issues and to follow PMRT pathway for review in June meeting
June	Stillbirth	26+6	Antenatal	Booked at another trust and transferred care had booking appointment and 1x ANC appointment next contact sadly IUFD diagnosed. On review issues highlighted for PN care no issues with AN care / missed opportunities. For review in August meeting
July	Stillbirth	31+0	Antenatal	Attended CMW clinic and unable to find FH transferred to DRI due to gestation on

				arrival to DRI USS performed and sadly IUFD. For review in August meeting
July	Stillbirth	25+3	Antenatal	Attended triage with reduced fetal movements unable to locate FH USS confirmed IUFD. For review in August meeting

2.4 Learning from PMRT reviews

Issues
None identified.

Learning
Q1 PMRT report is attached in Appendix 1.

3. Maternity and Newborn Safety Investigations (MNSI) and Patient Safety Incident Investigations

3.1 Investigation Progress Update

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

In April and May there was 0 qualifying incidents that needed reporting to MNSI (maternity and neonatal service investigation service) or ENS (Early notification scheme).

3.2 Reports Received since last report

None.

3.3 Current investigations

None.

3.4 Coroner Reg 28 made directly to the Trust

None.

3.5 Maternity Patent Safety Incident Investigations (PSII)

There is 1 PSII in progress related to a number of common injuries during birth, there were no immediate themes identified. One practitioner has been involved in more than one case and this has been reviewed.

An action plan is in place to address these areas, and this is monitored through the maternity and neonatal safety quality meeting.

4. Single Delivery Plan (which includes Ockenden / Maternity Self-Assessment (MSA))

Progress continues against the single delivery plan, this is updated on a monthly basis. All areas are progressing except for continuity of carer, this has been paused in line with the recommendation from NHSE in October 2021. Once the midwifery establishment and skill mix is suitable then the service will look to implement this in the most deprived areas.

The maternity self-assessment tool is reviewed on a quarterly basis. Work is ongoing and areas addressed in this quarter are:

- Programmed Activity (PA) allocations for lead obstetric consultant roles related to the single delivery plan, ockenden and particularly leadership

5. Training Compliance for all staff groups

Training figures as at June 2024 & July 2024 are detailed below:-

Table 1 & 2 - K2 / Competency Assessment (CA) & Study day
June 2024

Staff Group	K2 / CA Compliance June 24	Study Day Compliance June 24
90% of Obstetric Consultants & SAS Drs	**100%**	**88.2%**
90% of all other obstetric doctors contributing to the obstetric rota	**93.3%**	**100%**
90% of midwives including bank & agency staff	**92%**	**90.8%**

July 2024

Staff Group	K2 / CA Compliance Jul 24	Study Day Compliance Jul 24
90% of Obstetric Consultants & SAS Drs	**100%**	**94.1%**
90% of all other obstetric doctors contributing to the obstetric rota	**100%**	**100%**
90% of midwives including bank & agency staff	**100%**	**91.4%**

Note: This year there will be a transition period as the trust moves from K2 online package to a competency assessment (CA) the K2 / CA is the combined figure as we transition to CA only)**.**

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

Table 3 & 4 - PROMPT figures

June 2024

Staff Group	Prompt Compliance June 24
90% of Obstetric Consultants & SAS Drs	**100%**
90% of all other obstetric doctors contributing to the obstetric rota	**89.4%**
90% of midwives including bank & agency	**92.7%**
90% of maternity support workers and health care assistants	**86.6%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**82.3%**
90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity	**91.6%**
70% of non-obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity (no longer included in CNST)	**20.8%**

July 2024

Staff Group	Prompt Compliance Jul 24
90% of Obstetric Consultants & SAS Drs	**100 %**
90% of all other obstetric doctors contributing to the obstetric rota	**89.4%**
90% of midwives including bank & agency	**92.6%**
90% of maternity support workers and health care assistants	**86.8 %**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**93.7%**
90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity	**91.6 %**
70% of non-obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity (no longer included in CNST)	**66.6%**

Whilst the requirement for all anaesthetic doctors has been removed for Year 6 CNST (please see above), the service is continuing with the training as in preparation for year 7.

Table 5 & 6 - NLS figures

June 2024

Staff Group	NLS Compliance June 24
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**88%**
90% of neonatal junior doctors (who attend any births)	**94%**
90% of neonatal nurses (Band 5 and above who attend any births)	**85%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**67%**
90% of midwives including bank & agency	**90.1%**

July 2024

Staff Group	NLS Compliance Jul 24
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**100%**
90% of neonatal junior doctors (who attend any births)	**94%**
90% of neonatal nurses (Band 5 and above who attend any births)	**87%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**60 %**
90% of midwives including bank & agency	**91.8%**

The 2 ANNP outstanding for NLSA training are booked on the next available course.

6. Safety Champion meetings

Meetings were held on 5th June and 31st July 2024, where the board safety champion and non-executive director meets with the perinatal quadruvirate leadership team.

6.1 Positive Points recognised

Midwifery recruitment has been successful this year.
Work is ongoing with year 6 CNST and this currently on track.

6.2 Concerns raised by the visit and staff

No concerns were raised during the visit at Bassetlaw.

6.3 Concerns raised by service users

No representation, this has been escalated to the LMNS for support.

6.4 Culture / SCORE survey findings, progress / updates on areas for improvement / any plans

It is recognised that there is still work to do related to the culture in the maternity service. The board safety champion has met with those labour ward coordinators who wished to do so as another route for them to raise concerns, primarily in relation to the current skill mix and involvement in decision making. In conjunction with the Director of Midwifery a wider plan is under development to support cultural improvements.

6.5 Any support required of Trust Board following Safety Champion meetings and progress to show implementation

Nothing identified for the Trust Board, however the Chief Nurse as Board level safety Champion has developed and agreed a series of actions in collaboration with the Director of Midwifery to support culture improvement work.

7. Saving Babies Lives V3

7.1 Update

The SBLCBv3 was launched in May 2023 and represents Safety Action 6 of the Clinical Negligence Scheme for Trusts.

An implementation tool is available to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three.

The following outlines element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element and gives the percentages calculated within the national implementation tool.

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	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	86%	Partially implemented	87%	CNST Met

8. NHS Resolution Incentive Scheme Update in month (MIS/ CNST)

Work in is progressing on Year 6 CNST, this is overseen by the CNST/ SDP oversight committee and reported to the maternity and neonatal safety quality group (MNSQG) which is chaired by Chief Nurse as the maternity board safety champion.

All safety actions are currently on track to be able to submit full compliance in March 2025. Training compliance (Safety Action 8) remains the most challenging, and is proactively managed by the education team, ward managers and matrons.

9. The number of patient safety events logged graded as moderate or above and what actions are being taken

June - 14

These were 3rd & 4th degree tears, the ATAIN baby admissions and one neonatal re-admission.

July - 11

All cases have been reviewed within the patient safety incident review framework (PSIRF) process. No immediate concerns have been identified, and any learning will be shared within the maternity and neonatal service.

10. Safe Maternity & Neonatal Staffing

Maternity and Midwifery staffing bi-annual report is reported separately to the Children's and families Division and Trust Board to meet the requirements for the maternity incentive scheme.

Midwifery staffing

Midwifery staffing remains stable, and currently the service has 206.61 WTE contracted midwives against 225.04 WTE recommended. Recruitment of the agreed newly qualified midwives is progressing as planned. Further newly qualified midwives are expected in October 2024.

All rotas are planned to have a supernumerary coordinator on every shift for June and July 2024.

100% 1:1 care in labour was achieved at Bassetlaw and Doncaster.

10.1 Neonatal Nursing - Fill rates planned versus actual

Neonatal staffing is 90% recruited with 87% of establishment at work. The Qualified in Speciality ratio is below the 70% standards at 64% on the Neonatal Unit (NNU) at DRI. During July we had 100% of shifts at BDGH and 99% at DRI resourced within British Association of Perinatal Medicine (BAPM) standards. All the shifts below BAPM standards were due to a missing supernumerary co-ordinator.

A review was undertaken in September 2023 which showed the BAPM standards for neonatal nursing workforce were not met in year 5 of CNST. An action plan was developed and agreed by Trust Board with a 4 year proposed plan to meet the BAPM standards. A business case has been developed for year 2 of the proposal, which requests investment to support a supernumerary coordinator on the Neonatal unit at DRI for 24 hours. The ODN annual workforce calculator has been complete and submitted. We are currently awaiting the results.

Progress continues with to meet the BAPM standards for neonatal nursing, below is an update on the current action plan:

Year	Investment	Progress Update
2023/2024	Increase clinical roles to 25% uplift at SCBU and NNU	Business case (BC) has been developed to go to CIG 5th September 2024 with phased approach to support years 23/24 & 24/25. It is proposed that future years models 25/26 & 26/27 are discussed following the expected commissioner changes which are planned for next year, enabling a practical discussion on operational risk and activity number requirements.
2024/2025	Quality roles on SCBU and coordinator at night NNU	
2025/2026	24 hr coordinator for SCBU at night	
2026/2027	AHP at recommendations	

10.2 Obstetric Staffing

Ongoing monthly monitoring of compliance of short-term locums and engagement of long term locums is continuing. In June / July 2024 there were no episodes of non-compliance. Compensatory rest is continuing to be monitored and there have been no recorded incidents of consultant non-attendance in an emergency in June and July 2024.

10.3 Neonatal medical staffing

Following the last review in year 5 the Trust met the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce. A review has been undertaken against the year 6 requirements and the new BAPM standard requirements have not been met at DRI due to not being funded for a separate dedicated night SHO for neonates. An action plan to address this has been developed (Appendix 2) for approval and it is requested that approval be formally recorded in the minutes and noted that the BAPM standards have not been met to date.

10.4 Anaesthetic Workforce

Weekly rotas for the anaesthetic medical workforce are collated to evidence ongoing compliance with the Anaesthetic Clinical Services Accreditation (ACSA) standard 1.7.2.1. The Trust is compliant with this standard.

10.5 Red Flags

The red flags are recorded on the birth rate+ ® app on a four hourly basis and for April and May have been recorded below:

Table 7 & 8 - DRI

Red Flag (June)	**Number of times**
Delayed or cancelled critical time activity	2
Delay between admission for induction and beginning of process	3
Management Actions taken	
Redeploy staff internally	16

Staff unable to take allocated breaks	1
Unit on divert	2
Escalate to Manager on call	6

Red Flag (July)	**Number of times**
Delayed or cancelled critical time activity	1
Missed or delayed care	1
Delay between admission for induction and beginning of process	8
Delay between presentation and triage	1
Coordinator unable to maintain supernumerary status providing 1:1 care	1
Management Actions taken	
Redeploy staff internally	22
Staff unable to take allocated break	2
Staff sourced from bank / agency	3
Utilise on call midwife	1
Unit on divert	4
Escalate to Manager on call	10

Table 9 & 10 - BDGH

Red Flag (June)	**Number of times**
Coordinator unable to maintain supernumerary status providing 1:1 care	2
Delay between admission for induction and beginning of process	1
Management Actions taken	
Redeploy staff internally	9
Staff unable to take allocated breaks	1
Unit of divert	11
Escalate to manager on call	11

Red Flag (July) None for July	**Number of times**
Management Actions taken	
Redeploy staff internally	3
Unit of divert	5
Escalate to manager on call	4

11. Insights from the service users and maternity and neonatal voices partnership Co-production

The service remains committed to working with the maternity and neonatal partnership, work has been paused over the summer holiday period due to representatives leave. On recommencement in September the service users, DBTH and the LMNS will work together to develop a plan going forward.

12. Quality Improvement projects / progress

The service has a number of quality improvement projects registered these are:

- To improve the service for diabetics in ante natal clinic, and accommodate the increasing demand for this service
- To improve the transitional care offer
- Reviewing and improving ante clinic provision in light of increasing high risk pregnancies

All projects are registered, have identified leads and are in progress.

13. Implementation of the A EQUIP model

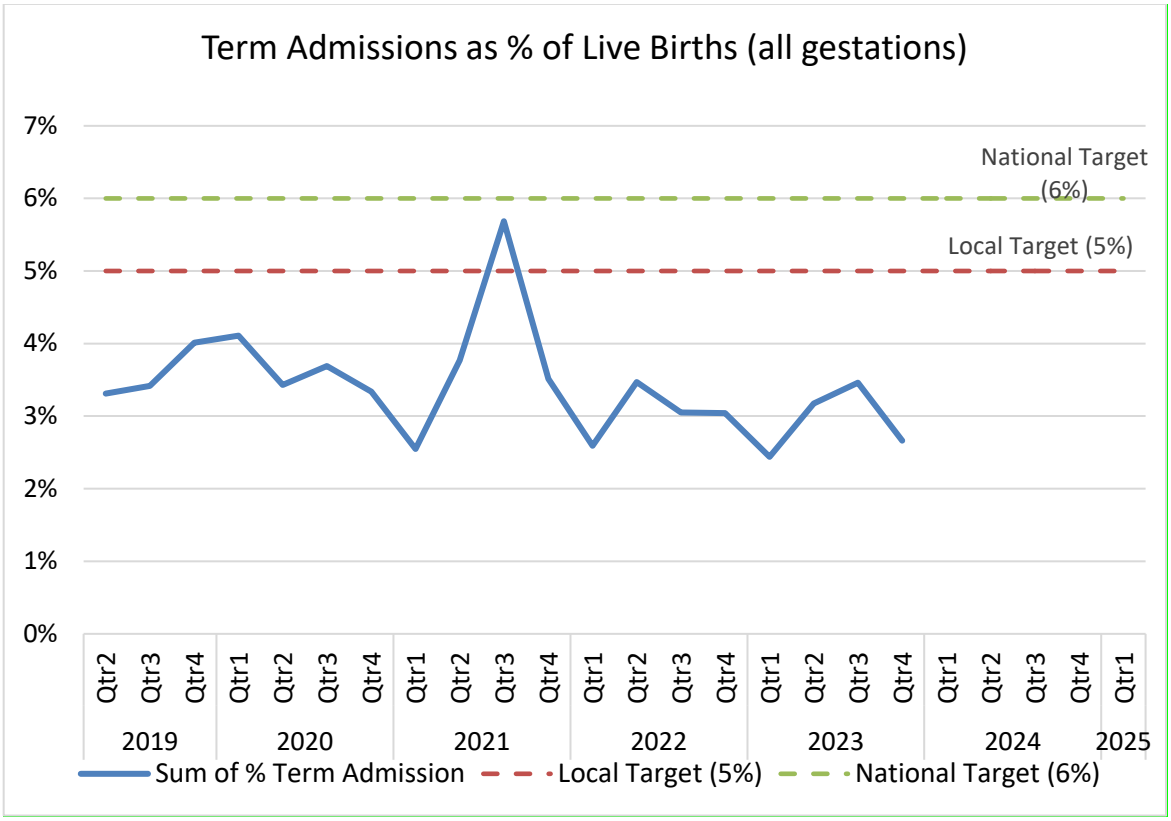
The service has a 0.6 WTE lead professional midwifery advocate (PMA) and is currently building the team of PMAs to commence the A Equip model to support all midwives in the maternity service.

14. Avoidable Admission into the Neonatal unit (ATAIN)

14.1 The national Ambition

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. The national ambition for term admissions is below 6%, however Trusts should strive to be as low as possible.

All term babies admitted to neonatal unit have a multidisciplinary review, and this informs an action plan for the maternity service. The Trust performance is detailed below:



All elements of the current action plan are on track these include:

- Ensuring women are provided with consistent and adequate information regarding the use of steroids
- QI project to improve transitional care
- Further education on neonatal abstinence observations

Attached is the Q1 ATAIN report (Appendix 3).

14.2 DBTH transitional care

There is an ongoing transitional care quality improvement project to improve the offer at DBTH. The reopening of M1 ward will create an opportunity together with the improved recruitment of midwives to offer an improved service.

At November 2023 board meeting the transitional care action plan was approved and due to the changes as part of the year 6 requirements and progress made from year 5 a new action plan was approved at July 2024 board meeting. The new action plan is for a move towards a transitional care pathway based on the BAPM framework for babies from 34+0.

Progress against the plan will be provided before the year 6 submission deadline.

15. Red Risks / Risk Register Highlights

Risk	Mitigation in place	Plan to address risk
Increased demand in diabetic clinic, and the ability for the diabetic team to meet this demand	Risk assessments of patients and individual plan to ensure care in line with NICE	Ongoing work between medicine and C & F divisions to find a long term solution

All high risks are discussed and monitored at the risk management board, and others are monitored through the governance and divisional meetings.

16. Neonatal Services

We have ongoing challenges due to the estate with frequent water leaks from the roof, this is an ongoing risk but there are plans to replace the roof this financial year.

As part of ongoing improvement to improve family care we have introduced offering meals to inpatient Parents. Currently we are non-compliant with having a bliss volunteer and continue to try recruit in coffee mornings and on the mini marvels social media page. This is a problem across the region. We are unable to offer Parent sleeping facilities beside the cot due to limited space in the nurseries.

17. Perinatal Metrics

The new maternity dashboard has been included in Appendix 1.

Metrics with significant deterioration:

- Unexpected admission to neonatal unit

These are currently under review by the multidisciplinary team, and any themes or learning will be shared.

Metrics with no significant change are:

- Number of births
- 3rd and 4th degree tears
- Stillbirth rate
- PPH > 1500mls
- Neonatal deaths
- Hypoxic-Ischaemic encephalopathy (HIE) average days between
- Unexpected admission to the neonatal unit

Metrics with a significant improvement:

- HIE rate
- Stillbirth

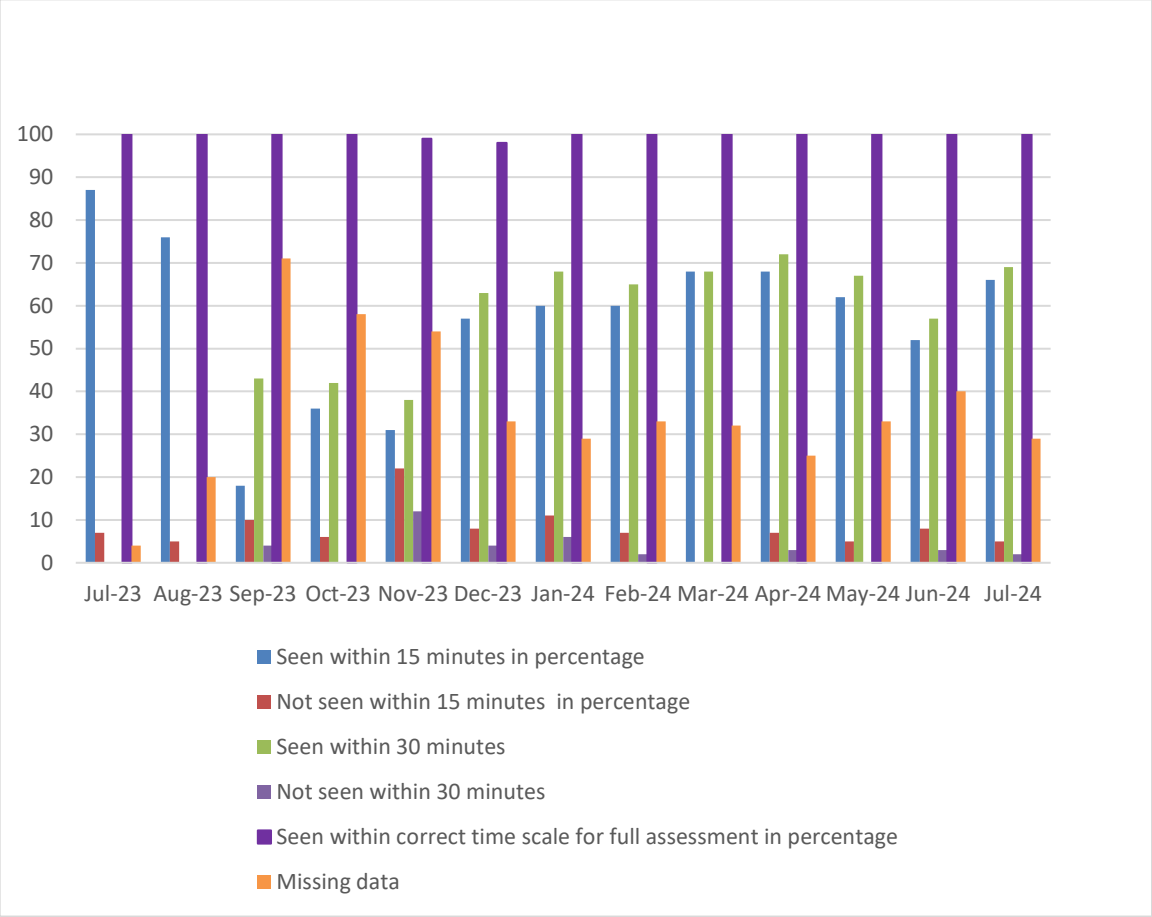
Metrics with a significant deterioration

- Neonatal Death

Analysis and learning is currently in progress.

18. The Triage Service

The service continues to audit performance against the standards, these are the results for June and July:



There was a decrease in missing data in July, and more women were seen in 15 minutes. The service has recruited a further three new core staff improving the skill mix within the triage service. This will improve the performance with maintaining the Birmingham symptom specific obstetric triage system (BSOTs).

19. Recommendation

This report contains the details of the Trust performance against local and nationally agreed measures to monitor maternity services, actions are in place to improve and monitor the quality and safety in maternity services.

The Board of Directors is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence

for the maternity incentive scheme that the following have been reviewed and approved:

- Q1 PMRT report (Appendix 1)
- Neonatal Medical Workforce Action plan (Appendix 2)
- Neonatal nursing workforce progress update
- Q1 ATAIN report (Appendix 3)

And formally record that:

- The relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce has not been met but there is an action plan in place to achieve.
- Board Safety Champions are meeting with the perinatal leadership team bi monthly and any support required of the trust board has been identified and is being implemented.
- Progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support.

PMRT - Perinatal Mortality Reviews Summary Report

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

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

Quarter 1 period: 01/4/2024 to 30/6/2024

1. Introduction

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

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

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

In accordance with the requirements of the Clinical Negligence Scheme for Trusts (CNST) – NHS Resolution, all stillbirths and Neonatal deaths eligible for review using the PMRT from 8th December 2023 to 30 November 2024 will be part of Quarterly Reports submitted to the Trust Board and will include details of all deaths reviewed and consequent action plans**.**

This report also documents whether the required standards within Safety Action standard 1 have been met.

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

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

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

The definition of labour used by HSIB is

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

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

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

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

The latest MBRRACE Report for births 2022 gives a national stillbirth rate of 3.35 per 1000, a minimal increase from the 3.33 figure for 2020 births. This figure is calculated from births at 24 weeks or over, and excluding terminations of pregnancy.

The Trust annual stillbirth rate for 2023 **from 24+0 weeks** of pregnancy and above across both sites is to 3.12 stillbirths per 1,000 births. In numerical values this was 14 stillbirths. During this same period from **22 weeks of pregnancy to full term** there were in addition to the 14 stillbirths there was 1 late fetal loss.

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

During the first quarter of 2024-2025, from 1st April 2024 to 30th June 2024 there have been **2** stillbirths of the 1,097 births across both sites (2 at DRI, 0 at BDGH) and **1** medical termination of pregnancy (MTOP) for fetal abnormality above 24 weeks gestation. Of this time period, there were a total of 1,128 births, of which 743 births at DRI and 385 Births at BDGH.

There have been **0** late fetal losses between 22+0-23+6 weeks gestation during this quarter. During the same timescale, there have been **2** MTOP's of this same gestation.

This provides a trust adjusted stillbirth rate of **1.8 per 1000 births for this quarter 1**, from 24 weeks gestation; which is a decrease from last quarter (quarter 4 of 2023-2024 adjusted stillbirth rate of 3.6 per 1000 births).

Combining the figures from quarters 2, 3 and 4 of 2023-2024 and quarter 1 of 2024-2025 the rolling adjusted stillbirth rate is **3.5** per 1000 births. This equates to 16 stillbirths from 24 weeks of gestation (total births for this period is 4,508 for both sites).

3. NEONATAL DEATHS

The latest MBRRACE Report for births 2022 gives a national neonatal death rate of 1.7 deaths per 1,000, an increased rate compared to the 2020 rate of 1.5 per 1000. The rate is calculated for births over 24 weeks and includes deaths to 28 days.

Deaths that are included in the Trust rates are those of babies that were born and died within the trust. The Trust annual 2023 stabilised and adjusted rate for 2022 was 1.1 per 1000.

During the first quarter of 2024-2025, from 1st April 2024 to 30th June 2024 there have been **0** Neonatal and post-Neonatal deaths of the 1,128 births across both sites. 743 births being at DRI and 385 Births being at BDGH.

This provides the Trust with a stabilised and adjusted rate for this quarter 1 of 2024-2025 of 0 per 1,000.

Combining the figures from quarters 2, 3 and 4 of 2023-2024 and quarter 1 of 2024-2025 (excluding the deaths under 22+0 and MTOP resulting in NND) the rolling adjusted neonatal and post-neonatal deaths rates of 1 equates to a rate of **0.2** per 1000 births from 22 weeks of gestation (total births for this period is 4,508 for both sites).

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

CNST requirements - Safety Action 1

Requirements	CNST requirement compliance	CNST Trust Compliance
a) All eligible perinatal deaths from 8 December 2023 should be notified to MBRRACE-UK within seven working days.	**100%**	**100%**
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions / comments they have sought from 8 December 2023 onwards.	**95%**	**100%**
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8th December 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	**95%**	**100%**
	60%	**100%**
d) Quarterly reports should be submitted to the Trust Executive Board from 8 December 2023.		**Q3 submitted and presented –including 1 case in December 23 27/02/24** **Q4 submitted and presented 02/07/24** **Q1 detailed within this report**

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

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *2*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
6	4	1	1	0

Neonatal and post-neonatal deaths

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

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACEUK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

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

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Case ID **(SB)**	Date	Gestation	Antenatal/ Intrapartum	PMRT and investigation /review outcome
93261	11/05/2024	27+3	Antenatal	Care graded C, A Review outcome: CMW commended on how assisted patient to obtain housing. More collaborative working with interlinking of agencies could have prevented missed opportunities to provide personalised care and support – such as including anaesthetists with hospital appointments for booking bloods to be obtained, and the increase of awareness of the mental health support for during/following pregnancy
93939	22/06/2024	26+6	Antenatal	To be presented to PMRT August 2024 meeting Review outcome:
Case ID **(NND)**	Date	Gestation and Age	Initial review findings care until the birth of the baby	PMRT and investigation /review outcome

Social, economic and deprivation data **(SB)**		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25							
	26-35			1				
	36-45			1				
	46+							
Smoking status	Never smoked							
	Non-smoker stopped before conception			1				
	Non-smoker stopped after conception							
	Smoker			1				
	Unspecified							
Ethnicity	White			2				
	Black							
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4			2				
	5-7							
	8-10							
Employment	Employed			1				
	Not employed							
	Student							
	Homemaker							
	Sick/Disabled			1				
	Unknown							
Marital status	Married / Civil Partner							
	Single			1				
	Cohabiting			1				
Learning or communication difficulties	Yes			1				
	No			1				

Social, economic and deprivation data **(NND)**		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25							
	26-35							
	36-45							
	46+							
Smoking status	Never smoked							
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker							
Ethnicity	White							
	Black							
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4							
	5-8							
	8-10							
Employment	Employed							
	Not employed							
	Homemaker							
	Sick							
	Not stated							
Marital status	Married							
	Single							
	Cohabiting							
Learning or communication difficulties	Yes							
	No							

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

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

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

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

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

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	1	100% (1)
Bereavement Team	1	100% (1)
Community Midwife	1	100% (1)
External	3	100% (1)
Management Team	3	100% (1)
Midwife	14	100% (1)
Neonatal Nurse	3	100% (1)
Neonatologist	5	100% (1)
Obstetrician	9	100% (1)
Other	3	100% (1)
Risk Manager or Governance Team	5	100% (1)
Safety Champion	1	100% (1)

- Chair was present for the meeting review for one case which had been presented at PNMM admin error MBRRACE not updated – completed retrospectively after the closure

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

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

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

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

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**1 causes of death out of 1 reviews**
	The cause of death was undetermined
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother booked late. Did this affect her care?	1	No action entered

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

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

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
Mental health support	1	Increase awareness of mental health support during and after pregnancy
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	Head of Equity, Equality & Inclusivity- Maternity Services to explore alternative care plans for women with extreme social complexities' to ensure we have a robust care plan which can meet the needs of these women and their families
This mother has a psychological/mental health disorder, this was identified in a previous pregnancy, but she not receive specialist preconception counselling/management	1	No action entered

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

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

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Patient Factors - Physical Factors	1	This mother booked late. Did this affect her care?

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Neonatal Medical Workforce

Action plan to meet BAPM standards at DRI, Tier 1

Gap	Actions	Lead	Timescale
Increase SHO complement to allow for a 2nd SHO at night time to provide dedicated cover for neonatal services.	Complete rota options appraisal	Dr Rao	31/08/24
	Draft and seek approval of business case	Nigel Brooke/ Sarah Plowman	30/09/24
	Commence recruitment	Sarah Plowman	October 24
	SHO in place	Sarah Plowman	31/03/25

08/08/24

AL Final

South Yorkshire and Bassetlaw
Local Maternity System
Transforming your maternity services together

Improvement Academy

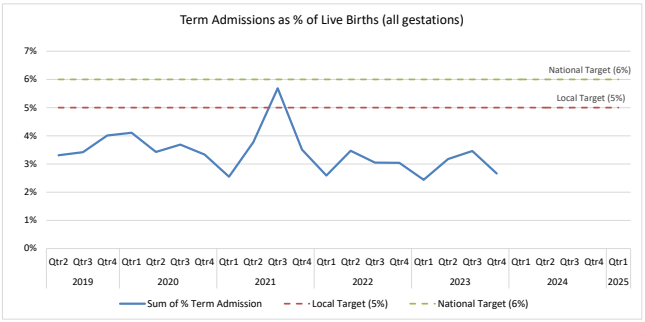
SYB ATAIN - QI Dashboard v4.0

Unit/Trust: Doncaster & Bassetlaw **Person completing data:** Alex Merriman

Month	Live Births All Gestations	Term babies Inborn (>37/40)	Inborn admissions: (all gestations) excl transfers	Inborn TERM admissions (37/40) excl transfers	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions
Apr-24	401	355	39	12	3.0%	5.0%	6.0%	2	5.1%
May-24	392	359	25	10	2.6%	5.0%	6.0%	2	8.0%
Jun-24	366	350	27	11	3.0%	5.0%	6.0%	2	7.4%
Jul-24					0.0%	5.0%	6.0%	0	#DIV/0!
Aug-24					0.0%	5.0%	6.0%	0	#DIV/0!
Sep-24					0.0%	5.0%	6.0%	0	#DIV/0!
Oct-24					0.0%	5.0%	6.0%	0	#DIV/0!
Nov-24					0.0%	5.0%	6.0%	0	#DIV/0!
Dec-24					0.0%	5.0%	6.0%	0	#DIV/0!
Jan-25					0.0%	5.0%	6.0%	0	#DIV/0!
Feb-25					0.0%	5.0%	6.0%	0	#DIV/0!
Mar-25					0.0%	5.0%	6.0%	0	#DIV/0!

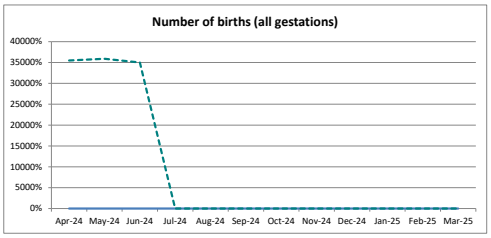
Number of inborn term babies (>37/40) admitted to neonatal unit with avoidable condition

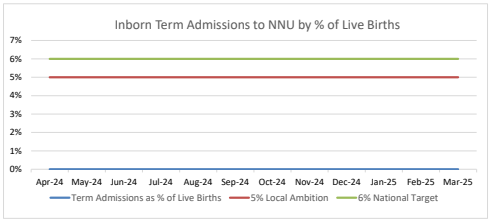
Select PRIMARY Reason (only 1 entry per admission)		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
R1	Management of a respiratory problem	1	1											2
R2	Hypothermia or need for temperature monitoring													0
R3	Hypoglycaemia/intervention to maintain blood glucose – BAPM pathway not followed	1		1										2
R5	Administration of antibiotics with no additional requirement for care.													0
R6	Requires period of observation													0
R7	Observation following resuscitation													0
R8	Suspected sepsis													0
R9	Jaundice (regardless of onset)		1											1
R12	Management of seizures													0
R13	Diagnosed NAS			1										1
A15a	Well baby admitted for social reasons e.g appropriate social care preparations not implemented, or mum admitted to ITU where provision could have been made for birthing partner to care for baby													0
A15b	Could have been cared for in an NTC setting, if available													0
A15c	Admitted for congenital anomaly that could have be managed on PNW (eg cleft palatte doesnt automatically need NNU)													0
A15	Other: (enter number)													0
A15-reason	Other (enter reason)													0
	Total	2	2	2	0	0	0	0	0	0	0	0	0	6

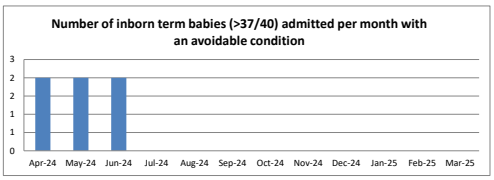


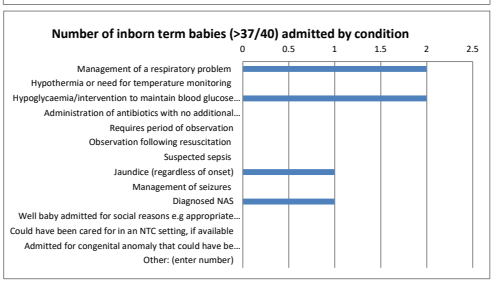
SYB ATAIN - QI Run Charts

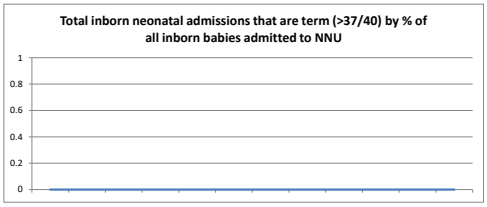
Doncaster & Bassetlaw

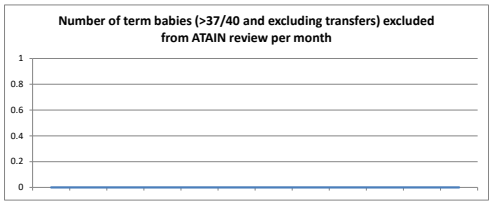


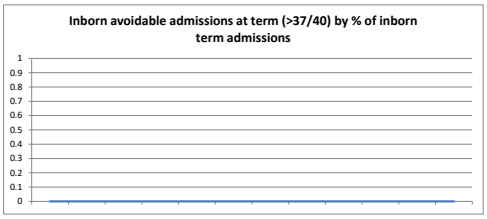







Total inborn neonatal admissions that are term (>37/40) by % of all inborn babies admitted to NNU
1
0.8
0.6
0.4
0.2
0


Number of term babies (>37/40 and excluding transfers) excluded from ATAIN review per month
1
0.8
0.6
0.4
0.2
0


Inborn avoidable admissions at term (>37/40) by % of inborn term admissions
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0

South Yorkshire and Bassetlaw
Local Maternity System
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Improvement Academy

SYB ATAIN - QI Dashboard v4.0

Unit/Trust: Doncaster & Bassetlaw **Person completing data:** Emma Merkuschev

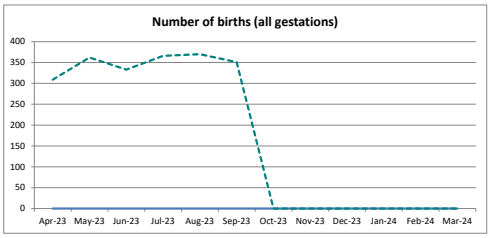
Month	Live Births All Gestations	Term babies Inborn (>37/40)	Inborn admissions: (all gestations) excl transfers	Inborn TERM admissions (37/40) excl transfers	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions
Apr-23	331	309	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	16	4.2%	5.0%	6.0%	5	13.2%
Jul-23	404	366	46	16	4.0%	5.0%	6.0%	0	0.0%
Aug-23	397	370	34	15	3.8%	5.0%	6.0%	2	5.9%
Sep-23	384	351	27	13	3.4%	5.0%	6.0%	3	11.1%
Oct-23					0.0%	5.0%	6.0%	0	#DIV/0!
Nov-23					0.0%	5.0%	6.0%	0	#DIV/0!
Dec-23					0.0%	5.0%	6.0%	0	#DIV/0!
Jan-24					0.0%	5.0%	6.0%	0	#DIV/0!
Feb-24					0.0%	5.0%	6.0%	0	#DIV/0!
Mar-24					0.0%	5.0%	6.0%	0	#DIV/0!

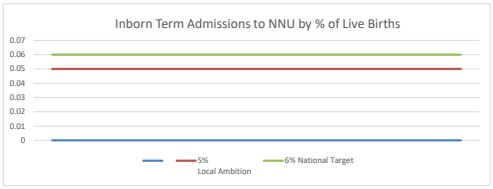
Number of inborn term babies (>37/40) admitted to neonatal unit with avoidable condition

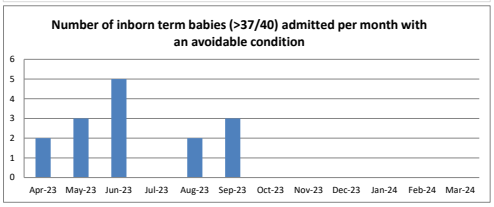
Select PRIMARY Reason (only 1 entry per admission)		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
R1	Management of a respiratory problem	1	3	3		1	1							9
R2	Hypothermia or need for temperature monitoring	1												1
R3	Hypoglycaemia/intervention to maintain blood glucose – BAPM pathway not followed			1		1								2
R5	Administration of antibiotics with no additional requirement for care.													0
R6	Requires period of observation						1							1
R7	Observation following resuscitation													0
R8	Suspected sepsis													0
R9	Jaundice (regardless of onset)													0
R12	Management of seizures													0
R13	Diagnosed NAS			1										1
A15	Other: (enter number)						1							1
A15-reason	Other (enter reason)													0
	Total	2	3	5	0	2	3	0	0	0	0	0	0	15

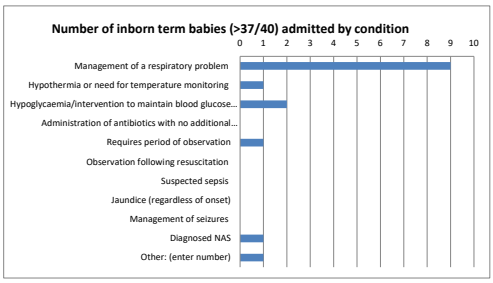
SYB ATAIN - QI Run Charts

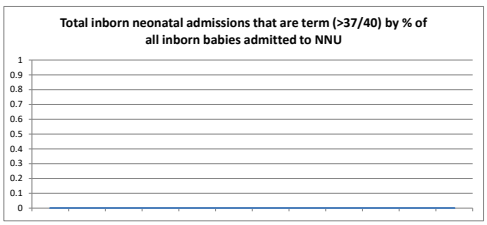
Doncaster & Bassetlaw







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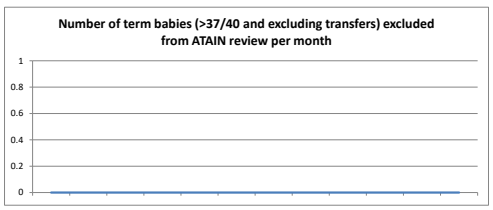
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0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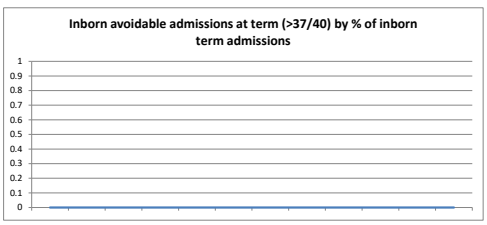
0.6
0.4
0.2
0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0

South Yorkshire and Bassetlaw
Local Maternity System
Transforming your maternity services together

Improvement Academy

Action No	Date	Avoidable Condition	Datix No.	Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Progress Rag Rating	Comments/Evidence
1		RDS		Review management and care of neonatal transitioning.	Agree action plan with neonatal leads, including - consider further for themes around annp/MEDICAL Attendance - Escalate emerging concerns and proposed actions to maternity and divisional governance Consultant Paediatrician	Dr Pramod	Jul-23		Data from Q4 22/23. ongoing theme.- compelted
					Audit to identify themes related to LSCS and subsequent admission to neonatal unit at term . Consider, priority of LSCS , anaesthesia, etc.	M Proctor	Sep-23		Audit commenced Jul 2023. Audit complete. Presented at audit meeting in 2023.
					Review regional and nationally any SOP or guidance on time to transfer to Neonatal ward	A Merriman / LMNS	Aug-23		October 2023 Awaiting review. MAY UPDATE: AM to pick this up woth LMNS as
9				Ensure women are provided with consistent and adequate information regarding the use of steroids	Review antenatal information provide and amend leaflet/information. Ensure information available in a variety of formats.	A Merriman	Sep-24		MAY UPDATE: Local steriod leafelt being drafted. Currently using RCOG leafelt. JUNE UPDATE: Draft started.
13		Hypoglyc		Review care pathways for management of hypoglycaemia and monitor trends and themes	Quality Improvement project to implement Transitional Care	Danielle Bhavra/ Alex Merriman	Apr-24		13/10/23 Draft guidelines cascaded for comments. MAY UPDATE: Qi project registered to implement TC across both sites to commence Auguat 24 once M1/M2 unmerged. JUNE UPDATE: Ongoing.
18		Hypertherm		Reduce the number of babies being admitted to neonatal unit with low temperature.	Datix to be completed when neonates are admitted with low temperature to identify underlying cause. Undertake QI project if required	CE/JG/KO/KT	Jul-23		against admissions and datix reports - retrospective datix completed by governance team as failsafe. MAY UPDATE: DATIXs being compelted,
19		Other		NAS Obs - high score on ward resolving quickly on admsission to NNU	Michelle Clark and A Merriman to work together to provide some education to wards.	AM/MC	Jul-24		MARCH - education materilas shared by M Clarke. AM, LJ & KOS to arrange dates for education to be shared. MAY UPDATE: Meeting on 19th June to prepapre tea trolley trainnig. Education materials ready to be shared with staff following tea trolley trainig on both sites. JUNE UPDATE: Meeting held. Tea trolley with NNU and Maternity PDMs to commence.

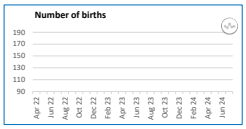
20		Socail		Incerase in admissions for social reasons throughout Q4 23/24	work ewith SG midwives and SS team to ensure robust plans in place for babies in the antenatal period. If we had decidcated TC consider if this could be used as place of safety.	LJ/SS/CB/DRP	Sep-24		JUNE UPDATE: Email sent to SG Midwives to ask fro input re use of TC (when unmerge) is suitable for social admissions.

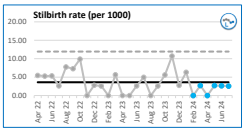
Action No	Avoidable Condition	Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Progress Rag Rating	Comments/Evidence
1	RDS	Avoidable admissions with RDS were attributed to inadequate time to allow transition to life. Time of birth to transfer was 18mins to 28 minutes.	DW neonatal lead and nursing neonantal lead regarding fidnings from review and agree next steps - look nationally for guidance/SOP on time to wait for trasnfer - do we need to look further for themes around annp/MEDICAL Attendace - Take to paedatric, maternity and divisional governance Consultant Paediatrician to	Dr Pramod	Jul-23		Data from Q4 22/23. ongoing theme.-
			Look at any themes and trends with individuals whom attend births from the NNU	DR Pramod/ Dr Brookes/ Alison Boldy	Aug-23		
			Deep dive into themes re all LSCS where babys have been admitted to neonatal unit at term . Consider, priority of LSCS , anaesthesia, etc.	M Proctor	Sep-23		Audit commenced Jul 2023
			Look across the region and nationally any SOP or guidance on time to transfer to Neontal ward	C Emmerson / LMNS	Aug-23		
2		Q1 23/24 change in perinatal management may have prevented admission	Case reviewed at incident review meeting and actions for learning discussed. Manager for CDS to implement local learning/ discuss with Consultant on call for learning.	Dr Bobey			B:\Maternity Safety\1. Incident Review Meeting\2023\4. April\26.04.2023\Case Review JA.docx
3		3 out of the 6 avoidable admissions in Q4 22/23 were IOL.	Audit IOL to ensure these IOL were in guidance . Look for identifiable themes that may have contributed to ATTAIN.	S Sharpe		Complete	Completed
4		Noted that several of the admissions in Q4 were less than 24 hours and 2 less than 4 hours. SS undertaking more indepth audit of length of stay.	Length of stay	S Spencer	Jul-23		Ongoing review by sarah spencer
5		3 out of the 7 admissions were emergency LSCS	Look at themes and trends surrounding the emergency LSCS. Any learning need implementation.	C Emmerson			
6	HIE	1 admission with low cord gases pH 6.9. Did not meet criteria b and therefore downgraded	Did not meet criteria for cooling	Dr Pramod		Complete	
7	Social	Mother required admission to ITU. Father not presetn. Place of safety required.	Place of safety	S Spencer		Complete	
8	Hyperthermia	3 admissions were hypothermic in June 2023 1 PN from the ward and 2 cases from obstertric theatres.	Further piece of work being commenced to increase theatre temperatures	M Clarke / Dr Brookes	Oct-23		B:\Maternity Safety\1. Incident Review Meeting\2023\6. June\19.06.2023\Case Review NNU 141019 discussed.docx
9		Consequencial finding of steroids not discussed in the antenatal period consistently	New antenatla information leaflet to be uploaded onto K2 . JH IT specialist to commence this piece of work	Lucy Mae	Oct-23		B:\Maternity Safety\1. Incident Review Meeting\2023\6. June\29.06.2023\Case Review GW 142259.docx
10	Janudice	SMB result mismanaged on the postnatal ward .	Q.I work into transitional care workstrem commenced.	D Bhanvra Sam Fawkes Cemmerson A Boldy	Oct-23		B:\Maternity Safety\1. Incident Review Meeting\2023\6. June\15.06.2023\Moved from 12th\NNU admission AM 48hrs after birth.docx
11	RDS	1/1 Avoidable admissions for RDS were atributed to delay allowed to transition to life. Time from birth to transferwas 20 minutes 22/23 Q4 data	Consultant Paediatrician to discuss this in Neonatal Governance and peer reviews to be implemented	Dr Promod	Jul-23		guideline completed awaiting approval from guideline group. SOP completed by LAW awaiting approval- staff training then to commence
12			Length of time spent on NNU to be reviewed	Sarah Spencer	Jul-23	Complete	
13	Hypoglyceamia	Low blood sugars managed on the ward and SOP followed . BS not corrected .Transitional care unit would have prevented admission Q4 Data 22/23	Transitional care work QI to commence July 23	Danielle Bhavra/ Clair emmerson	Sep-23		
14	Other	? Trisomy 21 Baby had a low temp of 36.1oC BM 4.6mmol Dysmorphic features	Transitional care would have prevented an admission to manage thermoregulation . 16% increased risk of temperature instability in T21 Study shown over 6 years Serma et al 2020	Danielle Bhavra/ Clair emmerson	Sep-23		
15	Hypoglycaemia	SOP Buccal Glucoboost on the ward, Antenatal breast milk harvesting .	To promote education at BDGH as 1 baby did not receive the Glucosboost. Antenatal EBM harvesting discussed by the infant feeding team and antenatal education and health promotion to take place in the AN clinics and Diabetic AN clinics.	KT/KO BFI Team	Jul-23		guideline completed awaiting approval from guideline group. SOP completed by LAW awaiting approval- staff training then to commence
16	RDS	When elective LSCS booked for diabetic women under 38 weeks for further consideraton re the use of steroids and how surfactant production can be inhibited with Insulin.(2) Review of all LSCS performed for LGA. Compare weights at delivery againes EFW.	Review of MSG 159 Management of Diabetes in pregnancy. LC asked to do literature search and update as required. (2) Audit of LSCS for LGA against actual birthweight. To audit informed consent re El LSCS and the evidence of increased NNU admission being discussed. (3) Review of the use of GA as apposed to a spinal aneasthetic for CAT 1 LSCS R.M Consultant to take this to consultant meeting.	KT/KM/MC/RM	Jul-23		SEE DRI Dashboard/ action plan
17	RDS	earlier escalation to expedite delivery may have improved outcome	Discussed at OCR review meeting. MDT meeting. Also discussed at Incident review panel with governance involvement.		Jan-23		Shared learning disemminated on governance newsleter. Staff involved, reflections.

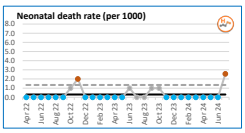
18	Hyperthermia	Several babys continue to be admitted with low temperatures to the neonatal unit. Although this may not be recorded as the primary cause of admission it most certainly is a contributory factor in 6 of the cases reviewed in quarter 3.	Q.I project to be started by both PN ward managers .Evidence gathering from ward staff first. Evidence of 5 cases from Quarter 3 November where a TC would have prevented an admission where thermoregulation was one of the contributing factors to admission.Recognition of a deteriotating baby . Recommendations from the National Pateint safety Improvement Programme on a revised Newborn Early warning trigger and track document. To be discussed at Guideline/governance group.	CE/JG/KO/KT	Jul-23		To be discuseed at governance.

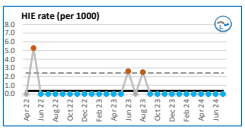
Maternity overview

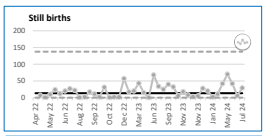
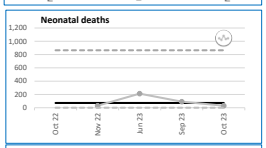
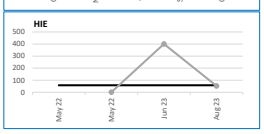
Trust Total

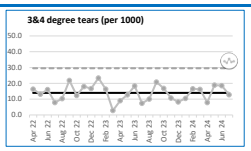
Latest month: 01/07/24 Number of births: 390 No significant change		Latest month: 01/07/24 Still birth rate/1000: 2.6 Significant Improvement
Latest month Safer staffing fill rate No significant change		Latest month: 01/07/24 Neonatal Death rate/1000: 2.6 Significant deterioration
Latest month Proportion of staff with concerns about No significant change		Latest month: 01/07/24 HIE rate/1000: 0.0 Significant Improvement

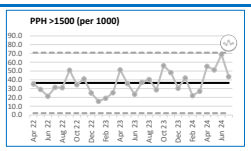


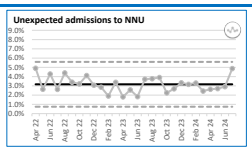




Date of last stillbirth: 27/07/24 Average days between stillbirths: 13.4 No significant change	
Date of last neonatal death: 01/10/23 Average days between deaths: 71.6 No significant change	
Date of last HIE: 08/08/23 Average days between HIE: 58.3 No significant change	

Latest month: 01/07/24 3&4 degree tears (per 1000): 12.8 No significant change		Latest month: 01/07/24 PPH >1500 (per 1000): 43.6 No significant change



Latest month: 01/07/24 Unexpected admissions to NNU: 0.0 No significant change	

Data sheet

This is the data entry sheet.
You can enter up to 25 metrics here with dates from left to right. You can fill this table in any way you like **but cutting and pasting within the table will break the tool.**
The tool is designed for up to 60 dates. (enough for an XmR SPC chart)
Metric names can be entered on the set-up sheet. Data series do not need to start or end on the same date the tool will identify the first entry and plot or calculate from the point.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Date Metric name	01/04/22	01/05/22	01/06/22	01/07/22	01/08/22	01/09/22	01/10/22	01/11/22	01/12/22	01/01/23	01/02/23	01/03/23	01/04/23	01/05/23	01/06/23	01/07/23	01/08/23	01/09/23	01/10/23	01/11/23	01/12/23	01/01/24	01/02/24	01/03/24	01/04/24	01/05/24	01/06/24	01/07/24
Number of births	367	379	374	382	387	412	405	389	359	385	367	355	331	391	381	404	397	384	357	373	361	475	363	370	380	370	378	390
Stillbirth rate (per 1000)	5.45	5.28	5.35	2.62	7.75	7.28	9.88	0.00	2.79	2.60	0.00	5.63	0.00	0.00	2.62	4.95	0.00	2.60	5.60	10.72	2.77	6.32	0.00	2.70	0.00	2.70	2.65	2.56
Neonatal death rate (per 1000)	0.0	0.0	0.0	0.0	0.0	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6
HIE rate (per 1000)	0.0	5.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Unexpected admissions to NNU	4.9%	2.6%	4.3%	2.6%	4.4%	3.4%	3.2%	4.1%	3.1%	2.9%	1.9%	3.4%	1.8%	2.6%	1.8%	3.7%	3.8%	3.9%	2.2%	2.7%	3.3%	3.2%	3.3%	2.4%	2.6%	2.7%	2.9%	4.9%
3&4 degree tears (per 1000)	16.3	13.2	16.0	7.9	10.3	21.8	12.3	18.0	16.7	23.4	16.3	2.8	9.1	12.8	18.4	7.4	10.1	20.8	16.8	10.7	8.3	10.5	16.5	16.2	7.9	18.9	18.5	12.8
PPH >1500 (per 1000)	35.4	29.0	21.4	31.4	31.0	51.0	34.6	41.1	25.1	15.6	19.1	25.4	51.4	35.8	23.6	37.1	40.3	28.6	56.0	48.3	30.5	42.1	22.0	27.0	55.3	51.4	68.8	43.6
Safer staffing fill rate																												
Proportion of staff with concerns about safety																												

Data sheet 1 - monthly data

Enter dates and data

	DATES	Apr-24	May-24	Jun-24	Jul-24
Trust Total	Number of births	380	370	378	390
Trust Total	Stilbirth rate (per 1000)	0	2.7027027	2.64550265	2.56410256
Trust Total	Neonatal death rate (per 1000)	0	0	0	2.56410256
Trust Total	HIE rate (per 1000)	0	0	0	0
Trust Total	Unexpected admissions to NNU (%)	0.02631579	0.02702703	0.02910053	0.04871795
Trust Total	3&4 degree tears (per 1000)	7.89473684	18.9189189	18.5185185	12.8205128
Trust Total	PPH >1500 (per 1000)	55.2631579	51.3513514	68.7830688	43.5897436
Trust Total	Safer staffing fill rate				
Trust Total	Proportion of staff with concerns about safety				
DRI	Number of births	255	255	233	263
DRI	Stilbirth rate (per 1000)	0	3.92156863	4.29184549	0
DRI	Neonatal death rate (per 1000)	0	0	0	3.80228137
DRI	HIE rate (per 1000)	0	0	0	0
DRI	Unexpected admissions to NNU (%)	0.02352941	0.02745098	0.03004292	0.03422053
DRI	3&4 degree tears (per 1000)	7.84313725	11.7647059	21.4592275	19.0114068
DRI	PPH >1500 (per 1000)	54.9019608	43.1372549	68.6695279	38.0228137
DRI	Safer staffing fill rate				
DRI	Proportion of staff with concerns about safety				
BDGH	Number of births	125	115	145	126
BDGH	Stilbirth rate (per 1000)	0	0	0	7.93650794
BDGH	Neonatal death rate (per 1000)	0	0	0	0
BDGH	HIE rate (per 1000)	0	0	0	0
BDGH	Unexpected admissions to NNU (%)	0.032	0.02608696	0.02758621	0.07142857
BDGH	3&4 degree tears (per 1000)	8	34.7826087	13.7931034	0
BDGH	PPH >1500 (per 1000)	56	69.5652174	68.9655172	55.5555556
BDGH	Safer staffing fill rate				
BDGH	Proportion of staff with concerns about safety				
Trust 4	Number of births				
Trust 4	Stilbirth rate (per 1000)				
Trust 4	Neonatal death rate (per 1000)				
Trust 4	HIE rate (per 1000)				
Trust 4	Unexpected admissions to NNU (%)				
Trust 4	3&4 degree tears (per 1000)				
Trust 4	PPH >1500 (per 1000)				
Trust 4	Safer staffing fill rate				
Trust 4	Proportion of staff with concerns about safety				
Trust 5	Number of births				
Trust 5	Stilbirth rate (per 1000)				
Trust 5	Neonatal death rate (per 1000)				
Trust 5	HIE rate (per 1000)				
Trust 5	Unexpected admissions to NNU (%)				
Trust 5	3&4 degree tears (per 1000)				
Trust 5	PPH >1500 (per 1000)				
Trust 5	Safer staffing fill rate				
Trust 5	Proportion of staff with concerns about safety				
Trust 6	Number of births				
Trust 6	Stilbirth rate (per 1000)				
Trust 6	Neonatal death rate (per 1000)				
Trust 6	HIE rate (per 1000)				
Trust 6	Unexpected admissions to NNU (%)				
Trust 6	3&4 degree tears (per 1000)				
Trust 6	PPH >1500 (per 1000)				
Trust 6	Safer staffing fill rate				
Trust 6	Proportion of staff with concerns about safety				

Data sheet 2 Rare event data

Enter the date of each rare event in the correct column as they occur. Data must be in order

Trust Total	Trust Total	Trust Total	DRI	DRI	DRI	BDGH	BDGH	BDGH
Still births	Neonatal deaths	HIE	Still births	Neonatal deaths	HIE	Still births	Neonatal deaths	HIE
17/04/22	01/10/22	11/05/22	17/04/22	27/04/22	11/05/22	05/05/22		
24/04/22	01/11/22	12/05/22	24/04/22	22/09/22	12/05/22	10/06/22		
25/04/22	01/06/23	17/06/23	25/04/22	01/10/22	17/06/23	20/08/22		
05/05/22	01/09/23	08/08/23	29/05/22	14/03/23	08/08/23	17/09/22		
29/05/22	01/10/23		30/06/22	28/03/23		23/10/22		
10/06/22			27/07/22			25/10/22		
30/06/22			18/08/22			02/06/23		
27/07/22			18/08/22			06/07/23		
18/08/22			06/09/22			07/01/24		
18/08/22			19/09/22					
20/08/22			20/10/22					
06/09/22			21/10/22					
17/09/22			21/12/22					
19/09/22			07/01/23					
20/10/22			27/01/23					
21/10/22			11/03/23					
23/10/22			26/03/23					
25/10/22			26/03/23					
21/12/22			31/07/23					
07/01/23			09/09/23					
27/01/23			11/10/23					
11/03/23			17/10/23					
26/03/23			04/11/23					
26/03/23			12/11/23					
02/06/23			15/11/23					
06/07/23			20/11/23					
31/07/23			18/12/23					
09/09/23			09/01/24					
11/10/23			20/01/24					
17/10/23			02/03/24					
04/11/23			11/05/24					
12/11/23			22/06/24					
15/11/23			28/06/24					
20/11/23			27/07/24					

Total Births	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	367	379	374	382	387	412	405	389	359	385	367	355	331	391	381
DRI	255	255	254	263	252	269	273	250	238	253	228	231	213	261	244
BDGH	112	124	120	119	135	143	132	139	121	132	139	124	118	130	136
Still Births	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	2	2	2	1	3	3	4	0	1	1	0	2	0	0	1
DRI	2	1	1	1	2	2	2	0	1	1	0	2	0	0	0
BDGH	0	1	1	0	1	1	2	0	0	0	0	0	0	0	1
Neonatal Deaths	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	0	0	0	0	0	0	1	2	0	0	0	0	0	0	1
DRI	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0
BDGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
HIE	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1
DRI	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1
BDGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unexpected Admissions to NNU	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	18	10	16	10	17	14	13	16	11	11	7	12	6	10	7
DRI	6	5	11	7	15	10	9	14	9	7	6	9	5	7	5
BDGH	12	5	5	3	2	4	4	2	2	4	1	3	1	3	2
3rd and 4th Degree Tears	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	6	5	6	3	4	9	5	7	6	9	6	1	3	5	7
DRI	4	3	2	2	4	5	1	4	2	5	3	1	2	3	5
BDGH	2	5	4	1	0	4	4	3	4	4	3	0	1	2	2
PPH >1500	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	13	11	8	12	12	21	14	16	9	6	7	9	17	14	9
DRI	8	6	3	7	7	15	11	11	5	5	4	8	8	10	5
BDGH	5	5	5	5	5	6	3	5	4	4	3	1	9	4	4

Total Births	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	404	397	384	357	373	361	475	363	370	380	370	378									
DRI	275	264	255	233	244	318	250	231	255	255	255	233									
BDGH	129	133	128	124	129	130	125	132	115	125	115	145									
Still Births	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	2	0	1	2	4	1	3	0	1	0	1	1									
DRI	1	0	1	2	4	1	2	0	1	0	1	1									
BDGH	1	0	0	0	0	0	1	0	0	0	0	0									
Neonatal Deaths	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	0	0	1	1	0	0	0	0	0	0	0	0									
DRI	0	0	1	0	0	0	0	0	0	0	0	0									
BDGH	0	0	0	0	0	0	0	0	0	0	0	0									
HIE	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	0	1	0	0	0	0	0	0	0	0	0										
DRI	0	1	0	0	0	0	0	0	0	0	0										
BDGH	0	0	0	0	0	0	0	0	0	0	0										
Unexpected Admissions to NNU	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	15	15	15	8	10	12	15	12	9	10	10	11									
DRI	13	10	10	7	7	9	14	11	8	6	7	7									
BDGH	2	5	5	1	3	3	1	1	1	4	3	4									
3rd and 4th Degree Tears	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	3	4	8	6	4	3	5	6	6	3	7	7									
DRI	2	2	5	4	3	2	4	5	3	2	3	5									
BDGH	1	2	3	2	1	1	1	1	3	1	4	2									
PPH >1500	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	15	16	11	20	18	11	20	8	10	21	19	26									
DRI	9	13	7	12	11	7	12	5	6	14	11	16									
BDGH	6	3	4	8	7	4	8	3	4	7	8	10									

Still Births (per 1000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	5.45	5.28	5.35	2.62	7.75	7.28	9.88	0.00	2.79	2.60	0.00	5.63	0.00	0.00	2.62
DRI	7.84	3.92	3.94	3.80	7.94	7.43	7.33	0.00	4.20	3.95	0.00	8.66	0.00	0.00	0.00
BDGH	0.00	8.06	8.33	0.00	7.41	6.99	15.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.35
Neonatal Deaths (per 1000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	0	0	0	0	0	0	2.46914	5.14139	0	0	0	0	0	0	2.62467
DRI	0	0	0	0	0	0	3.663	8	0	0	0	0	0	0	0
BDGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7.35294
HIE (per 1000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	0	5.27704	0	0	0	0	0	0	0	0	0	0	0	0	2.62467
DRI	0	7.84314	0	0	0	0	0	0	0	0	0	0	0	0	4.09836
BDGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unexpected Admissions to NNU (per 1000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	5%	3%	4%	3%	4%	3%	3%	4%	3%	3%	2%	3%	2%	3%	2%
DRI	2%	2%	4%	3%	6%	4%	3%	6%	4%	3%	3%	4%	2%	3%	2%
BDGH	11%	4%	4%	3%	1%	3%	3%	1%	2%	3%	1%	2%	1%	2%	1%
3rd and 4th Degree Tears (per 1000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	16.34877	13.1926	16.0428	7.8534	10.3359	21.8447	12.3457	17.9949	16.7131	23.3766	16.3488	2.8169	9.06344	12.7877	18.3727
DRI	15.68627	11.7647	7.87402	7.60456	15.873	18.5874	3.663	16	8.40336	19.7628	13.1579	4.329	9.38967	11.4943	20.4918
BDGH	17.85714	40.3226	33.3333	8.40336	0	27.972	30.303	21.5827	33.0579	30.303	21.5827	0	8.47458	15.3846	14.7059
PPH >1500 (per 1000)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	35.42234	29.0237	21.3904	31.4136	31.0078	50.9709	34.5679	41.1311	25.0696	15.5844	19.0736	25.3521	51.3595	35.8056	23.622
DRI	31.37255	23.5294	11.811	26.616	27.7778	55.7621	40.293	44	21.0084	19.7628	17.5439	34.632	37.5587	38.3142	20.4918
BDGH	44.64286	40.3226	41.6667	42.0168	37.037	41.958	22.7273	35.9712	33.0579	30.303	21.5827	8.06452	76.2712	30.7692	29.4118

Still Births (per 1000)	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	4.95	0.00	2.60	5.60	10.72	2.77	6.32	0.00	2.70	0.00	2.70	2.65	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DRI	3.64	0.00	3.92	8.58	16.39	3.14	8.00	0.00	3.92	0.00	3.92	4.29	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
BDGH	7.75	0.00	0.00	0.00	0.00	0.00	8.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Neonatal Deaths (per 1000)	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	0	0	2.60417	2.80112	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DRI	0	0	3.92157	0	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
BDGH	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
HIE (per 1000)	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	0	2.51889	0	0	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DRI	0	3.78788	0	0	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
BDGH	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Unexpected Admissions to NNU (per 1000)	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	4%	4%	4%	2%	3%	3%	3%	3%	2%	3%	3%	3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DRI	5%	4%	4%	3%	3%	3%	6%	5%	3%	2%	3%	3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
BDGH	2%	4%	4%	1%	2%	2%	1%	1%	1%	3%	3%	3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
3rd and 4th Degree Tears (per 1000)	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	7.42574	10.0756	20.8333	16.8067	10.7239	8.31025	10.5263	16.5289	16.2162	7.89474	18.9189	18.5185	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DRI	7.27273	7.57576	19.6078	17.1674	12.2951	6.28931	16	21.645	11.7647	7.84314	11.7647	21.4592	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
BDGH	7.75194	15.0376	23.4375	16.129	7.75194	7.69231	8	7.57576	26.087	8	34.7826	13.7931	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PPH >1500 (per 1000)	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	37.1287	40.3023	28.6458	56.0224	48.2574	30.4709	42.1053	22.0386	27.027	55.2632	51.3514	68.7831	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DRI	32.7273	49.2424	27.451	51.5021	45.082	22.0126	48	21.645	23.5294	54.902	43.1373	68.6695	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
BDGH	46.5116	22.5564	31.25	64.5161	54.2636	30.7692	64	22.7273	34.7826	56	69.5652	68.9655	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Proportion of staff with concerns about safety	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust	1	0	0	0	2	0	0	0	0	0	0	0	1	1	6
Proportion	0.003247	0	0	0	0.00649	0	0	0	0	0	0	0	0.00325	0.00325	0.01948
Staff (people in post)	308	308	308	308	308	308	308	308	308	308	308	308	308	308	308

Proportion of staff with concerns about safety	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Trust	5	1	0	0	0	1	0	10	24	0	18	0				
Proportion	0.01623	0.00325	0	0	0	0.00325	0	0.03247	0.07792	0	0.05844	0	0	0	0	0
Staff (people in post)	308	308	308	308	308	308	308	308	308	308	308	308	308	308	308	308

Background to Maternity and Neonatal Board Paper and Glossary of terms / Definitions

For use with the maternity board papers

Glossary of Terms

A-EQUIP - model used for midwifery advocacy for education and quality improvement

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)

IRM - Incident review meeting

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

MIS - maternity Incentive Scheme (CNST)

MNSI - maternity and neonatal services investigations (formerly HSIB)

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

MSDS - Maternity dataset

NED - Non-executive director

NICU - neonatal intensive care unit

NLS - Newborn life support (resuscitation)

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)

PSII - Patient safety incident Investigations

QI - Quality Improvement

Quadrumvirate - management team including obstetric, midwifery, neonatal & business (Quad)

RDS - respiratory distress syndrome (breathing problems)

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

RIP - rest in peace

SVD - Spontaneous vaginal delivery

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

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

Other information

Term is 37-42 weeks long

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

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

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

Background

3. MNSI

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone and was comatose and had seizures of any kind

To meet the requirements against the 7 Immediate and Essential Actions (IEAs) in the Ockenden report all SI's concerning maternity services adhere to the Trusts Incident management Policy. There is also a robust process for reporting cases that meet the criteria for MNSI.

13. A-EQUIP Model

The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

Lois Mellor
Director of Midwifery
Updated 26.8.24

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**E1**
Report Title:	**Maternity & Neonatal Independent Senior Advocate Bi-annual update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Abbey Harris, Maternity and Neonatal Independent Senior Advocate		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

The purpose of this paper is to provide an update of the Maternity and Neonatal Independent Senior Advocate (MNISA) pilot service for South Yorkshire.

The paper provides data regarding referrals into the service since it became active in January 2024, as well as highlighting emerging themes and learning so far.

Recommendation:	For information and assurance.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications

Relationship to Board assurance framework:	**x**	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
	X	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
		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

		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
		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
	x	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
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal/ Regulation:	CQC - Regulation 12 Potential high impact *Clinical Negligence Scheme for trusts - High impact*		
Resources:			
Assurance Route			
Previously considered by:	The Maternity and Neonatal Safety Quality Committee Divisional Governance Meetings		
Date:	Monthly		
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

Maternity and Neonatal Independent Senior Advocate Bi-annual Update

LMNS Collaborative Board Meeting

August 2024

Author(s)	Abbey Harris - Maternity and Neonatal Independent Senior Advocate, South Yorkshire ICB
Sponsor Director	Jodie Deadman – Local Maternity and Neonatal System Programme Director, South Yorkshire ICB

Purpose of Paper

The purpose of this paper is to provide an update of the Maternity and Neonatal Independent Senior Advocate (MNISA) pilot service for South Yorkshire.

The paper provides data regarding referrals into the service since it became active in January 2024, as well as highlighting emerging themes and learning so far.

Key Issues / Points to Note

The MNISA service is receiving regular referrals from a variety of sources, and there is positive engagement with the service from all Trusts across South Yorkshire Local Maternity and Neonatal System. There is a need, however, to review messaging around service provision to ensure the service is clear and accessible to all families who are considering contact with the MNISA.

Emerging themes include challenges around communication and further harm for services users who have experienced an adverse outcome when they do not feel believed by their service providers. Families who have experienced an adverse outcome are also further impacted when they have additional complexities in their lives e.g., social issues, housing issues, mental health issues.

Broader learning has been identified around the Perinatal Mortality Review Tool (PMRT) process which has been escalated locally and nationally. A gap has also been recognised regarding baby loss – specific bereavement support in South Yorkshire, and there is now a plan in place to undertake further scoping work to ultimately address this.

Is your report for Approval / Consideration / Noting

For noting.

Recommendations / Action Required by the Board

To note the current position of the Maternity and Neonatal Independent Senior Advocate pilot programme for South Yorkshire LMNS and continue supporting the integration of the MNISA service.

To continue escalating challenges highlighted around the PMRT process and around baby-loss bereavement support via agreed escalation routes.

Board Assurance Framework

This report provides assurance against the following corporate priorities on the Board Assurance Framework (place ✓ beside all that apply):

Priority 1 - Improving outcomes in population health and health care.		Priority 2 - Tackling inequalities in outcomes, experience, and access.	x
Priority 3 - Enhancing productivity and value for money.		Priority 4 - Helping the NHS to support broader social and economic development.	

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference.	
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	x

Are there any Resource Implications (including Financial, Staffing etc)?

No

Have you carried out an Equality Impact Assessment and is it attached?

No

Have *you involved patients, carers and the public in the preparation of the report?*

Not directly, but service user feedback is included within the report.

Introduction

1.1. Background

NHS England are currently leading a Maternity and Neonatal Independent Senior Advocate (MNISA) Pilot Programme in response to an Immediate and Essential Action from the Ockenden Report which states*: "Maternity services must ensure that women and their families are listened to with their voices heard."* The pilot was initially due to conclude in March 2025, although consideration is now being given to an extension into 2025/26 (to be confirmed towards the end of 2024).

The South Yorkshire and Bassetlaw MNISA is employed by South Yorkshire Integrated Care Board (SY ICB) and sits within the Local Maternity and Neonatal System (LMNS) Programme team. The MNISA has been actively supporting families since receiving the 'greenlight' from NHS England in mid-January 2024, with a formal launch on 1st March 2024. Her role is to help ensure the voices of women, birthing people and families are listened to, heard, and acted upon by their maternity and neonatal care providers when they have experienced a serious adverse outcome during their maternity and/or neonatal care.

For the purposes of the pilot, the term 'serious adverse outcome' specifically relates to:

- Stillbirth (after 24 weeks' gestation).
- Neonatal death (up to 28 days after birth).
- Proven or suspected brain injury for baby.
- Maternal death.
- Unplanned critical care admission for the person giving birth.
- Unplanned hysterectomy for person giving birth.

1.2. Reporting

The MNISA has an agreed escalation and reporting structure for SY ICB, Trusts and NHS England. This includes providing quarterly updates at the SY LMNS Perinatal Quality Surveillance Group (PQSG) and reporting to SY LMNS Collaborative Board and to Trust Boards bi-annually.

This is the first MNISA paper to be presented since the service became active, so will cover all South Yorkshire and Bassetlaw referrals between 17th January- 31st July 2024. Subsequent papers will have more specific timeframes as the reporting process becomes more embedded.

This paper will share early data around referrals into the MNISA service and will go on to discuss emerging themes based on the experiences families are sharing. The support currently being provided by the MNISA will be explored, as well as challenges faced and what is working well. Broader system learning will then be addressed, followed by next steps.

1. Referrals into the MNISA Service

2.1. Referral process

There are several routes to refer a family into the MNISA service, and these have been collectively agreed with Trust Maternity and Neonatal Governance teams across South Yorkshire, as well as shared with various other teams and agencies through early MNISA engagement e.g., midwifery and obstetric teams, neonatal teams, PALS, psychological support services, Healthwatch, Maternity and Neonatal Voice Partnerships.

The MNISA was supported by the ICB Communications team to further raise awareness of the service with South Yorkshire Trusts, primary care and to the public via a formal service launch in March 2024. This highlighted that either families can self-refer or professionals can refer families via an online form on the MNISA webpage, or via phone call, text or email. Referrals meeting MNISA criteria can be progressed once families reach out to the service or give consent for their contact details to be shared with the MNISA. In cases where referrals do not meet MNISA criteria, the MNISA will signpost families to

other support services and will collect non-identifiable information to understand in which circumstances families are seeking support. This will help to inform future learning for the service.

2.2. Overall referral data

Figure 1 shows the overall number of referrals into the MNISA service per month since it became active (total number: 31), while Figure 2 identifies the referral status and referral sources. Referral sources include a range of professionals e.g., Governance teams, Bereavement Midwives, Ward Leaders, Heads of Midwifery, Chief Nurses, Consultants, Coroner's Officers, and Psychological Support services.

It is noted that there are 7 families who meet criteria and have yet to consent to MNISA contact. The MNISA plans to develop a way of understanding why this might be in case the referral process or accessibility to the service can be improved for these families.

It is also recognised that most referrals which do not meet criteria are where families have self-referred. The MNISA acknowledges the courage it must take for families to reach out themselves, only for them to be disappointed at being unable to access MNISA support. While the MNISA still endeavours to listen and provide appropriate onward signposting for these families, she also plans to review the information which is available to the public and ensure that the service criteria are as clear as possible.

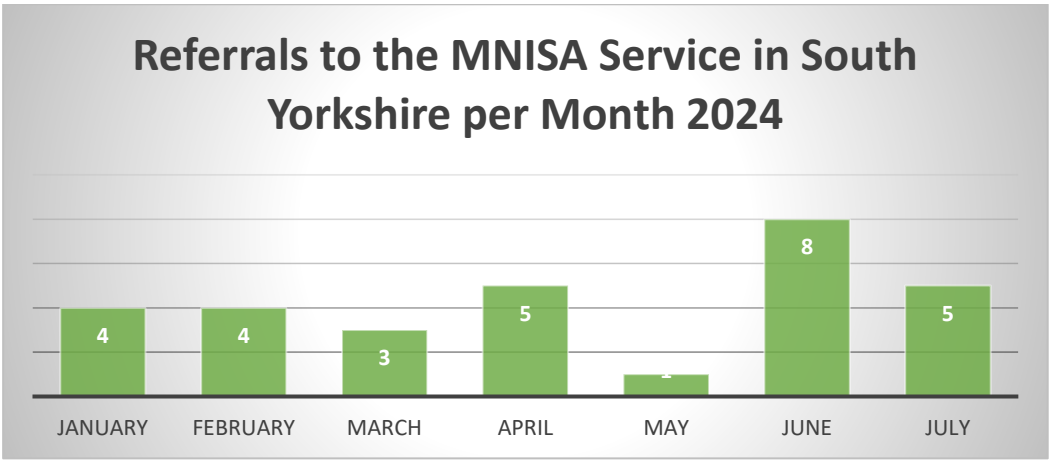


Figure 1

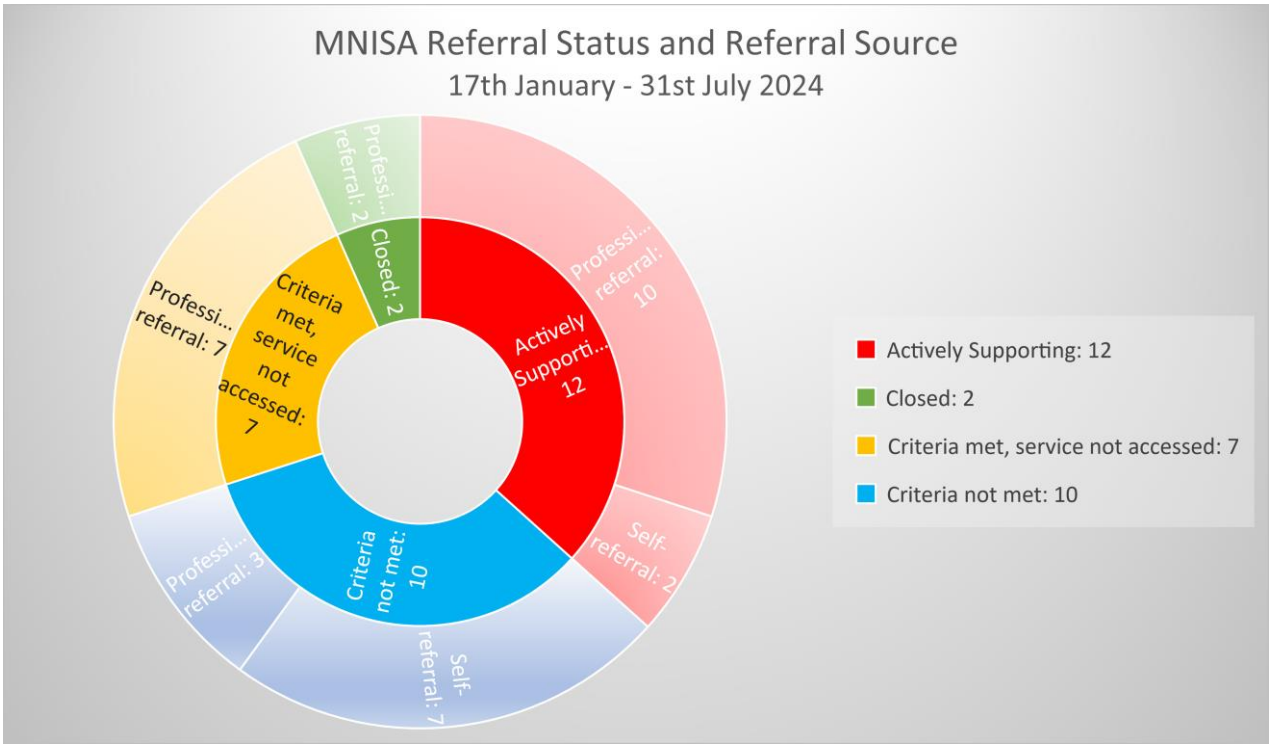


Figure 2

2.3. Referral data where MNISA support has been provided.
The MNISA has provided/is providing support to 14 families across South Yorkshire and in most cases, the family has sadly experienced a neonatal death, or their baby has a proven or suspected brain injury This is highlighted in figure 3, where the green bars represent total referrals in each category, and of these, the blue bars represent how many of the referred families are accessing the service. Of the 5 families referred to the service due to their baby being stillborn, only 1 of these has consented to MNISA support. The reasons for this are not yet clear, although as previously mentioned, the MNISA plans to understand why in time and improve the service accordingly.

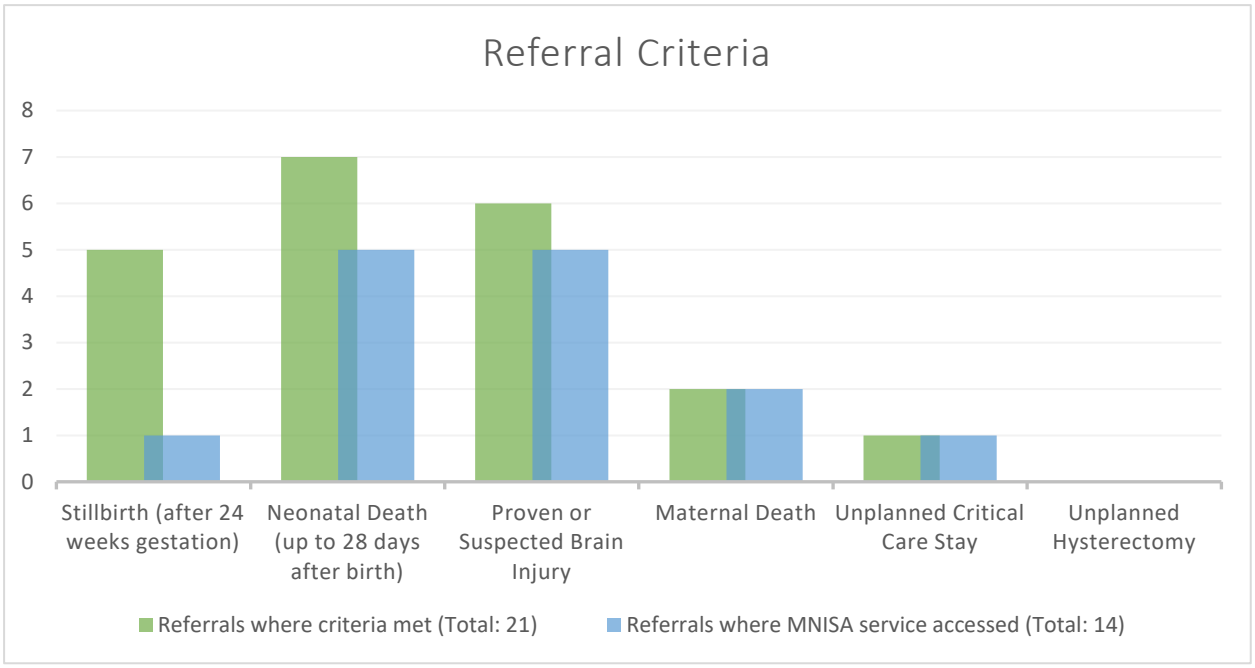


Figure 3

Figure 4 shows that all four South Yorkshire Trusts have been involved in providing maternity and/or neonatal care for the families who have or are receiving support from the MNISA, and these figures appear proportionate to the number of births per Trust (see appendix 1). Some families have also received care in multiple Trusts, although may only request support in engaging with one of them.

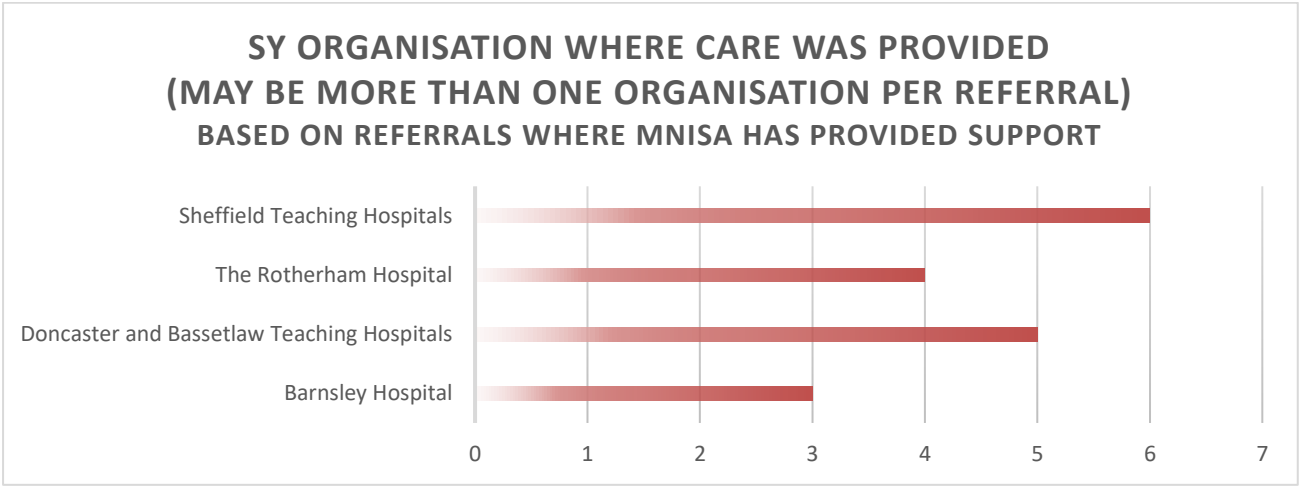


Figure 4

Most families (71.4%) receiving MNISA support live in the 30% most deprived areas of South Yorkshire (figure 5). This is a greater percentage than the number of women and birthing people within the same deciles in South Yorkshire who had babies between 2021-2024 (see appendix 1).
Almost two thirds of the families being supported by the MNISA have an ethnic background of White (figure 6). South Yorkshire data indicates that comparatively, there is a slightly higher proportion of white women and birthing people who had babies (see appendix 1). Several national sources (e.g., MBRRACE-UK, Invisible, FiveXMore) however, highlight that women and birthing people are disproportionately affected and more likely to experience a serious adverse outcome during their maternity and/or neonatal care if they have a minority ethnic background, and/or if they suffer social deprivation. They are also less likely to feel heard when they have concerns or questions about their care and are less likely to have access to support.
It should be noted that this early South Yorkshire MNISA data is based on small numbers, although indicates that while the MNISA service appears to be accessible for families experiencing deprivation, there is more to do in ensuring the service is also accessible for families with a minority ethnic background when considering disproportionality of adverse outcomes.

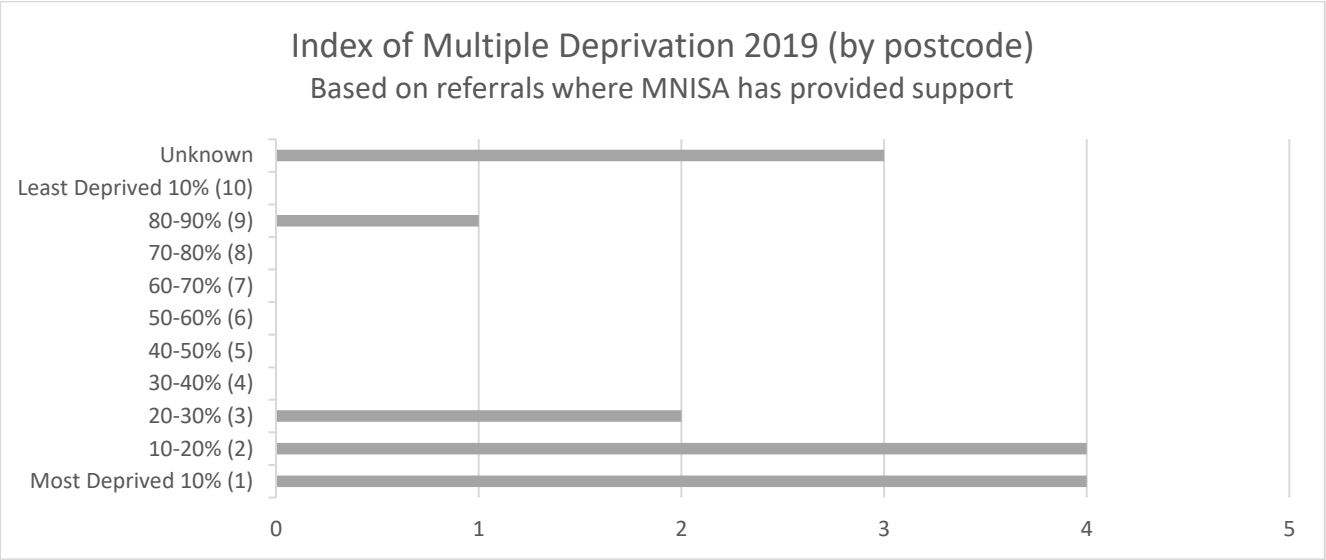


Figure 5

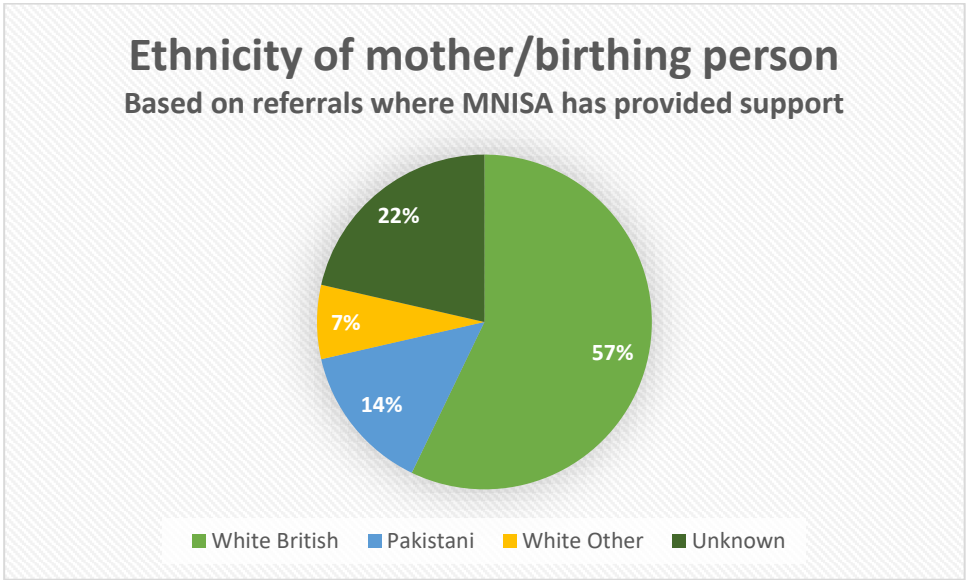


Figure 6

2. Emerging Themes

The MNISA is in an incredibly privileged position to be invited into the lives of families who are going through the most distressing of times, and to be given an opportunity to support them, as well as identify and share where there might be learning and improvement. It is acknowledged that identifying themes from what families share can be a subjective process which is open to interpretation, although the MNISA has endeavoured to approach this as objectively as possible. While it should be noted that these themes are currently emerging via a small number of families, as more access the MNISA service - it is envisaged that themes will become clearer still.
Table 1 lists the most frequently described issues experienced by families following an adverse outcome, although numerous other concerns have also been identified by individuals receiving MNISA support. The MNISA is always guided by the family in how they wish to respond to concerns, and where families consent, these issues are escalated to the relevant Trust teams and addressed individually, as well as informing wider learning.

Emerging Themes (Each theme is present in at least a third of active/closed cases)
Communication: Not knowing own/baby's plan of care.
Bad news delivered in a way which was harmful to parents.
Communication: Not involved in decision-making/feeling coerced to make decision.
Word of staff/documentation taken over patient/family recollection.
Communication: Delay/omission in explaining what happened or in providing updates later.
Loss of trust with whole hospital.
Defensive responses when families ask questions after the event.
The feeling of not being believed during clinical care and/or following an adverse outcome.
Complex additional needs (e.g., social/mental health/neurodiversity).
Impact of others' actions on the mental health of parents not fully considered.
Not reviewed/second opinion not sought quickly enough.
Conflicting information given which can lead to false hope.
Lack of baby loss-specific bereavement support.
Issues with inclusion/communication around PMRT.

Table 1

Communication is a clear theme which impacts on families at all points in their journey: they can vividly recall when it is done well and when it is approached in a way which causes or adds to distress.
It has also become obvious to the MNISA that harm is compounded when a service-user knows they have been listened to but the response they receive leaves them feeling as though they are not believed. The impact of this is evident when it occurs during clinical care and/or during interactions following an adverse outcome. Individuals and their families describe being left feeling as though they have nowhere else to go and are in a situation where their truth will never prevail.

The impact for a family where there are complex social needs alongside suffering an adverse outcome cannot be underestimated. The MNISA has witnessed the multitude of challenges faced by families in these situations and their subsequent difficulty in even considering participation in learning processes until their basic needs have been addressed. There have been examples where Trusts and other organisations have worked very closely with the MNISA to help navigate the overwhelming complexities these families face, as well as examples where families have experienced further challenge from Trusts.

3. Support and Learning

4.1. Types of support provided by the MNISA

As with all health care, every family requires individualised support. The MNISA offers home visits where she listens and is entirely guided by families; ensuring they are aware of all their options so they can make informed decisions. Some families request minimal input e.g., support with preparation and attendance at a Trust meeting followed by occasional contact, while others have more intensive needs such as calls or visits several times a week, and multiple supported interactions with various organisations.

Examples of how the MNISA has worked with families includes:

- Support with arranging and attending meetings.
- Liaising with key contacts in the Trusts to provide feedback, make requests, support ongoing individualised care.
- Support with developing questions for meetings.
- Support with reviewing reports or other documents.
- Help to navigate internal processes e.g., complaints processes, requesting access to records.
- Liaising with external agencies e.g., MNSI, Coroner's Officer, AvMA, solicitors, social care, housing companies, migration services, Registry Office.
- Ensuring family voices are heard within PMRT/off-pathway reviews.
- Signposting/referring to other agencies e.g., psychological support services.

4.2. What is working well/challenges

There have been multiple positive interactions and experiences, both for families directly and for the MNISA in her support of families. For example:

- Some families expressed that they were provided with really individualised, compassionate care following an adverse outcome, particularly where there is ongoing clinical care.
- For some families when meeting with Trusts face-to-face after concerns have been raised, there have been some excellent examples where families have described finally feeling heard, understood and as though the Trust have responded openly and honestly. The lasting benefits of in-person meetings where this can be facilitated has been evident for these families.
- There has been clear evidence of clinical colleagues working with external agencies and advocating for families themselves to ensure the right support is received.
- There have been real efforts from some Trust colleagues to ensure that families are heard as part of ongoing Trust processes, and that requests are accommodated.
- The MNISA is having positive interactions with many Trust colleagues (as well as other partners/external agencies) which is enabling families to receive the right support from the right people and in the right way. This also includes significant support from the LMNS Programme Team.

These positive examples have been fed back to relevant teams and individuals.
Some of the challenges include:

- There is a risk of further harm to families when they receive conflicting information. The MNISA is working with Trusts to minimise the risk as much as possible, and to support families and feed back to Trusts where permitted.
- Due to previous interactions, families and individuals may perceive that professionals sometimes hold preconceptions about them and feel a judgement has been made before meeting them. This can impact on the re-building of relationships between families and Trusts. The MNISA will

provide specific feedback where permitted by families and will otherwise broadly raise awareness.

- The MNISA should not hold information she cannot promptly share with the family. This can create a conflict between waiting to confirm what can be shared and how, with the risk that families will be caused harm and lose trust in the MNISA if they identify a lack of transparency. The MNISA will continue to provide clarity with colleagues regarding her position.
- The MNISA aims to support understanding of Trust processes and approaches for families e.g., the Just Culture approach. The MNISA must continue, however, to exercise caution and ensure it is not perceived that the MNISA is defending the actions of individuals or organisations.

4.3. Broader learning

The insight which families so generously share with the MNISA at such a difficult time for them provides opportunities to recognise where services might be improved more widely in the future. The following describes where learning has been identified and progress so far:

- Families are sharing difficulties with the Perinatal Mortality Review Tool (PMRT) process. This includes their level of involvement in the process, communication around the findings and their ability to challenge findings. The MNISA has escalated these issues via pre-agreed routes through SY LMNS, and they have been further escalated to the NHS England regional team. SY LMNS are now considering where system-wide improvements can be made, and actions are underway.
  MNISAs in other areas are identifying similar challenges for families so along with the SY MNISA, have collectively escalated family concerns to the NHS England MNISA Programme team, and to NPEU (National Perinatal Epidemiology Unit).
- It has been recognised that while local Bereavement Midwives offer excellent support following baby loss, South Yorkshire is an outlier compared to other nearby regions due to the lack of ongoing baby loss-specific bereavement support services. This has been escalated and the SY LMNS Service User Voice Lead is now undertaking a Bereavement Project. The project will involve scoping bereavement service provision, with an opportunity to develop a SY service offer.
- Families are increasingly requesting detailed information from early reviews of their care and there is currently no clear process to address such requests, which presents challenges to both families and Trusts. This was highlighted to the relevant organisations and requests were addressed. It has now been raised more widely within LMNS collaborative meetings and discussions are ongoing, recognising that these requests are likely to be relevant beyond just maternity and neonatal care.
- When relationships break down between families and the Trust where they received care, families are expressing a wish to receive follow-up care/have follow-up discussions with a different organisation. This has been recognised within the SY LMNS Programme team and discussions are underway about whether specific system-wide pathways can be developed to consider such requests.
- A recently bereaved South Yorkshire mother attended a routine dental appointment and was distressed to have to answer questions about her baby on a routine questionnaire. She bravely approached the dental practice to ask if the questions could be reworded for the future and received a very positive response and an amendment to the questionnaire. The mother allowed the MNISA to ask ICB colleagues to disseminate this learning to dental practices across South Yorkshire so that they can review their own questionnaires and minimise the risk of further distress to bereaved mothers and birthing people. The SY MNISA also shared within the MNISA network for wider learning.

4. Early feedback for the MNISA Service

Feedback from families:

"I just wanted to say thank you for yesterday. You were so helpful, caring and supportive- it meant a lot to both myself and [***]. Thank you for taking such comprehensive and detailed, informative notes too."

"…our Senior Advocate has been instrumental. For the first few weeks after [baby], we had to navigate this alone. I simply do not know what we would have done without [MNISA]. No words I write here can ever express mine and [***]'s gratitude towards her and we will be thankful for her until the days we die and reunite with our dear [baby]."

From a professional on behalf of a family:

"[***] was really appreciative and wanted to pass on her thanks – she was incredibly grateful for your support and expressed feeling really cared for and noted you hadn't really known her but made her feel significantly more at ease in a difficult situation."

Feedback from a clinician:

"…it has been great to meet you and learn what this amazing role can offer.

Your involvement really was the turning point for us, and feeling like we were making progress and supporting [***], as he deserved."

5. Next Steps

With the pilot in its early stages, there is still much to learn and improve on. The MNISA plans to initially focus on ensuring the messaging around the service in right for both service-users and professionals by:

- Continuing to work on a short MNISA video which will be shared with organisations and added to the MNISA webpage. This may provide more accessible information than just written material.
- Reviewing written information which is available to the public to ensure there is clarity around the MNISA service, so that harm to families who reach out and are then unable to access MNISA support is minimised.
- Considering the referral process to ensure eligible families receive relevant information about the service and are able to access it and utilise it in a way which works for them.
- Continuing to work together and learn together with Trust colleagues and organisations to provide the right support for families.

6. Conclusion

Since its launch earlier in 2024, families across South Yorkshire are now receiving additional support to navigate NHS complexities and other challenges following serious adverse outcomes in their maternity and/or neonatal care, and these families have provided some early positive feedback. Although the MNISA and LMNS colleagues are still learning how best to integrate the MNISA role alongside existing processes and services, there has been much positive engagement with the service, reflected by the number of referrals, and by direct interactions with Trust colleagues and support from the LMNS Programme team.

Board is requested to note progress to date and to continue supporting the integration of the MNISA service across South Yorkshire and Bassetlaw LMNS.

Board is also requested to continue escalating challenges highlighted around the PMRT process and around baby-loss bereavement support via agreed escalation routes.

Appendix 1

Data source: NHS Digital Maternity Statistics

Maternity Metrics from YH Maternity Dashboard: 2022/23							
Metric Category	**Metric**	**Barnsley District General Hospital**	**Doncaster & Bassetlaw Teaching Hospitals NHS FT**	**Sheffield Teaching Hospitals NHS FT**	**The Rotherham Hospital NHS FT**	**South Yorkshire**	
Activity	Number of women booked	2819	5167	6636	2959	17581	
Activity	Number of all babies born	2976	4526	5619	2509	15630	
Activity	Number of all women birthed	2933	4461	5532	2488	15414	
Note, in most cases, number of women booked exceeds women who deliver, as not all pregnancies progress to term.							
However, Barnsley is a popular choice of place of birth from "out of area" women - ie. Those booked to another area, so their birth numbers exceed the number or women booked							

Source: NHSE Regional Measures Dashboard - Derived from MSDS

Deliveries by Ethnicity Apr2021 to Mar2024

Period	Row Labels	Sum of Number of bookings%	Sum of Number of bookings
Apr 2021-Mar 2024	**Not stated**	**3.70%**	**1,370**
	Not known	0.04%	15
	Not stated	3.66%	1,355
	Other ethnicities - grouped	**21.04%**	**7,795**
	Any other ethnic group	5.11%	1,895
	Asian or Asian British	8.99%	3,330
	Black or Black British	4.79%	1,775
	Mixed	2.15%	795
	White	**75.26%**	**27,885**
	White	75.26%	27,885
2021-2024	**Grand Total**	**100.00%**	**37,050**

Deliveries by IMD Apr2021 to Mar2024

Period	IMD Decile	Population	%
Apr 2021-Mar 2024			
	1-Most deprived	11,335	31%
	2	5,670	15%
	3	3,890	10%
	4	2,770	7%
	5	2,710	7%
	6	2,805	8%
	7	2,695	7%
	8	1,980	5%
	9	1,980	5%
	10-Least deprived	1,320	4%
2021-2024	**Total**	**37,155**	**100%**

South Yorkshire
Local Maternity and Neonatal System (LMNS)

Maternity and Neonatal Independent Senior Advocate: Quarterly Update

SY LMNS PQSG

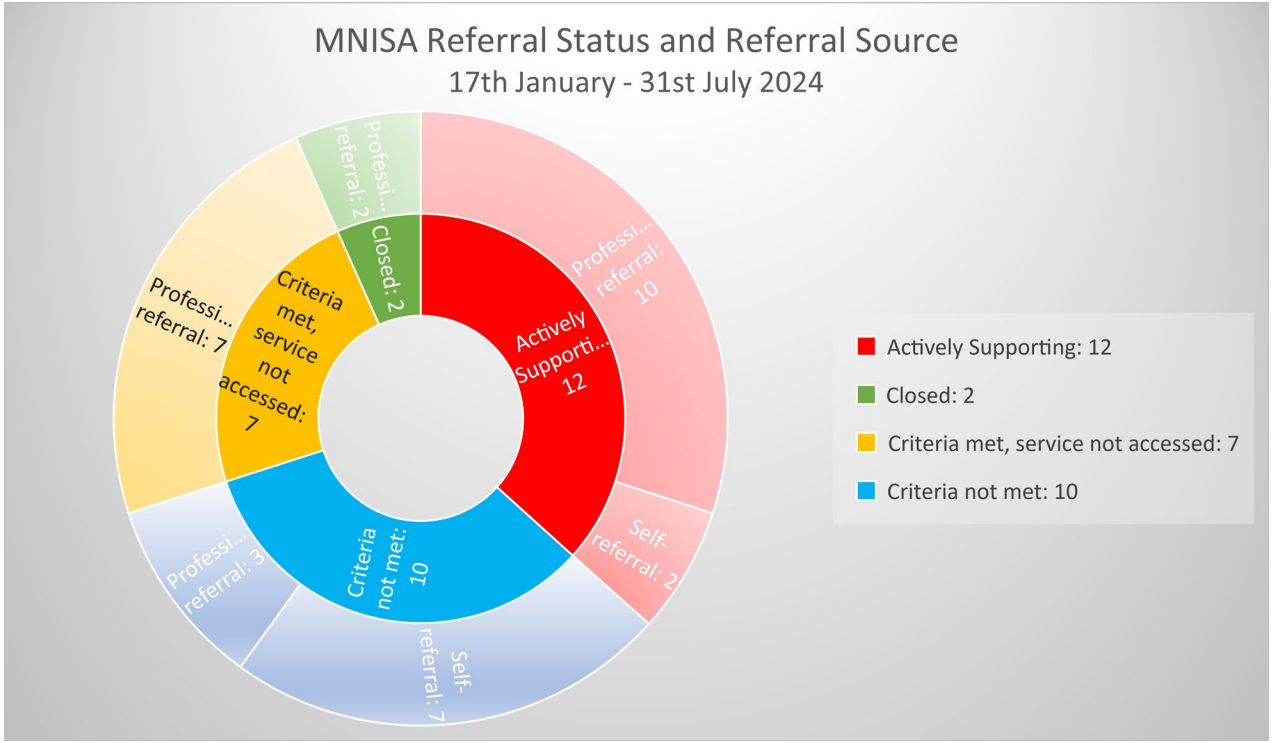
Abbey Harris

Tuesday 30th July 2024

Referrals to MNISA

- Greenlight for SY: 22/01/2024
- Official launch for SY: 01/03/2024
- Current data from Greenlight to: 31/07/2024

South Yorkshire
Local Maternity and Neonatal System (LMNS)



Referrals to MNISA where support has been provided

South Yorkshire
Local Maternity and Neonatal System (LMNS)

Referrals to MNISA where support has been provided

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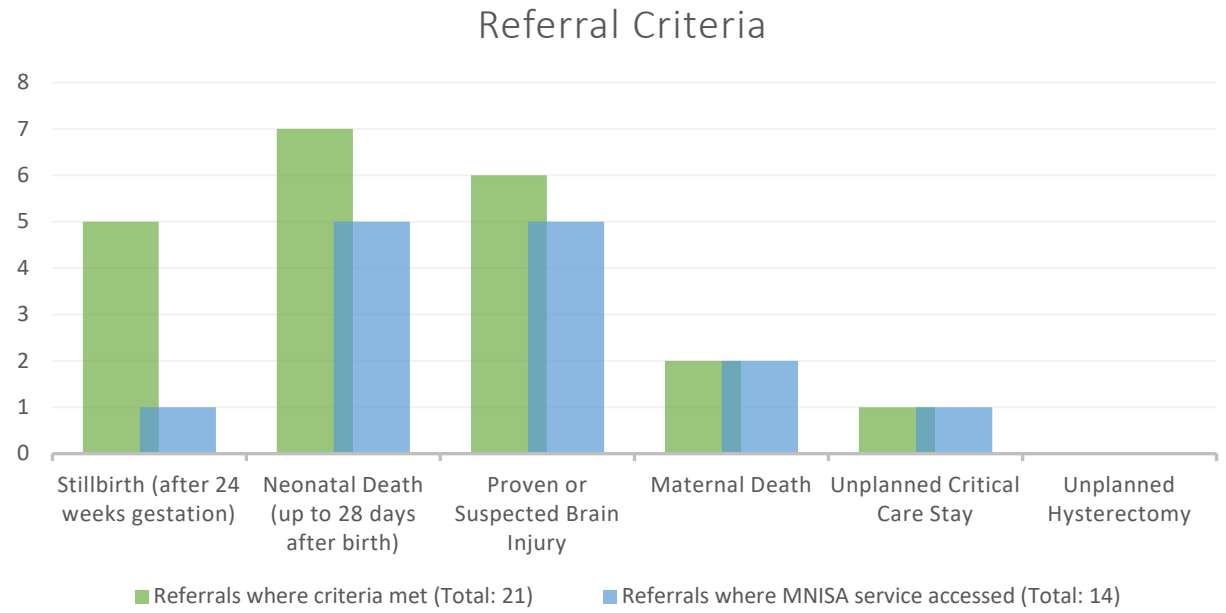
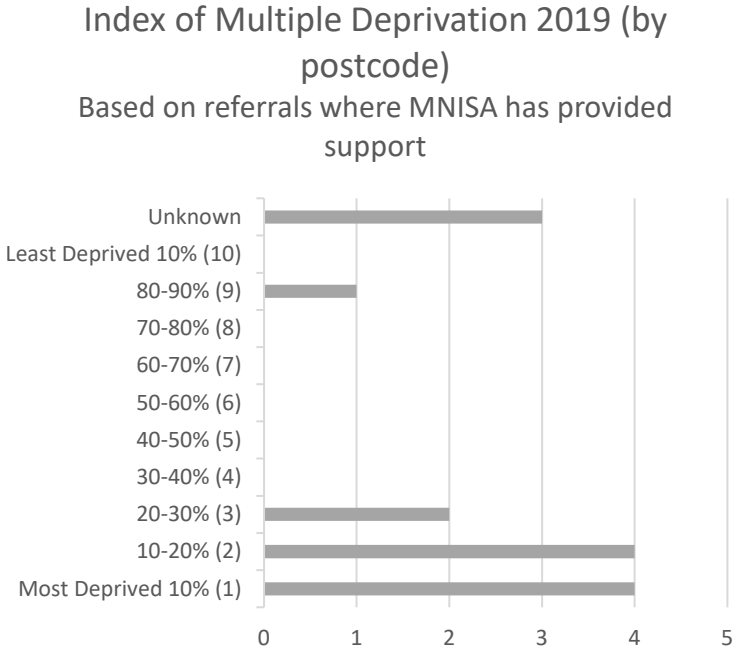
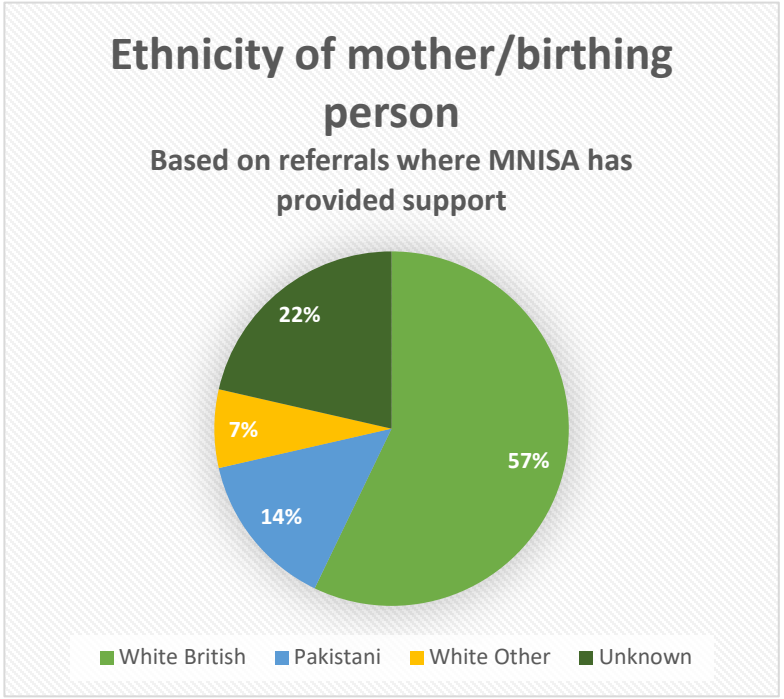


Referrals to MNISA where support has been provided

South Yorkshire
Local Maternity and Neonatal System (LMNS)





Types of MNISA Support

Examples of how the MNISA has worked with families includes:

- Support with arranging and attending meetings.
- Liaising with key contacts in the Trusts to provide feedback, make requests, support ongoing individualised care.
- Support with developing questions for meetings.
- Support with reviewing reports or other documents.
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- Ensuring family voices are heard within PMRT/off-pathway reviews.
- Signposting/referring to other agencies e.g., psychological support services.

Emerging Themes

South Yorkshire
Local Maternity and Neonatal System (LMNS)

Emerging Themes (Each theme is present in at least a third of active/closed cases)
Communication: Not knowing own/baby's plan of care.
Bad news delivered in a way which was harmful to parents.
Communication: Not involved in decision-making/feeling coerced to make decision.
Word of staff/documentation taken over patient/family recollection.
Communication: Delay/omission in explaining what happened or in providing updates later.
Loss of trust with whole hospital.
Defensive responses when families ask questions after the event.
The feeling of not being believed during clinical care and/or following an adverse outcome.
Complex additional needs (e.g., social/mental health/neurodiversity).
Impact of others' actions on the mental health of parents not fully considered.
Not reviewed/second opinion not sought quickly enough.
Conflicting information given which can lead to false hope.
Lack of baby loss-specific bereavement support.
Issues with inclusion/communication around PMRT.

What is working well?

South Yorkshire
Local Maternity and Neonatal System (LMNS)

There have been multiple positive interactions and experiences, both for families directly and for the MNISA in her support of families. For example:

- Some families expressed that they were provided with really individualised, compassionate care following an adverse outcome, particularly where there is ongoing clinical care.
- For some families when meeting with Trusts face-to-face after concerns have been raised, there have been some excellent examples where families have described finally feeling heard, understood and as though the Trust have responded openly and honestly. The lasting benefits of in-person meetings where this can be facilitated has been evident for these families.
- There has been clear evidence of clinical colleagues working with external agencies and advocating for families themselves to ensure the right support is received.
- There have been real efforts from some Trust colleagues to ensure that families are heard as part of ongoing Trust processes, and that requests are accommodated.
- The MNISA is having positive interactions with many Trust colleagues (as well as other partners/external agencies) which is enabling families to receive the right support from the right people and in the right way. This also includes significant support from the LMNS Programme Team.

Challenges

Some of the challenges include:

- There is a risk of further harm to families when they receive conflicting information. The MNISA is working with Trusts to minimise the risk as much as possible, and to support families and feed back to Trusts where permitted.
- Due to previous interactions, families and individuals may perceive that professionals sometimes hold preconceptions about them and feel a judgement has been made before meeting them. This can impact on the re-building of relationships between families and Trusts. The MNISA will provide specific feedback where permitted by families and will otherwise broadly raise awareness.
- The MNISA should not hold information she cannot promptly share with the family. This can create a conflict between waiting to confirm what can be shared and how, with the risk that families will be caused harm and lose trust in the MNISA if they identify a lack of transparency. The MNISA will continue to provide clarity with colleagues regarding her position.
- The MNISA aims to support understanding of Trust processes and approaches for families e.g., the Just Culture approach. The MNISA must continue, however, to exercise caution and ensure it is not perceived that the MNISA is defending the actions of individuals or organisations.

Broader Learning

South Yorkshire
Local Maternity and Neonatal System (LMNS)

- Perinatal Mortality Review Tool (PMRT) process – challenges for families have been escalated. SY LMNS are now considering where system-wide improvements can be made, and actions are underway.
- Baby loss-specific bereavement support services - SY LMNS Service User Voice Lead is now undertaking a Bereavement Project.
- Families are increasingly requesting detailed information from early reviews of their care and there is currently no clear process to address such requests, which presents challenges to both families and Trusts – ongoing discussions within SY LMNS.
- When relationships break down between families and the Trust where they received care, families are expressing a wish to receive follow-up care/have follow-up discussions with a different organisation. This has been recognised within the SY LMNS Programme team and discussions are underway about whether specific system-wide pathways can be developed to consider such requests.
- For a bereaved mother - distressing questions were asked via routine questionnaires at dental appointments. This was addressed by one brave SY mother, with a positive response from her dental practice. The mother has allowed for this learning to be shared across SY dental practices and more widely across the MNISA network.

What Next?

South Yorkshire
Local Maternity and Neonatal System (LMNS)

Next steps

- MNISA video
- Present to LMNS Collaborative Board in August and to Trust Boards (With DoMs/HoMs) from September onwards
- Review information which is available to the public to ensure clarity around MNISA service
- Consider the referral process to ensure eligible families receive information in a way which is meaningful to them and accessible for them
- Continue working with Trusts and other organisations to provide the right support for families

Requests

- Please keep working with the MNISA to offer the right support
- HoMs/DoMs - please invite the MNISA meetings where Trust-specific discussions can take place in more detail
- Please do ask if it would help for the MNISA to introduce the role to a family without any commitment for them to utilise the service

South Yorkshire
Local Maternity and Neonatal System (LMNS)

Abbey Harris

Maternity and Neonatal Independent Senior Advocate

07811 796494

syicb.advocate@nhs.net
abbey.harris@nhs.net

https://southyorkshire.icb.nhs.uk/your-health/MNISA
https://future.nhs.uk/SYBLMS

2409 - E2 THE NHS PREMISES ASSURANCE MODEL

Decision Item | Jon Sargeant, Chief Financial Officer | 12:35

10 minutes

REFERENCES

Only PDFs are attached

E2 - NHS Premises Assurance Board Report 2023-2024.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**E2**
Report Title:	**The Premises Assurance Model (NHS PAM) Assessment Report 2023/2024**		
Sponsor:	Jon Sargeant, Chief Financial Officer/Director Recovery, Innovation & Transformation		
Author:	Sean Tyler, Head of Compliance Estates and Facilities		
Appendices:	Appendix 1: Premises Assurance Visual Dashboard Summary – Safety 2023/2024 Appendix 2: Premises Assurance Visual Dashboard Summary – Patient Experience 2023/2024 Appendix 3: Premises Assurance Visual Dashboard Summary – Efficiency 2023/2024 Appendix 4: Premises Assurance Visual Dashboard Summary – Effectiveness 2023/2024 Appendix 5: Premises Assurance Visual Dashboard Summary – Organisational Governance 2023/2024 Appendix 6: Premises Assurance Visual Dashboard Summary – Facilities Management (FM) Maturity 001 2023/2024 Appendix 7: Premises Assurance Visual Dashboard Summary – Facilities Management (FM) Maturity 002 2023/2024		

Report Summary

The NHS Premises Assurance Model (PAM) provides a nationally consistent basis for assurance for Trust Boards on Regulatory and Statutory requirements relating to their estate and related services, and the NHS constitution right:

'To be cared for in a clean, safe, secure and suitable environment'.

This assurance can then be used more widely and be provided to commissioners, regulators, the public and other interested stakeholders.

The NHS PAM aims to bridge the space between NHS Boards and the operational detail of its day-to-day estates and facilities operations. However, it should be noted that PAM relates to how the organisation manages its infrastructure, not the quality, condition, fitness for purpose or risks associated with the infrastructure. Therefore, the PAM is providing assurance that the organisation has systems and processes which aim to mitigate the risks associated with non-compliant infrastructure and major systems as documented on the Trust risk register, it is not a reflection of how compliant the infrastructure itself is. The model can be used as a prompt for further investigation, and to stimulate better-informed dialogue as to how the premises can be more efficiently used, more effectively managed, and contribute to the overall strategic objectives of the organisation. Its purpose is to support the organisational aim of ensuring that the premises and associated services are as safe as possible.

The report provides information from the PAM assessment for 2023/2024, covering all five mandated PAM domains and the Cabinet Office Facilities Management Standard (FMS) Maturity Framework results for FMS 001: management and services and FMS: 002 asset and data maturity. The Trust Overall Summary Position for 2023/2024 for the domain SAQ's is 'Good' in 133 elements, 'Requires Minimal Improvement' in 151 elements 'Requires Moderate Improvement' in 31 elements, is 'Inadequate' in 5 elements, with 43 elements scoring as 'Not Applicable' (N/A).

The report outlines areas that require further improvement and in some cases investment to achieve compliance with Legislation, Approved Codes of Practice (ACOP's) and Guidance, to bring the Trust up to an all-round good rating.

Estates and Facilities Management (EFM) Strategic objectives and identified goals which are directly aligned to improving the elements requiring 'Inadequate', 'Requires Moderate and Minimal Improvement' within the Efficiency, Effectiveness and Organisational Governance PAM assessment are explained in detail within the report, identifying three main Strategic Objectives; Board approved Green Plan, E&F Operational Performance and Emergency Preparedness Resilience and Response (EPRR).

The report confirms positive progress, with an increase in the number of SAQ's achieving a rating 'Good' from 112 in 2022/23 to 133 in 2023/24. There has also been a reduction in the number elements deemed to be inadequate from 7 to 5, and a reduction in the elements requiring both minimal and moderate improvement from 160 to 151 and 38 to 31 respectively. The assessment also saw the introduction of a further 11 new elements for this year's assessment.

It should also be noted that foundations are now firmly in place within E&F to deliver further continued improvements in domains requiring moderate and minimal improvement, including the development of improvement action plans and designated subject leads for each area, which should be reflected in the 2024/2025 assessment.

Where improvement is required to achieve compliance, estimated capital and revenue costs are provided, identifying a need for approximately £670,500 in additional revenue funding and £120M capital investment to address high and significant risk critical infrastructure backlog maintenance, which again affects the level of compliance achieved via the assessment. The assessment provides a breakdown of where these costs sit against each element, providing the granular detail of where investment is required to enable the Trust to successfully achieve an overall rating of 'Good', which then informs the Trust's five year plan, capital programme and Estate's Strategy.

In conjunction to the revenue and capital funding identified above, the report also highlights that an Estates review has been completed as required as part of the Granger review action plan, confirming the need for additional resource to close identified gaps so that a maintenance regime reflective of the known and foreseeable risks present within the estate may be implemented. The business case recommends a phased approach, which would allow progressive recruitment into new roles and embedding of new ways of working. The business case is awaiting approval, therefore the costs have not been included in this report.

The FMS maturity framework assessments FMS 001: management and services and FMS 002: asset and data maturity for 2023/2024 were completed by the Trust E&F management team following the FMS standard self-assessment guidance documentation and peer reviewed with a local Trust South West Yorkshire Partnership FT (SWYFT) for consistency. This has provided a clear baseline for future mandatory data collections and aim of continual improvement within the Trust FM maturity status. Both FMS 001 and FMS 002 will be incorporated in future annual E&F business planning, informing the strategic priority objectives to attain at a minimum 'Good 'maturity standard level.
Currently the Trust the maturity status ratings are:

- FMS 001: developing/improving in four of the five maturity dimensions, attaining the standards good rating within the strategic reporting dimension.
- FMS 002: developing/basic within the data assurance quality dimension, developing/improving in the team capacity and capability dimension , good (attaining the standard) in data structure and data usage and best (best practice) in data ownership and data systems. The results within the majority of FMS 002 have remained static throughout this reporting period.

Recommendation:	The Board of Directors to note that the information within the report and PAM assessment 2023/2024 data will be submitted and committed through the NHSE online reporting system before the deadline of the 13 September 2024.			
Action Required:	**Approval**	~~Review and discussion~~	~~Take assurance~~	~~Information only~~
Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	*We work together to enhance our services with clear goals for our communities.*	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	NA		**NA**	

Implications			
Relationship to Board assurance framework:	**X**	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
	X	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
		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
	X	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
		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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal:	• The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. • Developing an Estate Strategy document • Health Building Note 00-08 • Health building Note 00-08: Land and Property Appraisal • Strategic Health Asset Planning & Evaluation (SHAPE) tool • Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services		

	• Monitor: Strategy development: a toolkit for NHS providers • Monitor: Developing strategy - What every Trust board member should know.
Regulation:	• Health and Safety at Work Act 1974 (HASAWA) • Management of Health and Safety at Work Regulations 1999 • The Workplace (Health, Safety and Welfare) Regulations 1992 • The Health and Safety (Display Screen Equipment) Regulations 1992 • The Manual Handling Operations Regulations 1992 (as amended) (MHOR) • The Personal Protective Equipment at Work Regulations 1992 • The Provision and Use of Work Equipment Regulations 1998 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) • The Control of Substances Hazardous to Health Regulations 2002 • Safety Representatives and Safety Committees Regulations 1977 • Health and Safety (Consultation with Employees) Regulations 1996.
Resources:	Capital Costs associated with SH1 and SH4 Compliance Revenue Consequences Costs associated with requirements to achieve PPM compliance with SFG20, Estates and Medical Technical Services Workforce Review and the 2021 National Standards of Healthcare Cleanliness.

Assurance Route	
Previously considered by:	No
Date:	N/A
Any outcomes/next steps	Continual Annual reporting the PAM to Board. Continual bi-annual reporting to Audit and Risk Committee and quarterly reporting to the Trust Health and Safety Committee.
Previously circulated reports to supplement this paper:	N/A

Table of Contents

List of figures within this report:

List of tables within this report:

1. Introduction

The assessment of the DBTH Premises Assurance Model (PAM) has been undertaken using the revised and updated PAM 2024 model and reflects the Trust's position as at 2023/2024. The methodology utilised adopts the NHSE PAM format and approach through the 5 identified Domains, integrated PAM Self-Assessment Questions (SAQ's) and Cabinet Office Facilities Management Standard (FMS) Maturity Framework Standards FMS 001: management services and 002: asset data maturity, in conjunction with the responsible DBTH Estates, Facilities and Clinical Trust management PAM leads.

Evidence for each PAM domain rating is provided by the named responsible Trust lead for each SAQ. Examples of evidence include Approved Policy and Procedural Documents (APD), other procedures and protocols, evidence of appointments and competencies, and any other supporting information that justifies that rating attributed to the SAQ. Approval, Review and Expiry dates are also provided to enable an auditing process through the PAM evidence file held on a new electronic assurance system, Concerto integrated software solutions.

The rationale and rating of each SAQ is further scrutinised and challenged by an ongoing process of review, which includes the accessing of evidence by the Head of Compliance, combined with open and challenging discussions with SAQ leads to ensure that the assessment is robust, accurate and transparent.

Once the evidence is considered to be complete, each SAQ element is rated in accordance with one of the following categories; 'Not Applicable', 'Inadequate', 'Requires Moderate Improvement', 'Requires Minimal Improvement', 'Good' or 'Outstanding'. Once complete, this allows an assessment of all evidence to determine an overall summary rating for the Trust.

The Trust's overall summary position for 2023/2024:

- Good in 133 elements,
- Requires Minimal Improvement in 151 elements
- Requires Moderate Improvement in 31 elements,
- Inadequate in 5 elements,
- Not Applicable in 43 elements

Figure 1 provides the overall summary position for the previous reporting period 2022/2023, with figure 2 illustrating the position in 2023/24, confirming positive progress in a number of areas. It should be noted that the 2023/24 assessment also included the addition of a new additional safety domain, SAQ; SH21: The built environment: Reducing harm by ligature practice, which added 8 additional SAQ's.

Figure 3 provides the distribution of SAQ ratings for each of the 5 domains, Safety (Hard FM/Soft FM), Patient Experience, Efficiency, Effectiveness and Organisational Governance. Note that for the purpose of the report, Hard and Soft FM safety domain elements are reported separately.

There has been an increase in the number of SAQ's achieving a rating 'Good' in the reporting period, increasing from 112 in 2022/23 to 133 in 2023/24. There has also been a reduction in the number elements deemed to be inadequate from 7 to 5, and a reduction in the elements requiring both minimal and moderate improvement from 160 to 151 and 38 to 31 respectively.

A quarterly review of the PAM Safety domain is presented to the Trust H&S Committee, utilising the DBTH PAM electronic assurance dashboard (Appendix 1) and is also included within the 6 monthly H&S report presented to the Trust Audit and Risk Committee (ARC).

A summary is also presented to the Finance and Performance (F&P) Committee within the annual Estates & Facilities performance report for assurance of the Trust's H&S compliance against the NHS PAM Safety Domain.

The Patient Experience domain results continue to be presented on an annual basis to the Patient Experience & Involvement Committee (PEIC) for information and assurance.

Figure 1: Overall Summary Position of Self-Assessment Question (SAQ) Scores 2022/2023

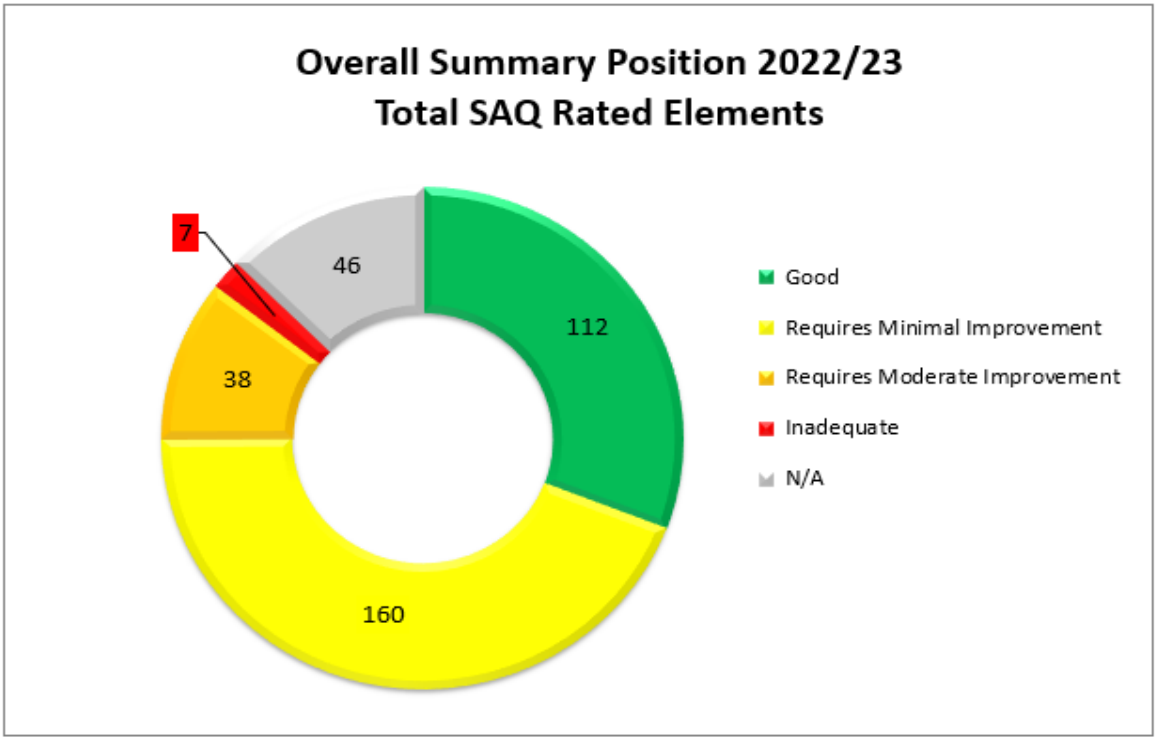


Figure 2: Overall Summary Position of Self-Assessment Question (SAQ) Scores 2023/2024

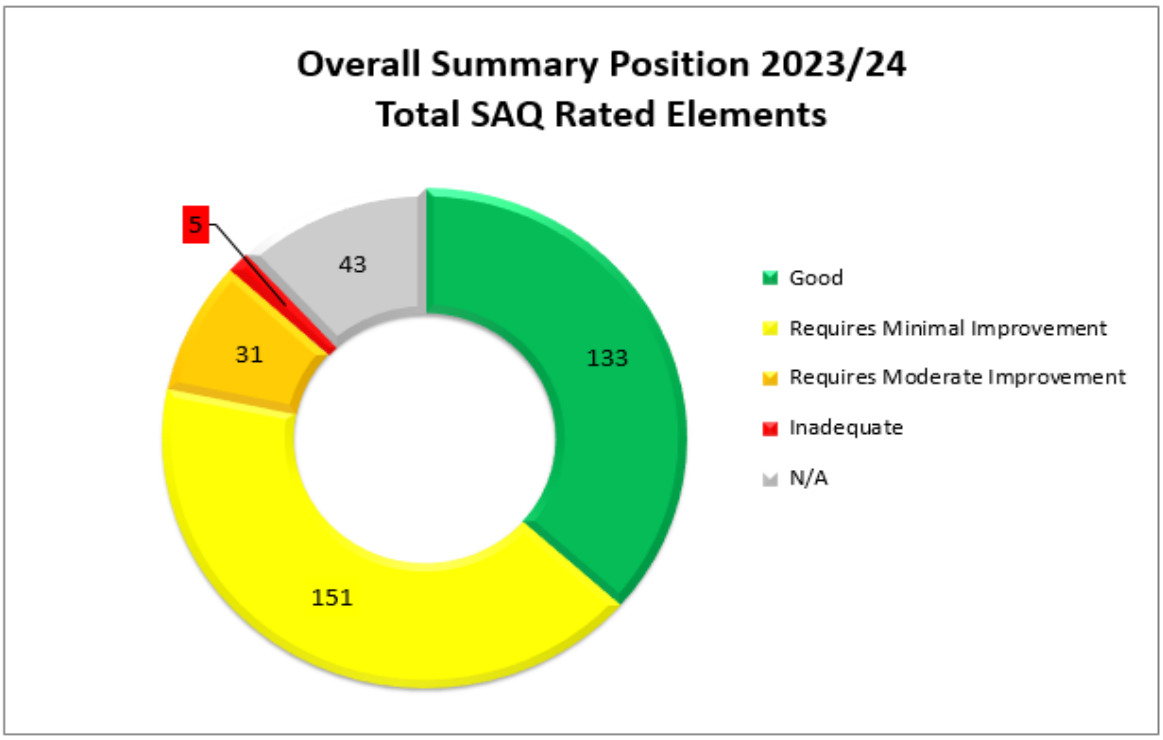
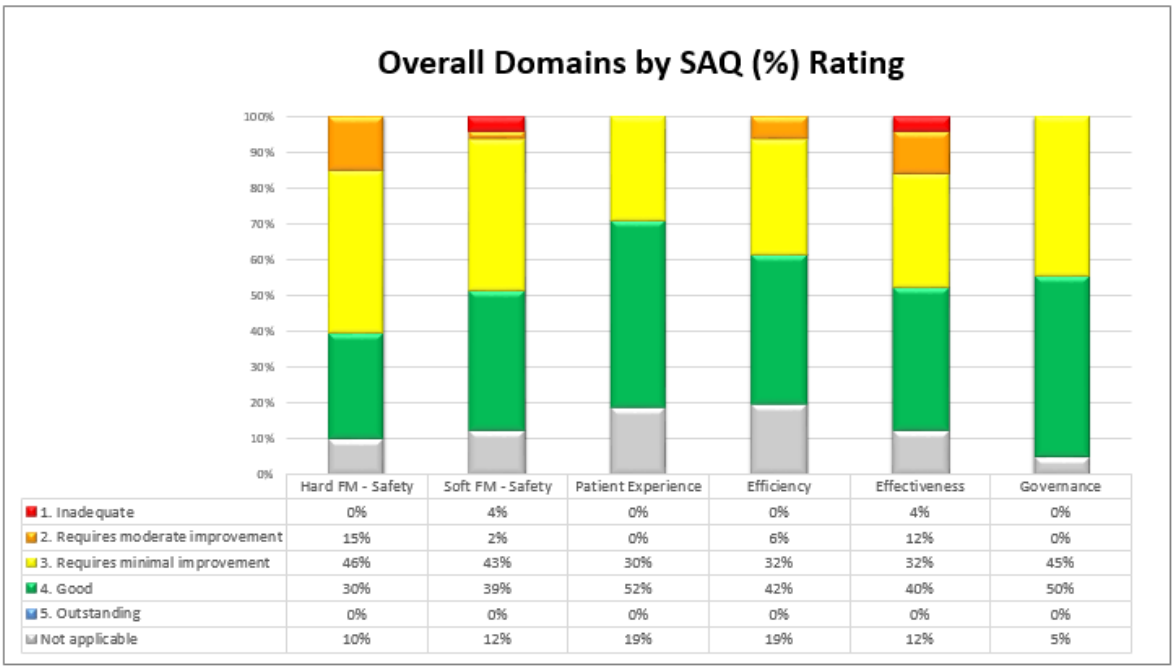


Figure 3: Overall, Distribution of Self-Assessment Questions (SAQ) Ratings (%) for 2023/2024



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
1. Inadequate	0%	4%	0%	0%	4%	0%
2. Requires moderate improvement	15%	2%	0%	6%	12%	0%
3. Requires minimal improvement	46%	43%	30%	32%	32%	45%
4. Good	30%	39%	52%	42%	40%	50%
5. Outstanding	0%	0%	0%	0%	0%	0%
Not applicable	10%	12%	19%	19%	12%	5%

2. Safety Domain

This domain contains SAQ's related to both Hard FM and Soft FM, but for reporting purposes sections 2.1 and 2.2 provides a breakdown of each area separately.

The PAM safety domain distribution indicates that the Trust is 'Good' in 86 elements, 'Requires Minimal Improvement' in 116 elements, 'Requires Moderate Improvement' in 26 elements and is 'Inadequate' in 4 elements. A further 28 elements were deemed 'Not Applicable'. The evidence suggests therefore that the majority of the SAQ's within this domain are either good or require only minimal improvement.

Continual progress is being made to the majority of SAQ elements, with a solid foundation to continually deliver anticipated overall reductions in 'Requires Moderate, Minimal Improvement' and 'Inadequate' scores within the following 2024/2025 PAM assessment reporting year.

2.1 Safety (Hard FM)

Figure 4 presents the PAM distribution of Hard FM SAQ ratings for 2023/2024 with figure 5 providing the DBTH PAM Distribution of SAQ Ratings for 2023/2024. Table 1 provides a legend listing the Hard FM SAQ's individual elements.

Figure 4: Safety Domain Hard FM Summary Position for 2023/2024

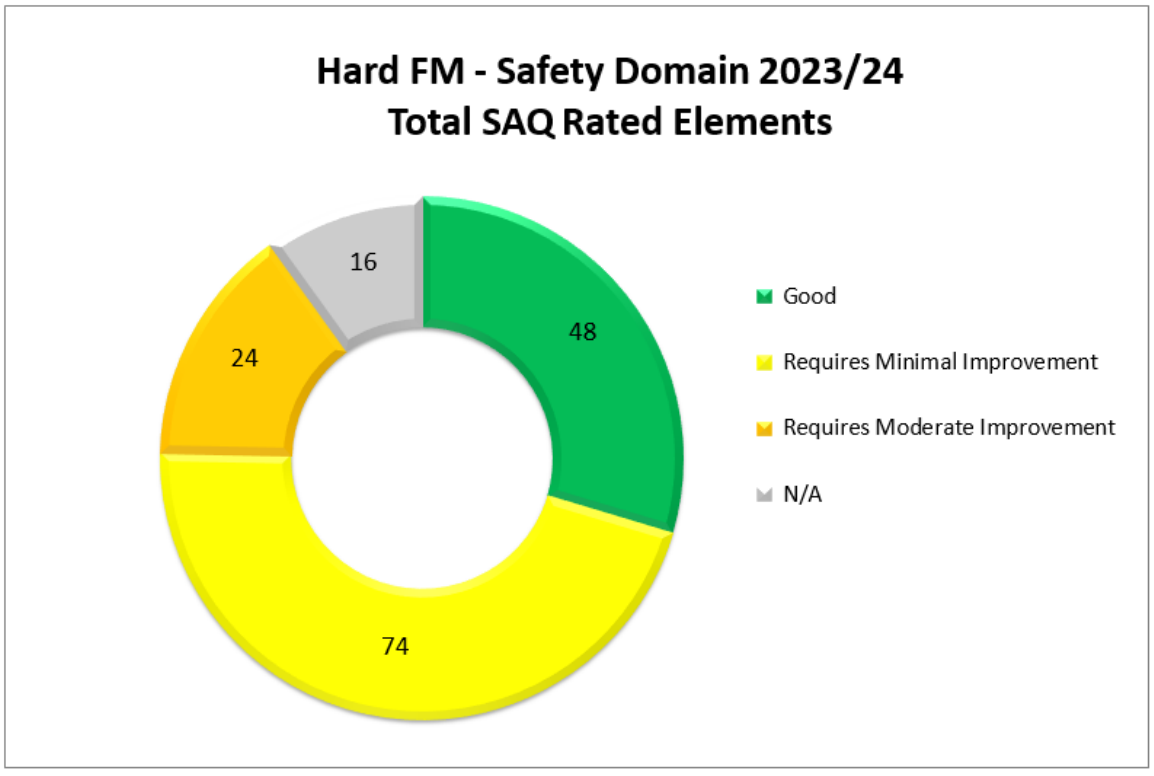


Figure 5: Distribution of SAQ Ratings (%) for Safety Hard 2023/2024

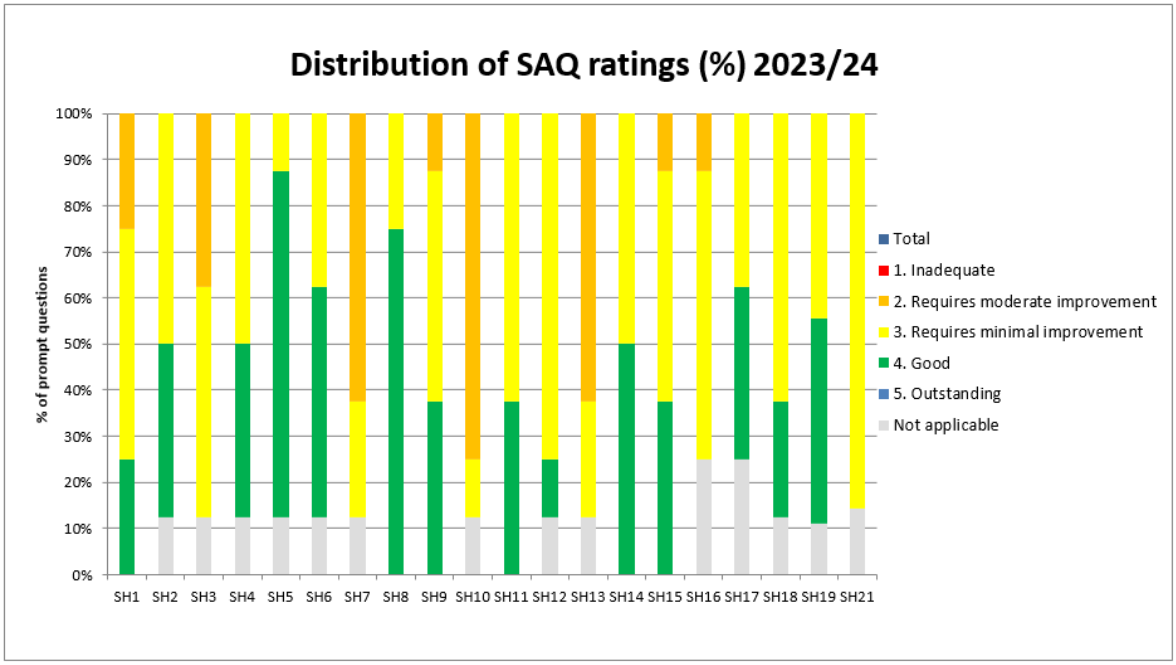


Table 1: Safety Domain Hard FM Individual SAQ Element Legend 2023/2024

Legend	
SAQ Code	**Self-Assessment Question – Is the Organisation/site safe and compliant with well managed systems in relation to:**
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Systems
SH9	Electrical Systems
SH10	Mechanical Systems e.g. Lifting Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Alerts
SH18	Externally Supplied Estate
SH19	Contractor Management
SH21	The Built Environment: Reducing Harm by Ligature Practice

Whilst positive progress has been made in the hard FM section, actions identified during Authorising Engineer (AE) audits regarding an ongoing requirement to appoint a greater number of Authorised Persons (AP's) and Competent Persons (CP's), along with work to review maintenance schedules in line with industry best practice (SFG20), means that there has been only limited improvement in the PAM score within the reporting period.

Taking into consideration the introduction of the new Reducing Harm Ligature SAQ with 7 associated elements, and a further new additional element within the contractor management SAQ delivering 8 new elements in total, there has been an increase in 'Good' ratings in 8 elements, a reduction of 5 areas 'Requiring Minimal Improvement', 1 'Requiring Moderate Improvement' and an increase in 2 'Not Applicable' ratings, delivering and an overall improvement within the domain for the reporting period.

An Estates review has been completed as required as part of the Granger review action plan, confirming the need for additional resource to close identified gaps so that a maintenance regime reflective of the known and foreseeable risks present within the estate may be implemented. The business case recommends a phased approach which would allow progressive recruitment into new roles and embedding of new ways of working. The business case is awaiting approval, therefore the costs have not been included in this report.

The majority of elements 'Requiring Minimal and Moderate Improvement' are related to Policies and Procedures, Roles and Responsibilities, Risk Assessments, Training and Development and Business Continuity, with anticipated improvements within this element as a direct result of the continued risk summit work being undertaken with NHSE and ICB colleagues. These deficiencies will continue to be reviewed through the PAM review process for 2024/2025, with action and review dates including clearly defined timescales presented to the individual responsible managers to improve progress in the overall PAM SAQ scores.

2.2 Safety (Soft FM)

Figure 6 presents the PAM distribution of Safety Soft SAQ ratings for 2023/2024, with figure 7 providing the DBTH PAM distribution of SAQ Ratings for 2023/2024. Table 2 provides a legend listing the Soft FM SAQ's individual elements.

Figure 6: Safety Domain Soft FM Summary Position for 2023/2024

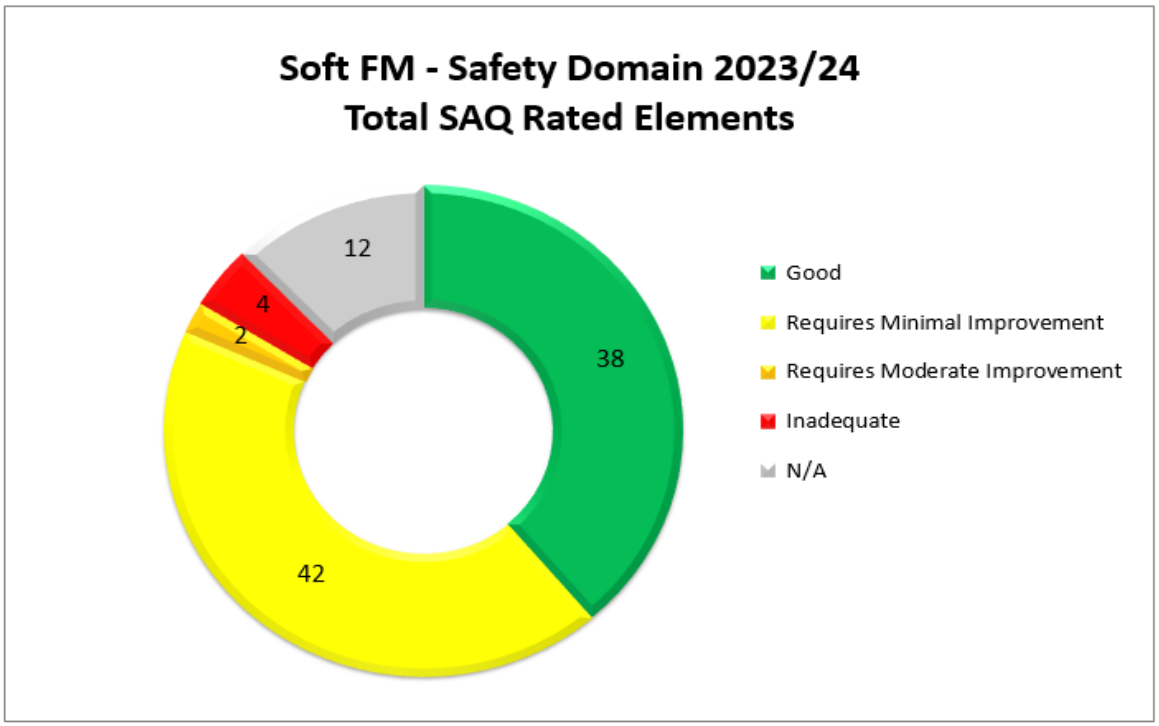


Figure 7: Distribution of SAQ Ratings (%) for Safety Domain Soft FM 2023/2024

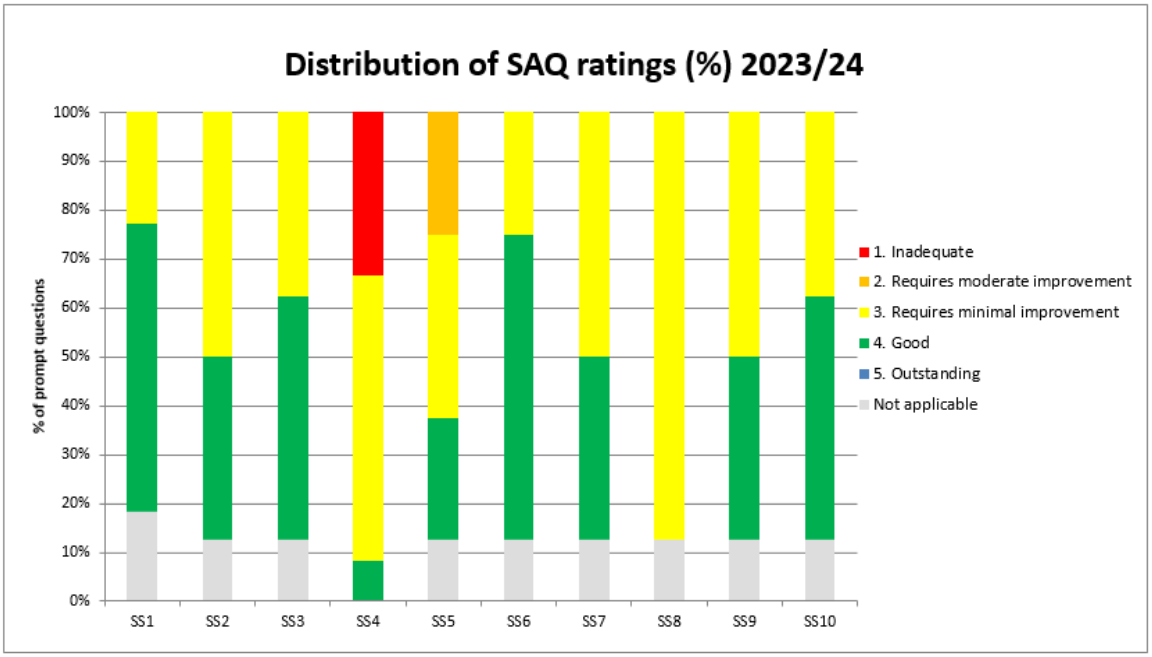


Table 2: Safety Domain Soft FM Individual SAQ Element Legend 2023/2024

Legend	
SAQ Code	**Self-Assessment Question – Is the Organisation/site safe and compliant with well managed systems in relation to:**
SS1	Catering Services
SS2	Decontamination Processes
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry Services and Linen
SS6	Security Management
SS7	Transport Services and access arrangements
SS8	Pest Control
SS9	Portering Services
SS10	Estates IT and Building Information Management (BIM) Systems

There has been a positive improvement in the safety soft FM domain, with an increase in 'Good' rating in 11 elements, an increase of 7 elements now only 'Requiring Minimal Improvement', and a corresponding reduction of 5 elements 'Requiring Moderate Improvement' and a reduction of 2 'Inadequate' ratings, providing an encouraging indication of progress.

The key Soft FM elements requiring improvement for the reporting period are cleaning and infection control, largely because the Trust do not currently achieve compliance against the 2021 National Standards of Healthcare Cleanliness. This is due to a requirement for additional resource, although the previous 2007 Cleanliness Standards are being achieved as identified within the Facilities cleanliness audits.

A derogation was previously agreed with NHS England in recognition of the need for additional resource, though this expired in March 2023. A business case has been developed and submitted for consideration by the Corporate Investment Group (CIG), outlining the additional funding required to achieve compliance with the new standards. The approximate Revenue Consequences to achieve compliance with the 2021 National Standards of Healthcare Cleanliness and deliver an overall good rating within PAM is £629,000. Following previous collaborative work with NHSE Leads for the new standard, the Trust are currently working on a phased implementation plan reflective of the Trust's current financial position with a projected commencement in Q3 FY24/25.

The majority of all other elements 'Requiring Minimal and Moderate Improvement' within this domain again relate to Policies and Procedures, Roles and Responsibilities, Training and Development and Business Continuity. Areas for improvement will continue to be reviewed through the PAM review process for 2024/2025, with action and review dates including clearly defined timescales presented to the individual responsible managers to improve progress in the overall PAM SAQ scores.

3. Patient Experience Domain

The PAM Distribution of SAQ Ratings for Patient Experience shows DBTH to be 'Good' in 14 elements, 'Requiring Minimal Improvement' in 8 elements and 5 'Not Applicable', improving the overall Domain rating with the removal of requires Moderate Improvement through positive work undertaken during the reporting period.

The Trust PAM Patient Experience summary position is illustrated in figure 8, figure 9 provides the PAM distribution of Patient Experience SAQ ratings and Table 3 provides a legend listing the Patient Experience SAQ's individual elements, with the visual dashboard provided in Appendix 2.

The full Patient Led Assessment of the Care Environment (PLACE) programme led by the by the Trust Head of Patient Engagement, Experience & Involvement along with the support of the E&F Management Team was successfully undertaken during the reporting period. Completion of PLACE and the positive outcomes from the assessment directly resulted in sustained delivery of 'Good' ratings within this domain. Work undertaken to improve staff engagement against the required assessment criteria has resulted in an improvement from moderate to minimal improvement within this individual SAQ.

Further SAQ's requiring minimal improvement include the requirement for improving other areas of Internal Assessment and improved Staff and Patient Engagement through the introduction of patient participation focus groups. These areas will be included within the reintroduced Patient Environment Group (PEG) agenda as well as through the continued PAM management and review process for 2024/2025.

Figure 8: Patient Experience Domain Summary Position for 2023/2024

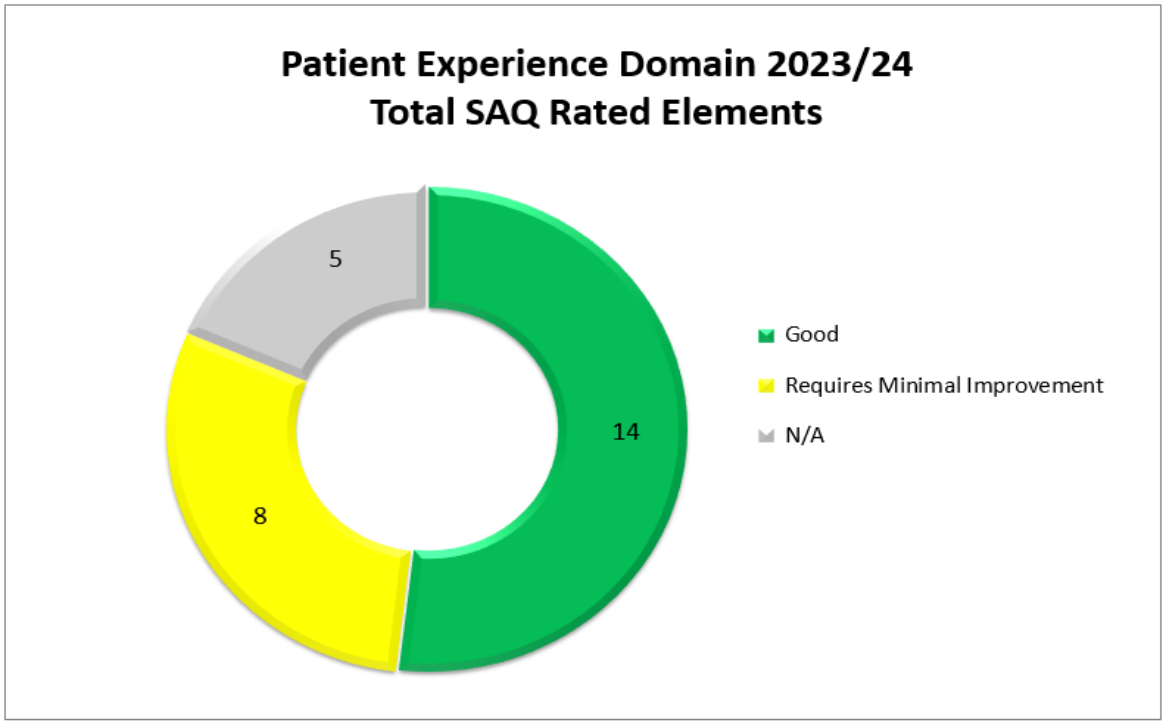


Figure 9: Distribution of SAQ Ratings (%) for Patient Experience Domain 2023/2024

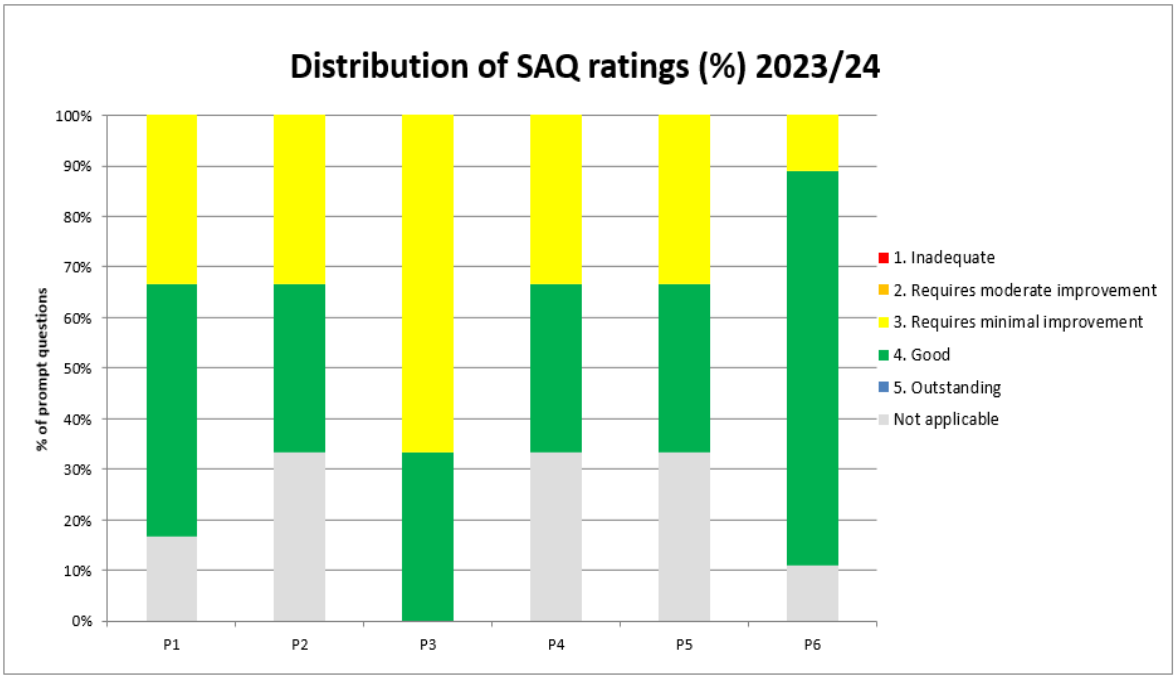


Table 3: Patient Experience Domain Individual SAQ Element Legend 2023/2024

Legend	
SAQ Code	**Self-Assessment Question – Does Your Organisation:**
P1	With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?
P2	With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?
P3	With regard to ensuring ensure that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?
P4	With regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?
P5	With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to grounds and gardens can your organisation evidence the following?
P6	How does your organisation/site ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?

4. Efficiency, Effectiveness and Organisational Governance Domains

Figure 10 presents the PAM distribution of Efficiency, Effectiveness and Organisational Governance SAQ ratings for 2023/2024, with figure 11 providing the distribution of SAQ Ratings for 2023/2024. Table 4 provides a legend listing the Efficiency, Effectiveness and Organisational Governance SAQ's individual elements with the individual domain visual dashboards provided in Appendix 3, 4 and 5.

Allowing for the introduction of 3 new additional elements within the domain SAQ's the assessment shows the Trust to be 'Good' in 33 elements, 'Requiring Minimal Improvement' in 27

elements, 'Requiring Moderate Improvement' in 5 elements and 'Inadequate' in 1 element, relating to Policies and Procedures for air pollution control. A further 10 elements were 'Not Applicable'.

The evidence gained during the PAM assessment process has identified a need to focus on the 'Inadequate' and 'Requires Moderate Improvement' elements within these domains. All elements 'Requiring Minimal Improvement' will also be targeted via the PAM review process for 2024/2025, with an aim to deliver further 'Good' rated scores.

It should also be noted that the evidence reviewed during the assessment highlighted three key strategic objectives included within the E&F annual business plan which directly align to the Efficiency, Effectiveness and Organisational Governance PAM assessment SAQ action plans to deliver sustained improvement within this reporting period:

1. The Board approved Green Plan including Strategy to improve the Trusts position with regards to sustainability, and achieve its objectives identified within the Strategy to;

    a) Continue Implementation of the Trust Green Plan and Green Action Plan by the Trust Sustainability Group.
    b) Completion of the Trust climate change risk assessment and climate change adaption plan.
    c) Introduction of a sustainable travel and transport plan.
    d) Completion of a decarbonisation strategy for DBTH explaining how the organisation will move away from the use of fossil fuels on the lead up to 2045.
    e) Develop sustainability objectives for 2024 in conjunction with sustainability steering group / anchor strategy group.
    f) Agree sustainability targets with ICB Estates group.

2. E&F operational performance through adoption of a 'balanced scorecard' (BSC) approach targeting continuous performance and quality improvement. Operational strategies are developed targeting improvements in four areas: 'Operational Performance', 'Financial Control, 'Departmental Learning and Development', and 'Improved Customer/Stakeholder Perception'.

    Guided by the Trust's Vision '**Healthier together – delivering exceptional care for all'** and the Estates & Facilities Mission to **"To provide sustainable services and environments that are safe, effective and resilient".** A strategy map outlining long term strategic objectives relevant to each of these areas has been developed to:

    a) Increase focus on workforce engagement and development in line with DBTH's People Strategy, the DBTH Way and Just Culture indicatives'; linked to the National 'People Plans' and NHS E workforce action plan.
    b) Target improved engagement and accountability throughout E&F.

c) Provide a comprehensive review of E&F KPI data to ensure that it is adequate identify opportunities for improvement and efficiency.
d) Implementation of E&F Performance Overview Support Meetings (POSM) chaired by the Director and Deputy Director of E&F.
e) Implementation of an E&F Performance Oversight Framework.
f) Further development and continual improvement of E&F financial management grip and control meetings.
g) Continuation of service reviews in:
    - Estates maintenance workforce
    - Cleaning Services in line with the NHS Standards of Healthcare Cleanliness 2021.
    - Catering services in conjunction with Sodexo in line with the NHS Standards for Healthcare Food and Drink 2022
    - Staff accommodation and introduction of a new staff accommodation policy
    - Medical Technical Services
    - Internal Transport services
h) Increased engagement with stakeholders to better understand the needs of service users.
i) Taking an active role in multi-disciplinary projects targeting improved safety, improved sustainability, and a reduction in incidences of violence and aggression against staff within the organisation.
j) Drive transformational change within the organisation in relation to improved health and safety management and culture.

3. DBTH's Estate presents a number of foreseeable critical infrastructure risks. Robust business continuity plans are therefore required to mitigate the risk.

   E&F will continue work with the Trust Emergency Preparedness Resilience and Response (EPRR) team and NHSE to develop regional mass evacuation plans in preparation for a major critical infrastructure issue, as well as targeting an improved approach to EPRR generally via a 10 point plan for improved EPRR following the NHS National EPRR Framework guidance.

   a) Continue work alongside DBTH EPRR and NHS E EPRR to develop business continuity plans for major foreseeable infrastructure failures leading to full or partial closure of DRI, including potential temporary relocation of service to regional partners
   b) Implementation of E&F's '10 point plan to improved EPRR'

Figure 10: Overall Summary Position - Efficiency, Effectiveness, Organisational Governance Domains 2023/2024

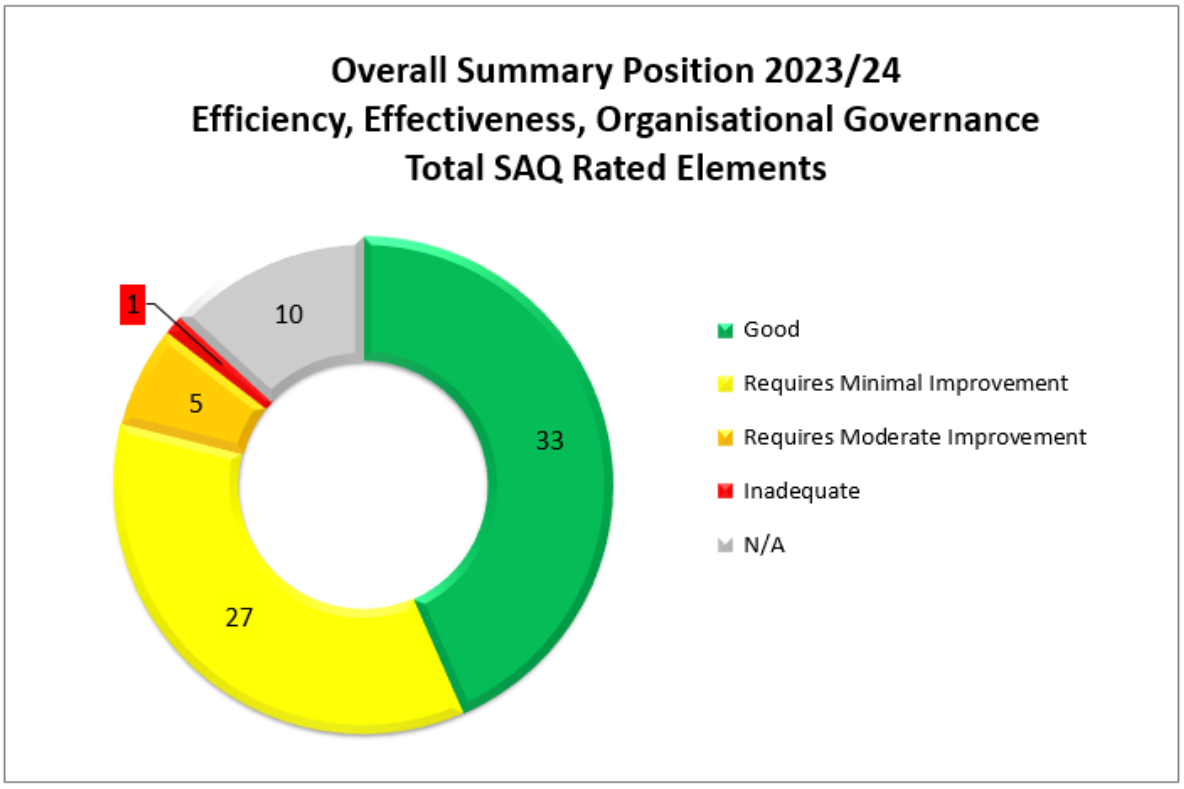
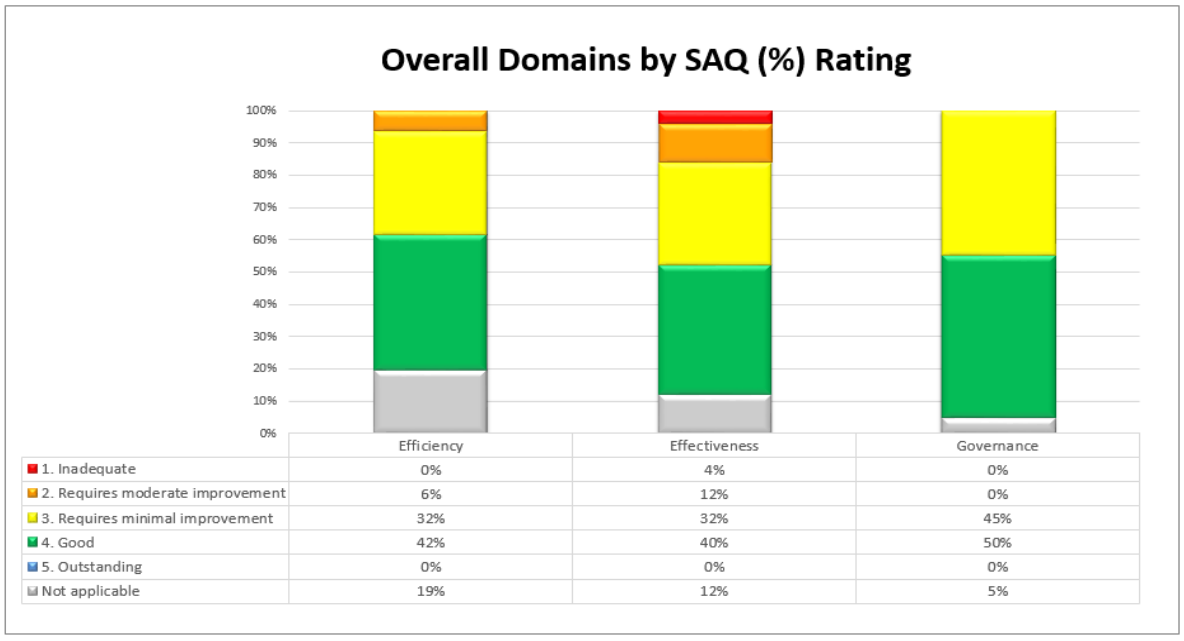


Figure 11: Overall Distribution of SAQ Ratings (%) for Efficiency, Effectiveness, Organisational Governance Domains 2023/2024



	Efficiency	Effectiveness	Governance
1. Inadequate	0%	4%	0%
2. Requires moderate improvement	6%	12%	0%
3. Requires minimal improvement	32%	32%	45%
4. Good	42%	40%	50%
5. Outstanding	0%	0%	0%
Not applicable	19%	12%	5%

Table 4: Efficiency, Effectiveness and Organisational Governance Domain SAQ Element Legend 2023/2024

Legend	
SAQ Code	**Self-Assessment Question –Efficiency**
F1	With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation provide evidence?
F2	With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation provide evidence?
F3	With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation provide evidence?
F4	With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation provide evidence?
F5	With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation provide evidence?
SAQ Code	**Self-Assessment Question –Effectiveness**
E1	With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation provide evidence?
E2	With regard to having a well-managed approach to town planning can the organisation provide evidence?
E3	With regard to having a well-managed robust approach to management of land and property can the organisation provide evidence?
E4	With regard to having a well-managed annually updated board approved sustainable development management plan can the organisation provide evidence?
SAQ Code	**Self-Assessment Question –Organisational Governance**
G1	With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation provide evidence?
G2	With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation provide evidence?
G3	With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation Provide evidence?

5. Capital Costs for Compliance and Revenue Consequences

Table 5 below provides a breakdown of the capital and revenue costs required to address gaps in compliance identified during the 2023/24 PAM assessment.

The Capital costs associated with SH1, Operational Management (maintenance SAQ element), have been provided from the annual 6 facet survey undertaken by external surveying consultancy Oakleaf for Critical Infrastructure Risk (High and Significant risk) reported through the ERIC returns.

Revenue costs include those associated with the resource required to close gaps in compliance against the National Standards of Healthcare Cleanliness (2021) and other requirements identified during the assessment.

The business case associated with the Estates review to deliver a phased approach allowing progressive recruitment into new roles and embedding of new ways of working is awaiting approval, therefore the costs have not been included in this report.

Table 5: Capital Costs for Compliance and Revenue Consequence 2023/2024

SAQ	Capital Cost for Compliance	
SH1: E&F Operational Management	Trust Critical Infrastructure Risk (For information Only)	£120,138,820
SAQ	**Revenue Consequence**	
SH1: E&F Operational Management	Estates Workforce Review	tbc
S4: Health and Safety at Work	Emergency First Aid at Work Training	£4,500
SH8: Water Safety	Water Safety Healthcare Technician Training	£8,000
SH9: Electrical Systems	Electrical Low Voltage (LV) Approved Person (AP) and Competent Person Training (CP)	£8,000
SH11: Ventilation, Air Conditioning and Refrigeration Systems	CP Heating, Ventilation and Air Conditioning (HVAC) training (HTM03)	£8,000
SH12: Lifts, Hoists and Conveyance Systems	Passenger Lift Training	£10,000
SH14: Fire Safety	Fire Risk Assessment Training	£3,000
SS4: Cleanliness and Infection Control	Compliance with NHS Cleaning Standards	Approximately £629,000

6. Facilities Management Standard (FMS) Maturity Framework 001 and 002

As part of this year's PAM reporting, the Cabinet Office have requested that NHSE encourage all Trusts to complete the Facilities Management Standard (FMS) maturity framework assessment. The FMS maturity framework has been developed to assist organisations in self-assessing against the FM management and service standard and FM asset data standard. The FMS maturity tool will support organisations in evidencing investment requirements to adhere to these FM standards, utilising a framework designed around five maturity stages (Developing – Basic, Developing – Improving, Good, Better, Best) within separate assessment dimensions.

The aim of the FMS framework and maturity tools is to improve quality, consistency and interoperability of FM provision across the whole Government Estate. The adoption of agreed FM management and services, and asset data standards will help improve consistency and quality across the public estate, through a common approach to FM service delivery within the public sector.

6.1 FMS 001: Management and Services Maturity

The FMS 001: management and services maturity tool is a new addition for 2023/24, as FMS 002: asset and data maturity tool and results was only previously required.

There are five FMS 001: management and services maturity framework assessment dimension requirements relating to FM, these are:

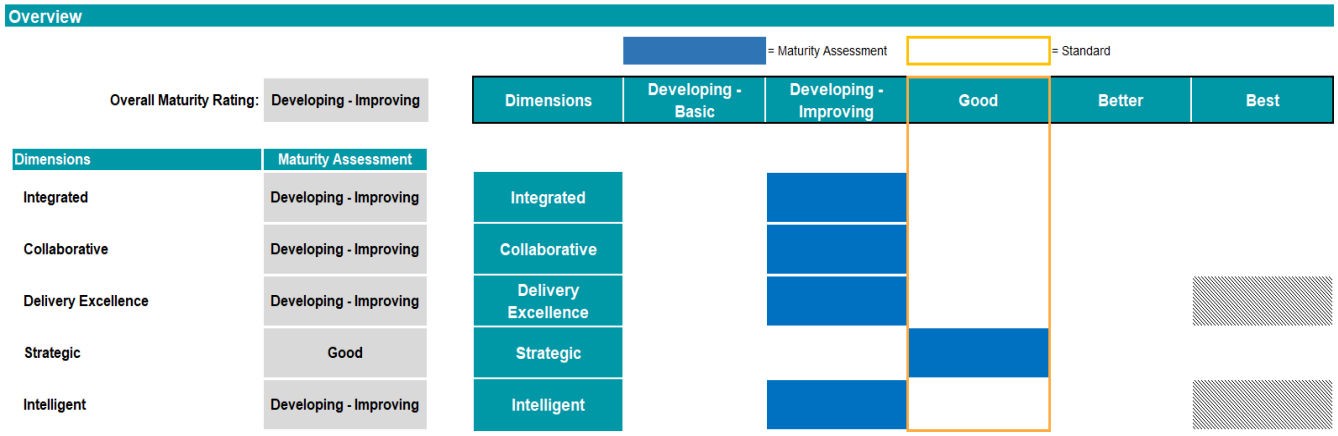
1. **Strategic** – including strategic planning, effective governance and adding value as an enabling service.
2. **Integrated** – having integrated leadership and working closely with related service areas. Able to present a single version of truth across the organisation.
3. **Intelligent** – an effective intelligent client, supporting management structure, the right capability and capacity of staff, forward planning and an understanding of levers available to improve performance.
4. **Collaborative** – the ability to work collaboratively with the delivery organisation, in a transparent way built on Trust.
5. **Delivery Excellence** – ability to evidence and validate asset compliance, use of industry standards and best practice and clearly defined roles both within the management organisation itself and between the management and delivery organisation.

The objectives of FMS 001 include:

- Collaborate and share knowledge through a clear standard and common language across FM services that will facilitate collaboration and knowledge sharing between organisations.
- Use common service standards that will help drive more experiences that are consistent across organisations, improving satisfaction ratings of government staff and maintenance standards, which will help reduce future maintenance costs.
- Strengthen FM management standards to improve interoperability and resilience across the estate, supporting a better customer experience and better value for money.

Figure 12 illustrates the Trust's current position following completion of the new FMS 001 maturity standard assessment tool (Appendix 6). With the Trust maturity status rated as developing/improving in four of the five maturity dimensions, attaining the standards good rating within the strategic reporting dimension.

Figure 12: Facilities Management (FM) Standard Maturity 001 - Summary Overview 2023/2024



6.2 FMS 002: Asset Data Maturity

The key principle that informs the FMS 002: asset data maturity tool is that public sector organisations must be able to produce an asset register of all their FM assets and be aware of the condition and maintenance requirements of each asset.

There are six FMS 002: asset and data maturity framework assessment dimension requirements relating to FM, these are:

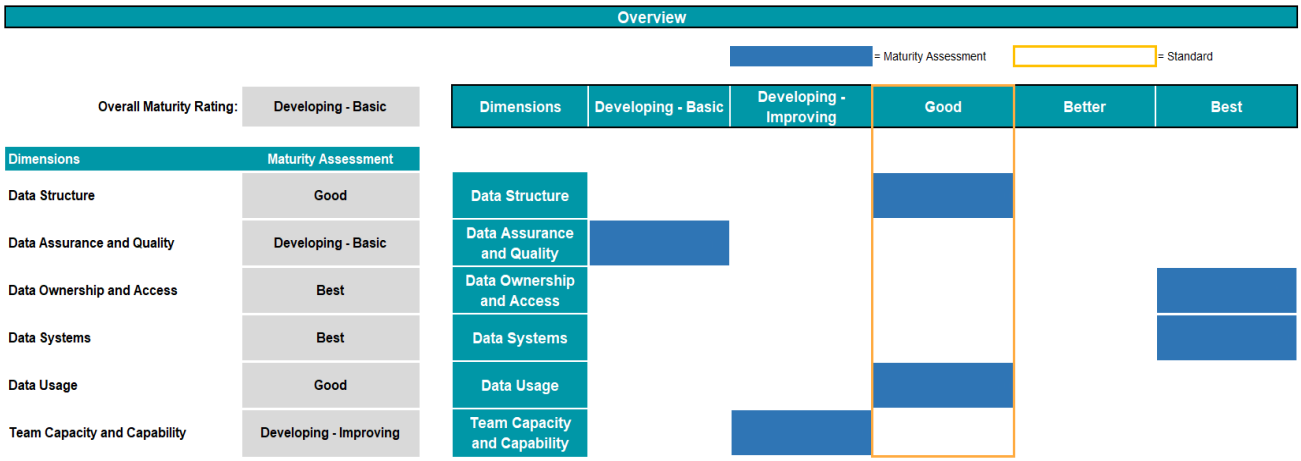
1. **Data Structure** – the requirements for FM asset registers and the parameters of assurance frameworks required to ensure ongoing validation of the data.
2. **Data Quality and Assurance** – the process and governances around data coverage and completeness. Ensure that across public sector organisations there is consistent FM asset data which is kept up to date.
3. **Data Ownership and Access** – the requirements for ownership and accessibility of FM asset data, along with the minimum requirements to ensure flexibility, interoperability, and security of the data.
4. **Data Systems** – the aim is to ensure that public sector FM asset data is portable between organisations and suppliers with flexibility, interoperability and security of data systems provided.
5. **Data Usage** – the requirement that policies and procedures are in place to ensure the application of FM asset data to support decision-making
6. **Team capacity and capability** – the supporting teams' and facilities managers have the capacity, capability, and responsibility to effectively utilise the FM asset data.

The main objective for Standard Maturity 002 is:

- To ensure that public sector organisations use the FM asset data to influence and drive improvements in maintenance and service delivery. The adoption of this standard across the public estate will help drive consistency and quality improvements via a common approach to FM asset data within the public sector.

Figure 13 illustrates the Trust's current position following completion of the FMS 002 maturity standard assessment tool (Appendix 7). With the Trust maturity status rated as developing/basic within the data assurance quality dimension, developing/improving in the team capacity and capability dimension , good (attaining the standard) in data structure and data usage and best (best practice) in data ownership and data systems. The results within the majority of FMS 002 have remained static throughout this reporting period.

Figure 13: Facilities Management (FM) Standard Maturity 002 - Summary Overview 2023/2024



The FMS maturity framework assessments were completed by the Trust E&F management team following the FMS standard self-assessment guidance documentation and peer reviewed with a local Trust South West Yorkshire Partnership FT (SWYFT) for consistency. This has provided a clear baseline for future mandatory data collections and to aid future work to improve the Trust's FM maturity status. Both FMS 001 and FMS 002 will be incorporated in future annual E&F business planning, informing the strategic priority objectives to attain at a minimum 'Good 'maturity standard level.

7. Conclusion and Recommendations

The reports outlines in detail the processes employed at DBTH during the implementation of the Premises Assurance Model for 2023/24.

The report evidences positive progress in a number of areas across the 5 domains, culminating in an overall improved position when compared to the assessment for 2022/23.

Whilst positive progress has been achieved, the reports suggests that the foundations have also been laid for further improvements throughout 2024/25, which will hopefully be reflected in next year's report. It should be noted, however, that in some cases further improvement requires investment to address shortfalls in compliance, particularly in the case of SAQ's related to the National Standards of Healthcare Cleanliness and Hard FM safety domain elements that relate to the appointment of Authorised Persons (AP's) and the implementation of maintenance standards that are reflective of the known and foreseeable risks present within the estate.

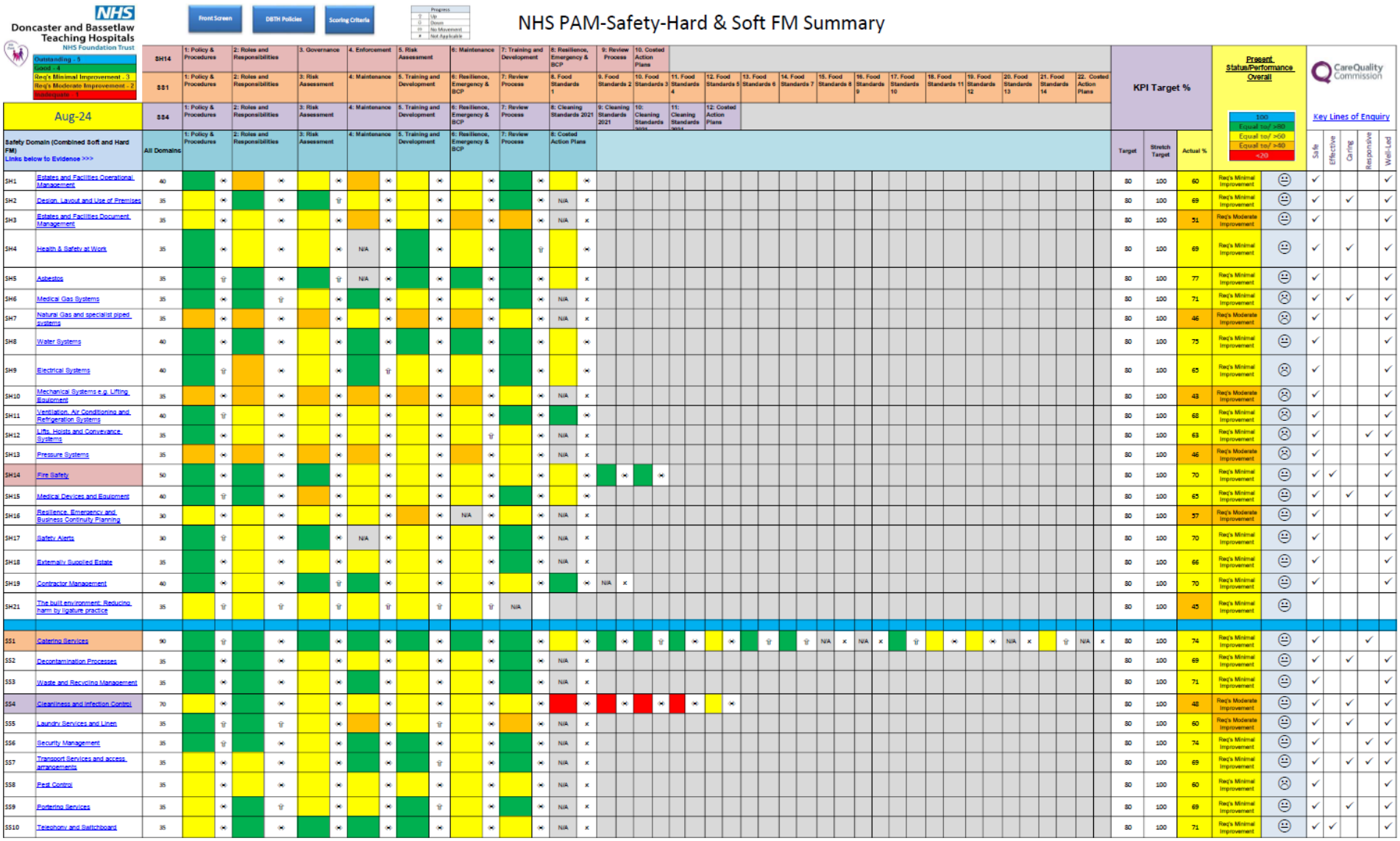
The alignment of strategic objectives within the E&F business plans with SAQ's in the effectiveness, efficiency and organisational governance domains provides a positive indication that the strategic direction of the directorate is aligned to national priorities, and that positive progress against the delivery of the business plan will lead to further future improvements in PAM ratings against this domain.

The inclusion of the Cabinet Office's FMS maturity assessment into the PAM process has provided a further level of insight into areas where improvement is required, and the data from both FMS

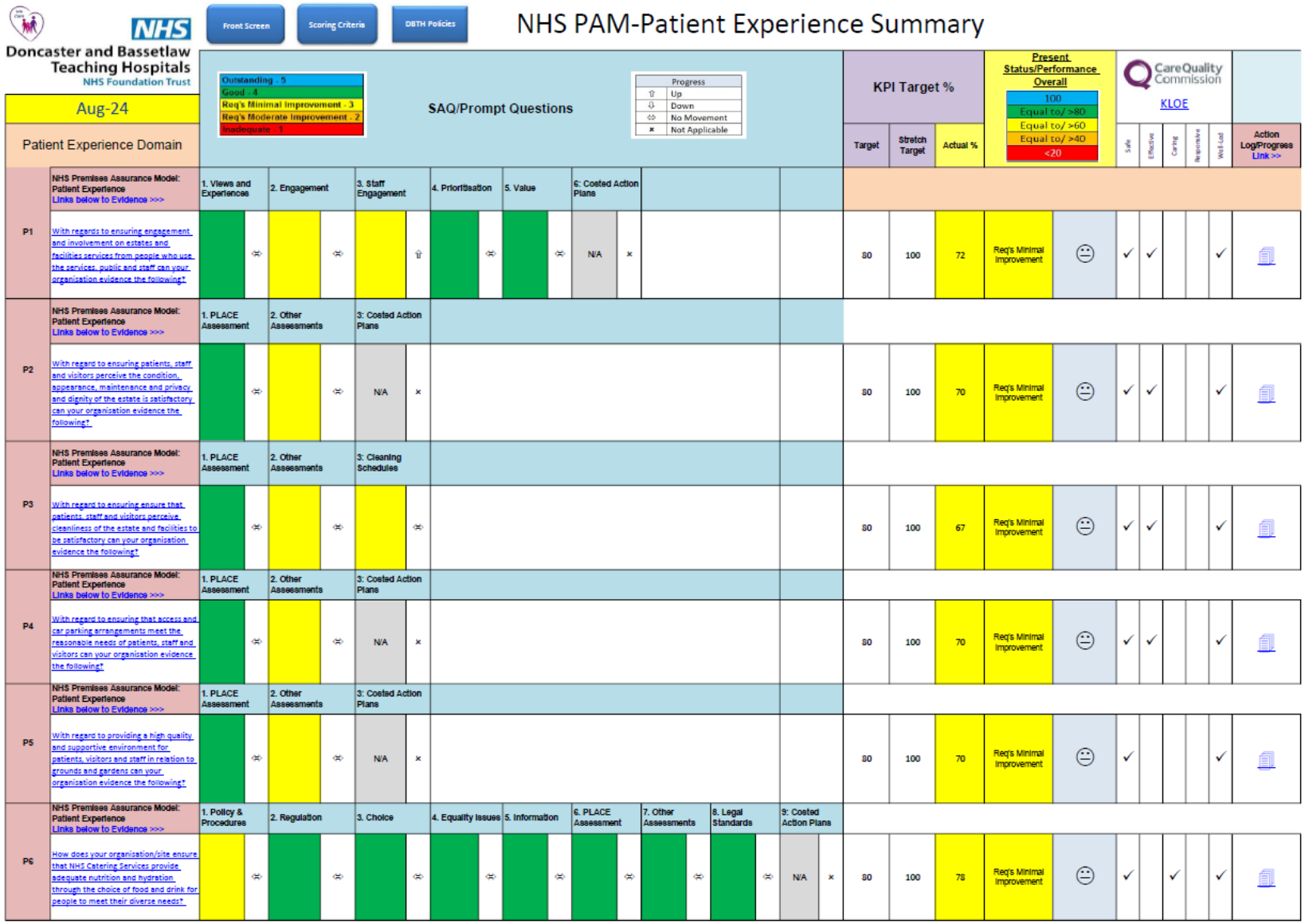
001 and FMS 002 will now be used as part of the business planning process for 2025/26 to identify strategic objectives for the year ahead.

In summary, the report indicates that positive progress has been made at DBTH within 2023/24, but that further work is required to close gaps in compliance. The report describes a robust assessment and review process, providing assurance that evidence for ratings attained during the PAM self-assessment process is scrutinised and challenged, ensuring that the model provides an accurate reflection of the Trust's position against required standards. The report further suggests that the foundations are in place for further improvement in the year ahead, though to some extent progress is conditional upon access to funding to address resource limitations.

Appendix 1: Premises Assurance Visual Dashboard Summary – Safety 2023/2024



Appendix 2: Premises Assurance Visual Dashboard Summary – Patient Experience 2023/2024



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Front Screen | Scoring Criteria | DBTH Policies

NHS PAM-Patient Experience Summary

Aug-24

Patient Experience Domain

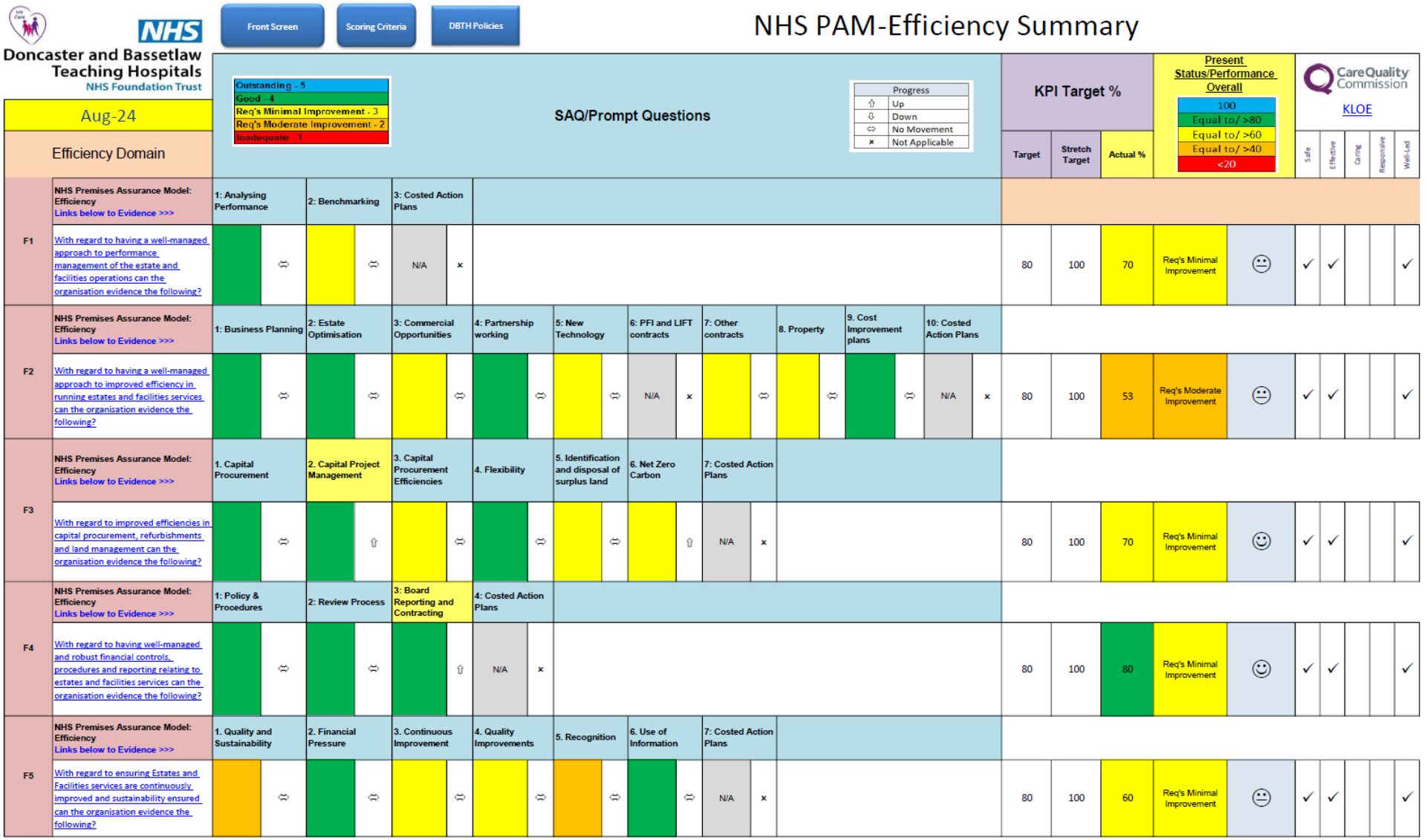
Outstanding - 5
Good - 4
Req's Minimal Improvement - 3
Req's Moderate Improvement - 2
Inadequate - 1

SAQ/Prompt Questions

Progress	
⇧	Up
⇩	Down
⇔	No Movement
✖	Not Applicable

		SAQ/Prompt Questions												KPI Target %			Present Status/Performance Overall (100 / Equal to/ >80 / Equal to/ >60 / Equal to/ >40 / <20)		CareQuality Commission KLOE: Safe	Effective	Caring	Responsive	Well-Led	Action Log/Progress Link >>
														Target	Stretch Target	Actual %								
P1	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. Views and Experiences	⇔	2. Engagement	⇔	3. Staff Engagement	⇧	4. Prioritisation	⇔	5. Value	⇔	6: Costed Action Plans	✖	80	100	72	Req's Minimal Improvement	😐	✓	✓			✓	
	With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?											N/A												
P2	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment	⇔	2. Other Assessments	⇔	3: Costed Action Plans								80	100	70	Req's Minimal Improvement	😐	✓	✓			✓	
	With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?					N/A	✖																	
P3	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment	⇔	2. Other Assessments	⇔	3: Cleaning Schedules								80	100	67	Req's Minimal Improvement	😐	✓	✓			✓	
	With regard to ensuring ensure that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?																							
P4	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment	⇔	2. Other Assessments	⇔	3: Costed Action Plans								80	100	70	Req's Minimal Improvement	😐	✓	✓			✓	
	With regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?					N/A	✖																	
P5	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment	⇔	2. Other Assessments	⇔	3: Costed Action Plans								80	100	70	Req's Minimal Improvement	😐	✓				✓	
	With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to grounds and gardens can your organisation evidence the following?					N/A	✖																	
P6	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. Policy & Procedures	⇔	2. Regulation	⇔	3. Choice	⇔	4. Equality Issues	⇔	5. Information	⇔	6. PLACE Assessment	⇔	7. Other Assessments	⇔	8. Legal Standards	⇔	9: Costed Action Plans		80	100	78	Req's Minimal Improvement	😐	✓		✓		✓	
	How does your organisation/site ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?																	N/A	✖						

Appendix 3: Premises Assurance Visual Dashboard Summary – Efficiency 2023/2024



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Front Screen | Scoring Criteria | DBTH Policies

NHS PAM-Efficiency Summary

Aug-24

Efficiency Domain

Outstanding - 5
Good - 4
Req's Minimal Improvement - 3
Req's Moderate Improvement - 2
Inadequate - 1

SAQ/Prompt Questions

Progress	
⇧	Up
⇩	Down
⇔	No Movement
×	Not Applicable

		SAQ/Prompt Questions													KPI Target %			Present Status/Performance Overall (100 / Equal to/ >80 / Equal to/ >60 / Equal to/ >40 / <20)		CareQuality Commission KLOE				
															Target	Stretch Target	Actual %			Safe	Effective	Caring	Responsive	Well-Led
	NHS Premises Assurance Model: Efficiency Links below to Evidence >>>	1: Analysing Performance		2: Benchmarking		3: Costed Action Plans																		
F1	With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?		⇔		⇔	N/A	×								80	100	70	Req's Minimal Improvement	😐	✓	✓			✓
	NHS Premises Assurance Model: Efficiency Links below to Evidence >>>	1: Business Planning		2: Estate Optimisation		3: Commercial Opportunities		4: Partnership working		5: New Technology		6: PFI and LIFT contracts		7: Other contracts		8. Property		9. Cost Improvement plans		10: Costed Action Plans				
F2	With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following?		⇔		⇔		⇔		⇔		⇔	N/A	×		⇔		⇔		⇔	N/A	×	80	100	53	Req's Moderate Improvement	😐	✓	✓			✓
	NHS Premises Assurance Model: Efficiency Links below to Evidence >>>	1. Capital Procurement		2. Capital Project Management		3. Capital Procurement Efficiencies		4. Flexibility		5. Identification and disposal of surplus land		6. Net Zero Carbon		7: Costed Action Plans										
F3	With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?		⇔		⇧		⇔		⇔		⇔		⇧	N/A	×							80	100	70	Req's Minimal Improvement	😊	✓	✓			✓
	NHS Premises Assurance Model: Efficiency Links below to Evidence >>>	1: Policy & Procedures		2: Review Process		3: Board Reporting and Contracting		4: Costed Action Plans																
F4	With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?		⇔		⇔		⇧	N/A	×													80	100	80	Req's Minimal Improvement	😊	✓	✓			✓
	NHS Premises Assurance Model: Efficiency Links below to Evidence >>>	1. Quality and Sustainability		2. Financial Pressure		3. Continuous Improvement		4. Quality Improvements		5. Recognition		6. Use of Information		7: Costed Action Plans										
F5	With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?		⇔		⇔		⇔		⇔		⇔		⇔	N/A	×							80	100	60	Req's Minimal Improvement	😐	✓	✓			✓

Appendix 4: Premises Assurance Visual Dashboard Summary – Effectiveness 2023/2024

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Front Screen | Scoring Criteria | DBTH Policies

NHS PAM-Effectiveness Summary

Aug-24

Effectiveness Domain

SAQ/Prompt Questions

Score
Outstanding - 5
Good - 4
Req's Minimal Improvement - 3
Req's Moderate Improvement - 2
Inadequate - 1

Progress	
⇧	Up
⇩	Down
⇔	No Movement
×	Not Applicable

Present Status/Performance Overall
100
Equal to/ >80
Equal to/ >60
Equal to/ >40
<20

CareQuality Commission KLOE

		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	KPI Target % Target	Stretch Target	Actual %	Present Status/Performance Overall		Safe	Effective	Caring	Responsive	Well-Led	Action Log/Progress Link >>
E1	NHS Premises Assurance Model: Effectiveness Links below to Evidence >>>	1. Vision and Values	2. Strategy	3. Development	4. Vision and Values Understood	5. Strategy Understood	6. Progress	7: Costed Action Plans													
	With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following?	⇔	⇔	⇔	⇧	⇔	⇔	N/A ×			80	100	73	Req's Minimal Improvement		✓	✓			✓	
E2	NHS Premises Assurance Model: Effectiveness Links below to Evidence >>>	1. Local Planning	2. Neighbourhood Planning	3. Planning Control	4. Special Interests	5. Enforcement	6: Costed Action Plans														
	With regard to having a well-managed approach to town planning can the organisation evidence the following?	⇔	⇔	⇔	⇔	⇔	N/A ×				80	100	76	Req's Minimal Improvement		✓	✓			✓	
E3	NHS Premises Assurance Model: Effectiveness Links below to Evidence >>>	1: Disposal of land and property	2: Granting of Leases	3: Acquisition of land and property	4: Costed Action Plans																
	With regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?	⇔	⇔	⇔	N/A ×						80	100	60	Req's Minimal Improvement		✓	✓			✓	
E4	NHS Premises Assurance Model: Effectiveness Links below to Evidence >>>	1: Green Plan / Sustainability Strategy	2: Energy	3: Waste	4: Air Pollution	5: Travel & Transport	5: Water	6: Climate Change Adaptation	7: Procurement	8: Costed Action Plans											
	With regard to having a well-managed annually updated board approved sustainable development management plan can the organisation evidence the following?	⇔	⇩	⇩	⇔	⇧	⇔	⇔	⇔	N/A ×	80	100	53	Req's Moderate Improvement		✓	✓			✓	

Appendix 5: Premises Assurance Visual Dashboard Summary – Organisational Governance 2023/2024

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Front Screen | Scoring Criteria | DBTH Policies

NHS PAM-Organisation Governance Summary

Aug-24

Organisation Governance

SAQ/Prompt Questions

Scoring
Outstanding - 5
Good - 4
Req's Minimal Improvement - 3
Req's Moderate Improvement - 2
Inadequate - 1

Progress	
⇧	Up
⇩	Down
⇔	No Movement
×	Not Applicable

KPI Target %: Target | Stretch Target | Actual %

Present Status/Performance Overall
100
Equal to/ >80
Equal to/ >60
Equal to/ >40
<20

CareQuality Commission – KLOE: Safe | Effective | Caring | Responsive | Well-Led

G1

NHS Premises Assurance Model: Organisation Governance
Links below to Evidence >>>

With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?

1. Framework	2. Roles	3. Partners	4. Framework	5: Assurance	6. Monitoring	7. Audit	8. Mitigation	9. Alignment	10: Costed Action Plans
⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	N/A ×

Target	Stretch Target	Actual %	Present Status/Performance Overall	Safe	Effective	Caring	Responsive	Well-Led
80	100	76	Req's Minimal Improvement	✓				✓

G2

NHS Premises Assurance Model: Organisation Governance
Links below to Evidence >>>

With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?

1. Effectiveness	2. Challenges	3. Visibility	4. Relationships	5. Respect	6. Behaviours	7. Culture	8. Honesty	9. Safety & Wellbeing	10. Healthier workplace	11. Collaboration	12. Costed Action Plans
⇔	⇔	⇔	⇔	⇧	⇔	⇔	⇔	⇔	⇔	⇔	N/A ×

Target	Stretch Target	Actual %	Present Status/Performance Overall	Safe	Effective	Caring	Responsive	Well-Led
80	100	62	Req's Minimal Improvement	✓				✓

G3

NHS Premises Assurance Model: Organisation Governance
Links below to Evidence >>>

With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?

1. Professional advice	2. In-house advisors	3. External advisors	4. Costed Action Plans
⇔	⇔	⇔	N/A ×

Target	Stretch Target	Actual %	Present Status/Performance Overall	Safe	Effective	Caring	Responsive	Well-Led
80	100	80	Good	✓				✓

Appendix 6: Premises Assurance Visual Dashboard Summary – Facilities Management (FM) Maturity 001 - 2023/2024

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Integrated

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Integrated	Integrated Leadership	Q1	How integrated is facilities management - Soft Services?	3+	
		1	Soft services is devolved around the organisation without a central "controlling mind".		
		2	A central team exists that manage a range of core buildings directly but are not fully integrated		
		3+	Soft services is integrated with a clear centre of expertise with delivery coordinated centrally		
		Q2	How integrated is facilities management - Hard Services?	3+	
		1	Hard services is devolved around the organisation without a central "controlling mind".		
		2	A central team exists that manage a range of core buildings directly but are not fully integrated		
		3+	Hard services is integrated with a clear centre of expertise with delivery coordinated centrally		
		Q3	How integrated is Property Leadership?	2	
		1	FM works in a silo, reactive to demand with little engagement with wider property leadership		
		2	FM links in some what with construction, design and asset management teams, but gaps remain.		
		3+	leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.		
	CAFM	Q4	How integrated are your FM Management IT Systems?	2	
		1	No CAFM, basic spreadsheets or similar used to monitor and manage FM.		
		2	Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.		
		3	A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of the truth.		
		4	An integrated CAFM is in use holding all but financial data, which is held in corporate finance system.		
		5	Organisation has a single, integrated CAFM system holding a single version of the truth, with other key systems feeding into a master system.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Collaborative					
Collaborative	**Partnership & Transparency**	**Q5**	**How closely does FM management work with the FM delivery organisation(s)?**	3	
		1	Minimal, adversarial relationship		
		2	Weekly or monthly meetings, focused on performance and reporting		
		3	Regular, joint meetings held taking both a backwards look at performance and a forward look at opportunity for improvement and upcoming changes		
		4	Genuine partnership, both sides work in an open and honest way to improve service delivery, built on trust. Very little discussion on poor performance or penalties.		
		5	A fully open and trusting relationship, working both ways to improve performance and value		
		Q6	**How strategic and effective are supplier relationships?**	2	
		1	Supplier relationships are transactional only.		
		2	A supplier relationship model (SRM) is in place (See CCS)		
		3+	Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective SRM model is in place.		
		Q7	**How transparent is FM delivery between the management organisation and delivery organisation?**	2	
		1	No transparency regarding performance or cost.		
		2	Data held by supplier but regularly validated and shared at monthly meetings.		
		3+	Organisation has real time access to key data in a transparent and open way and is regularly audited.		
		Q8	**Does the FM team collaborate outside of the management organisation?**	2	
		1	Little engagement with wider government departments, occasional attendance at events or key meetings.		
		2	Actively involved in cross government forums, such as those driven by CCS, GPA.		
		3+	In addition to formal cross gov groups, work closely with equals and leadership in other government departments to share best practice and go develop solutions, driving continuous improvement and innovation.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Delivery Excellence					
Delivery Excellence	**Compliance**	**Q9**	**How effective is your hard compliance management approach?**	3	
		1	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.		
		2	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.		
		3	Able to evidence compliance on high risk items (Asbestos, Water, Fixed Wiring, Fire, Gas, Lifts). Wider compliance held client side but regularly validated with robust QA.		
		4+	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.		
		Q10	**How effective is your soft compliance management approach?**	3	
		1	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.		
		2	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.		
		3	Able to evidence compliance on high risk items (security, risk assessments, data). Wider compliance held client side but regularly validated with robust QA.		
		4+	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.		
	Standards and Best Practice	**Q11**	**How well standardised is FM management in line with industry best practice? (E.g. ISO)**	2	
		1	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.		
		2	Use of some industry standards, such as ISO9001 but less maturity on other aspects		
		3+	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Delivery Excellence	Standards and Best Practice	Q12	How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	2	
		1	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.		
		2	Use of some industry standards, such as SFG20 but less maturity on other aspects.		
		3+	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
	Defined Roles	Q13	How well defined are FM roles and responsibilities within Hard Services?	3+	
		1	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).		
		2	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.		
		3+	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
		Q14	How well defined are FM roles and responsibilities within Soft Services?	2	
		1	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).		
		2	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.		
		3+	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension	Questions		Self-Assessment Score	Comment
Strategic					
Strategic	**Enabling**	**Q15**	**How flexible is FM to changing business needs?**	3	
		1	FM works on fixed price or square meter rate with complex or costly variation process.		
		2	Part fixed, part variable arrangement with clear and simple change control mechanisms .		
		3	Work in partnership with suppliers to continually improve support for changing business objectives.		
		4+	Supplier is engaged in the organisations service and strategy planning and understands their role. They work in partnership to proactively deliver change.		
	FM Strategy	**Q16**	**How strategic is FM?**	3	
		1	No FM strategy or service plan. FM is delivered in a reactive way.		
		2	Basic FM strategy and service plan in place, but not fully integrated with wider business priorities.		
		3	FM Strategy in place, considering 5 year + horizon, service plan refreshed annually.		
		4+	Long-term vision of what good FM looks like and how to get there. Consideration for external impact (e.g. sustainability) fully embedded into delivery model with robust monitoring and reporting in place. Horizon scanning undertaken including strategic risk management. Strategy fully aligned with aims and values of department/		
	Governance	**Q17**	**Do you have effective FM governance in place?**	3	
		1	No management/minimal management. Risk poorly allocated.		
		3	Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.		
		5	Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Intelligent					
Intelligent	**Intelligent Client**	**Q18**	**Do you have a clear definition and recognised Intelligent client function?**	3	
		1	The ICF is dispersed without a clear, recognised function.		
		3	A recognised intelligent client function is in place, with defined roles and responsibilities, recognised by the wider organisation and has the capabilities and capacity required to be effective.		
		4+	A highly effective ICF is in place with it's value recognised at an organisational level.		
		Q20	**Is an effective client department in place?**	3+	
		1	No recognisable client department, a number of individuals within the organisation may be responsible for various aspects		
		2	An identifiable client department is in place, acting as a conduit between the wider organisation and the delivery organisations to maximise value.		
		3+	A strong and effective client department is in place, with centralised oversight of all aspects of FM.		
	Control Levers	**Q19**	**How well do you understand the levers to improve performance?**	3+	
		1	A basic understanding of levers available in the contract, primarily performance failure driven		
		2	A good understanding of commercial, financial and quality control levers and their impact of performance		
		3+	Regular, demonstrable use of all types of control levers to drive continuous improvement		
	Management Structures	**Q21**	**Is there sufficient management, capability and capacity to be effective? Are roles clear?**	2	
		1	Unclear roles and responsibilities, disjoined management with FM and property spread over multiple departments, devolved FM model - no "corporate landlord".		
		2	A defined, central FM team undertaking most FM duties, but with some aspects still devolved.		
		3+	Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.		
	Forward Planning	**Q22**	**How proactive is FM service delivery in your organisation?**	3+	
		1	Reactive works only, failure driven.		
		2	Short term planning - next financial year only.		
		3+	Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.		

Questions completed: 22

Appendix 7: Premises Assurance Visual Dashboard Summary – Facilities Management (FM) Maturity 002 - 2023/2024

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Structure					
Data Structure	Hierarchy	Q1	What level of location hierarchy is asset data captured against?	3+	
		1	Asset level data is captured against the site and building it is in.		
		2	Asset level data is captured against the site, building, floor and location it is in.		
		3+	Asset level data is captured against the site, building, floor, location and system it is in.		
	Data Specification	Q2	Is there a consistent data specification aligned to the FM asset data standards (4.2)?	3	
		1	No defined data specification for FM asset data.		
		2	Defined data specification for FM asset data is not aligned to the data standard (4.2.1).		
		3	Defined data specification for FM asset data is consistently aligned to the data standard (4.2.1).		
		4	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and inconsistently aligned to 'non-core' fields (4.2.2).		
		5	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and 'non-core' fields (4.2.2).		
		Q3	How consistently is the data specification applied across the estate?	3+	
		1	No defined data specification for FM asset data.		
		2	The data specification is inconsistently applied across the estate.		
		3+	The data specification is consistently applied across the estate.		
Data Assurance and Quality					
Data Assurance and Quality	Coverage and Completeness	Q4	What is the level of coverage of assets in the asset register data?	3+	
		1	The asset data covers some assets in some estates.		
		2	The asset data covers all assets in some estates but only some assets in other estates.		
		3+	The asset data covers all assets in all estates.		
		Q5	How complete is the data captured against assets in the asset register?	4	
		1	Data is not captured against assets for the 'core fields' in the data standard (4.2.1).		
		2	Data is captured against some assets for the 'core fields' in the data standard (4.2.1).		
		3	Data is captured against all assets for the 'core fields' in the data standard (4.2.1).		
		4	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and some assets for the 'non-core fields' in the data standard (4.2.2).		
		5	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and all assets for the 'non-core fields' in the data standard (4.2.2).		
	Audit	Q6	Is a full asset verification exercise required to update the asset register (5.1)?	3+	
		1	Data is out of date or incomplete and requires a full asset verification exercise.		
		2	Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.		
		3+	Data is up to date and complete. An asset verification exercise is not currently required.		
		Q7	What regular sample surveys exist for on-going asset verification (5.2)?	3	
		1	No / limited sample surveys.		
		2	Inconsistent and ad-hoc sample surveys for some of the estates.		
		3	Consistent and regular sample surveys for all estates. There is a defined methodology to logically work through the all estates over time.		
		4	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in some parts of the estate.		
		5	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in all estates.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Assurance and Quality	Data Quality Control	Q8	What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	3	
		1	No / limited processes in place.		
		2	Inconsistent processes exist covering some parts of the estate.		
		3	Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.		
		4	Partially automated processes with frequent updates to change log.		
		5	Automated processes across all estates with close to real-time updates to change log.		
		Q9	What processes are in place for data quality checks (5.4)?	2	
		1	No / limited processes in place.		
		2	Inconsistent and ad-hoc processes exist using basic checks covering some parts of the estate.		
		3	Consistent and regular processes exist using checks based on business rules covering all estates.		
		4	Partially automated processes using data quality check algorithms and data quality dashboards.		
		5	Automated processes using real-time data quality check algorithms, business rules, quality control dashboards and user feedback.		
		Q10	What processes are in place for data update assurance (5.5)?	3	
		1	No / limited processes in place.		
		2	Inconsistent and ad-hoc processes exist using minimal data quality checks covering some parts of the estate.		
		3	Consistent and regular processes exist using verification tools and update logs covering all estates.		
		4	Partially automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering parts of the estate.		
		5	Automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering all estates.		
	Governance	Q11	What governance is in place to support data assurance and quality (5.6)?	1	
		1	No / limited governance / informal group for asset data quality.		
		2	A dedicated asset data-quality governance board exists but meets on an irregular basis or without the required attendees.		
		3	A dedicated asset data-quality governance board exists, which meets regularly with all the relevant attendees.		
		4	Along with the dedicated asset data quality governance board, there are additional sub-working groups with the suppliers.		
		5	Along with the dedicated asset data quality governance board, there are additional sub-working groups with suppliers and cross-organisational governance board/group.		
		Q12	What level of documentation exists for the these data quality processes and governance (5.7)?	1	
		1	No / limited documented items for processes and governance.		
		2	Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.		
		3+	Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Ownership and Access					
Data Ownership and Access	Ownership	Q13	Is the data contractually owned by the organisation (6.1)?	3+	
		1	The organisation does not contractually own the data.		
		2	The organisation contractually owns the data for some data stores/parts of estate.		
		3+	The organisation contractually owns the data for all estates.		
	Accessibility	Q14	What level of access does the organisation have to the data in the asset management systems (6.2)?	5	
		1	No / limited access to the data (e.g. data extracts requested via email to FM provider).		
		2	Access to some data tables/extracts across some data stores/parts of the estate.		
		3	Access to all data tables/extracts across all data stores/all estates and manually extract the required data.		
		4	The ability to access data in via desktop tool or automated APIs for some data stores/parts of estate.		
		5	The ability to access data in data in via desktop tool or automated APIs for all data stores/all estates.		
		Q15	What level of access management exists for controlling user privileges (6.3)?	3+	
		1	No / limited access management privileges.		
		2	Some access management privileges exist across some data stores/parts of the estate. These are inconsistently applied.		
		3+	Access management privileges exist across all data stores/all estates. These are consistently applied and tightly controlled.		
Data Systems					
Data Systems	Flexibility	Q16	Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	3+	
		1	Systems with limited flexibility to accommodate the data standards.		
		2	Systems with some flexibility to partially accommodate the data standards for some data stores/parts of the estate.		
		3+	Systems with flexibility to fully accommodate the data standards for all data stores/all estates.		
	Interoperability	Q17	Do the asset management systems allow interoperability of asset data (7.2)?	3+	
		1	Systems with limited interoperability between systems.		
		2	Systems with some interoperability between some systems and data is not transferable in COBie format.		
		3+	Systems with interoperability between all systems and data is transferable in COBie format.		
		Q18	Does the asset management systems sync to a common data platform (7.3)?	5	
		1	No common data platform exist.		
		2	Common data platform exists but data from some data stores/parts of the estate are stored. Data sources are updated on an ad-hoc basis.		
		3	Common data platform exists where data from all data stores/all estates are stored. Data sources are updated on a regular basis.		
		4	Common data platform exists where data from all data stores/all estates are aggregated using desktop tools and databases. Data sources are updated frequently.		
		5	Common data platform exists where data from all data stores/all estates are aggregated using automated APIs (applications). Data sources are updated in real-time.		
Data Systems	Management	Q19	Do the systems meet data security requirements (7.4)?	3+	
		1	No systems meet minimum requirements across any estate.		
		2	Some of the systems meet data security requirements across some data stores/parts of the estate.		
		3+	All systems meet data security requirements across all estates.		
		Q20	Do the systems meet data backup management requirements (7.5)?	3+	
		1	No systems meet minimum requirements across any estate.		
		2	Some of the systems meet data backup management requirements across some data stores/parts of the estate. Backup processes are ad-hoc.		
		3+	All systems meet data backup management requirements. Backup processes are on a regular basis.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Usage					
Data Usage	Management Information	Q21	What types of management information reports and dashboards are used for FM asset data (8.1)?	5	
		1	No / ad hoc reporting and dashboarding to support the use of FM asset data.		
		2	Inaccurate reports generated from data gathered point in time.		
		3	Standard reporting and interactive dashboards generated regularly with reliable processing and calculations.		
		4	Standard reporting and interactive dashboards generated from frequently updated data via robust data pipelines.		
		5	Ability to create bespoke customisable reports to answer the latest business questions.		
	Insights	Q22	How does asset data inform decisions relating to contract management (8.2)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		
		Q23	How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		
		Q24	How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		
		Q25	How does asset data inform decisions relating to Investment Prioritisation (8.5)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Team Capacity and Capability

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Team Capacity and Capability	Capacity	Q26	What is the capacity of the teams working with asset data (9.1)?	3	
		1	No dedicated teams/informal teams.		
		2	Dedicated team exists within the organisation covering some parts of the estate. Individuals do not have assigned responsibilities and accountabilities.		
		3	Dedicated team exists within the organisation covering some parts of the estate. Individuals have clear with responsibilities and accountabilities. Identified individuals with responsibilities and accountabilities to manage, monitor and generate required reports/insights from FM asset data.		
		4	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers.		
		5	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers and cross-organisational data team.		
	Capability	Q27	What is the capability of the teams working with asset data (9.2)?	3	
		1	No dedicated personnel/informal teams.		
		2	Team with some FM and data/technical understanding.		
		3	Team with good FM and data/technical understanding. Ability to extract, transform, load and report data to generate required reports and insights.		
		4	Team with the ability to create robust and repeatable data processes along interactive dashboard to support in generating insights.		
		5	Team with the ability to use predictive and prescriptive analytical techniques used to create forward-looking insights.		
	Training	Q28	What training is provided for teams working with asset data (9.3)?	2	
		1	No / limited training provided.		
		2	Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.		
		3	Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.		
		4	Frequent pieces of training focusing on better understanding and upskilling in extended processes and tools used within the organisation.		
		5	Frequent pieces of training focusing on upskilling in advanced analytical and automation skills.		
		Q29	What training materials exists relating to asset data (9.4)?	2	
		1	No training and guidance material for asset data and processes.		
		2	Some training and guidance material exist related to asset data and processes covering some parts of the estate. These are reviewed and referred to on an ad-hoc basis.		
		3+	Consistent training and guidance material exist covering onboarding, quality and audit processes, etc. for all estates. These are reviewed and referred to on regular basis.		
		Q30	What knowledge sharing exists relating to asset data (9.5)?	3	
		1	No / limited knowledge sharing in place.		
		2	Some knowledge sharing exists within the organisation and some irregular knowledge sharing exists between organisations.		
		3	Consistent knowledge sharing exists between different organisations on a regular basis.		
		4	Consistent knowledge sharing exists between different organisations on a regular basis. Some knowledge sharing with suppliers on an irregular basis.		
		5	Consistent knowledge sharing exists between different organisations. Consistent knowledge sharing with suppliers on a regular basis.		

Questions completed: 30

2409 - E3 SAFEGUARDING ANNUAL REPORT

Discussion Item | Karen Jessop, Chief Nurse & Denise Phiillip, Head of Safeguarding | 12:

5 minutes

REFERENCES

Only PDFs are attached

- E3 - Safeguarding Annual Report.pdf
- E3 - Safeguarding Annual Report 2023 - 2024.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**E3**
Report Title:	**Safeguarding Annual Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Denise Phillip, Head of Safeguarding		
Appendices:	n/a		

Report Summary

This annual report demonstrates that safeguarding remains a significant priority for the Trust. The report offers assurance that the safeguarding annual work programme has identified and achieved some key safeguarding work streams and the team has been responsive to emerging safeguarding themes within the Trust, and those also evident from wider multi-agency collaboration.

Key points:

- There has been an increase in activity for this reporting year across all areas of safeguarding.
- There was a significant increase noted in Deprivation of Liberty Safeguards (DOLS) applications from 222 applications in the previous year to 326 applications in this year, evidencing an increase by 46%
- During this reporting year, our Domestic Abuse Liaison officers have supported 284 people who have disclosed domestic abuse. 53 of these have resulted in a referral to a Multi-Agency Risk Assessment Conference (MARAC) as risk has been deemed high.
- A key focus this year has been to develop 'safeguarding liaison meetings' across paediatric areas of the Trust. Our safeguarding specialist nurse for children has been a key driver in scoping, developing, launching and embedding these across relevant areas of the Trust. This has increased the opportunities to support colleagues in having safeguarding conversations, assist in safeguarding escalations and referrals, whilst increasing the opportunities for safeguarding team members to be visible in key areas.
- All of the 2023/2024 priorities were achieved.
- The 2024/ 2025 priorities are included in the report.
- The report demonstrates the enhanced visibility of the team as our Trust safeguarding resources have expanded, and the positive impact this has had on increased safeguarding activity across Trust areas.

Recommendation:	Trust Board is asked to take assurance we have robust safeguarding systems in place to effectively respond to safeguarding concerns and uphold our statutory safeguarding responsibilities.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications			
Relationship to Board assurance framework:	**x**	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
		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
		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
		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
		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
	x	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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite ~~**YES**~~**/NO**		
Legal/ Regulation:	Health and Social Care Act and regulatory requirements (CQC). Could result in regulatory action if not achieved.		
Resources:	Nil		

Assurance Route	
Previously considered by:	Strategic Safeguarding Group
Date:	16.5.2024
Any outcomes/next steps	Approved.
Previously circulated reports to supplement this paper:	N/A

Safeguarding Annual Report 2023 – 2024

Contents

1. Foreword:

This annual report demonstrates that safeguarding remains a significant priority for the Trust. The report offers assurance that the safeguarding annual work programme has identified and achieved some key safeguarding work streams and the team has been responsive to emerging safeguarding themes within the Trust, and those also evident from wider multi-agency collaboration.

This reporting year, there has been an increased visibility from the safeguarding team across all areas of the Trust, this has resulted in increased knowledge for our colleagues and enhanced opportunities to safeguard our patients, whilst they are in our care.

The Trust recognises its continued commitment to demonstrate compliance to safeguarding statutory duties and the continued focus on increasing safeguarding team resources in the year ahead, which will further enhance our arrangements.

It is evident that there has been a clear shared safeguarding vision, underpinned by a detailed safeguarding team work plan that has assisted in driving forward the achievements that have been recognised in this report. It is also clear that safeguarding activity and divisional collaboration has greatly increased, with the recognition to increased visibility and increased resources in the safeguarding team that has undoubtedly impacted upon this observation.

We look forward to another successful year to come and continuing to support the team to achieve the priorities that have been outlined for the forthcoming year ahead.

Karen Jessop
Chief Nurse

Simon Brown
Deputy Chief Nurse

2. Introduction

Doncaster and Bassetlaw NHS Teaching Hospitals (DBTH) provides acute services for 420,000 people across South Yorkshire, North Nottinghamshire, and the surrounding areas. As a Trust we employ over 6000 colleagues.

As a Safeguarding team covering the DBTH footprint, we are pleased to support all DBTH colleagues every day in identifying and managing safeguarding concerns. This annual report is an opportunity to share with you our safeguarding achievements, improvements, innovations and areas of priorities that we have driven forward over the past 12 months.

This report also provides an overview of the safeguarding activity that has occurred within our Trust, and summarises our areas of risk, good practice and significant developments that have occurred over the last reporting year (1st April 2023 – 31st March 2024).

Safeguarding has remained a Trust priority and this has been evidenced by the significant support and engagement across all Divisions, in the continuation of working together to protect our patients from harm, whilst they access our services.

Safeguarding will always remain unremittingly complex and challenging, but as a Trust we have a clear picture of our areas of safeguarding focus and a clear safeguarding work plan that outlines our commitment to progress, and to address identified and emerging safeguarding themes.

The purpose of this report is also to provide assurance that as a Trust we have robust safeguarding systems in place to effectively respond to safeguarding concerns and uphold our statutory safeguarding responsibilities.

The message that '**safeguarding is everyone's responsibility'** has been at the forefront of all our work and will remain a central focus as we also look forward to the year ahead.

3. Safeguarding Governance

Figure 1: Safeguarding lines of Accountability at DBTH (March 2024 position)

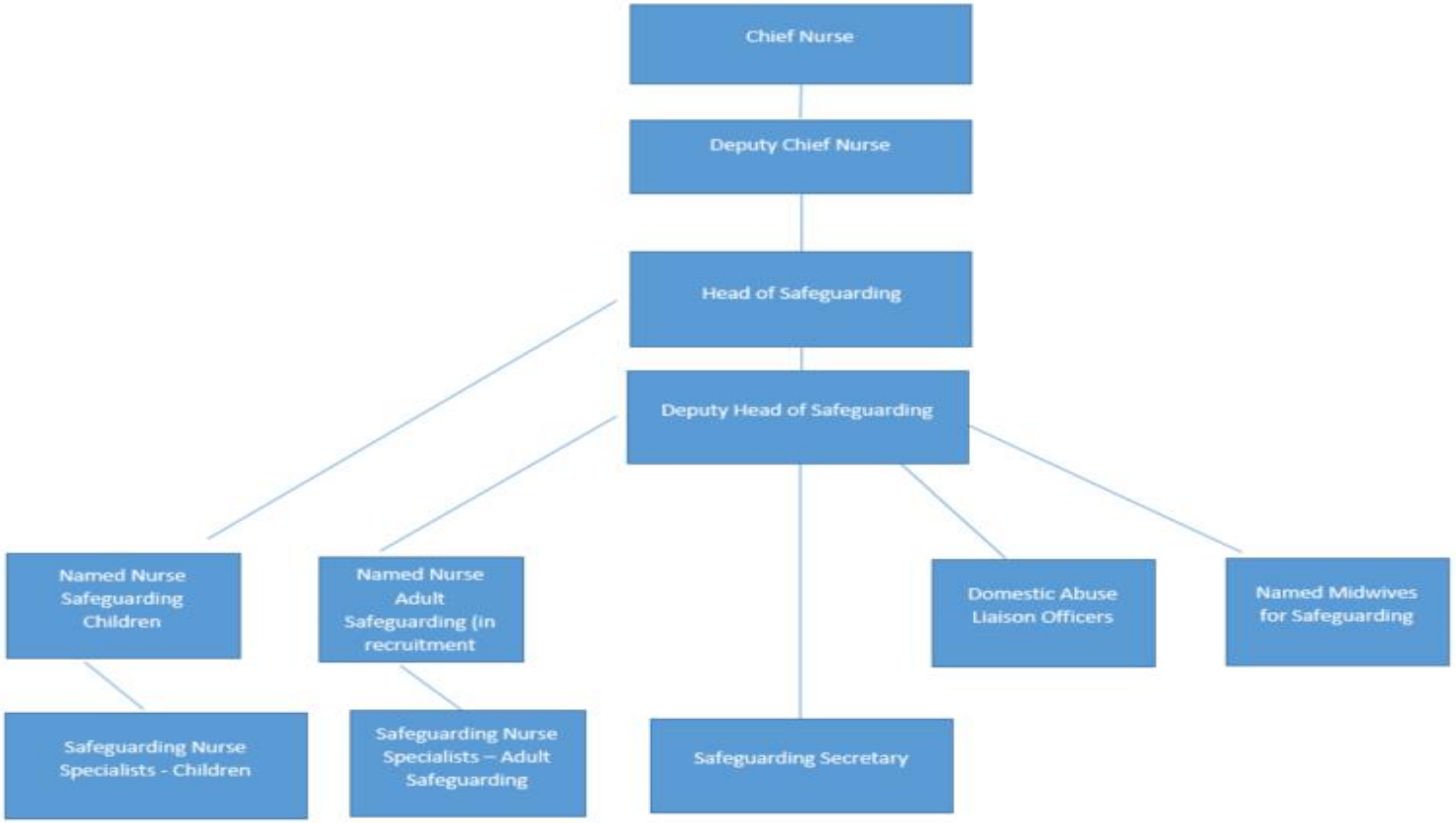


Figure 1.1: Evidences the governance flow and oversight at year end.

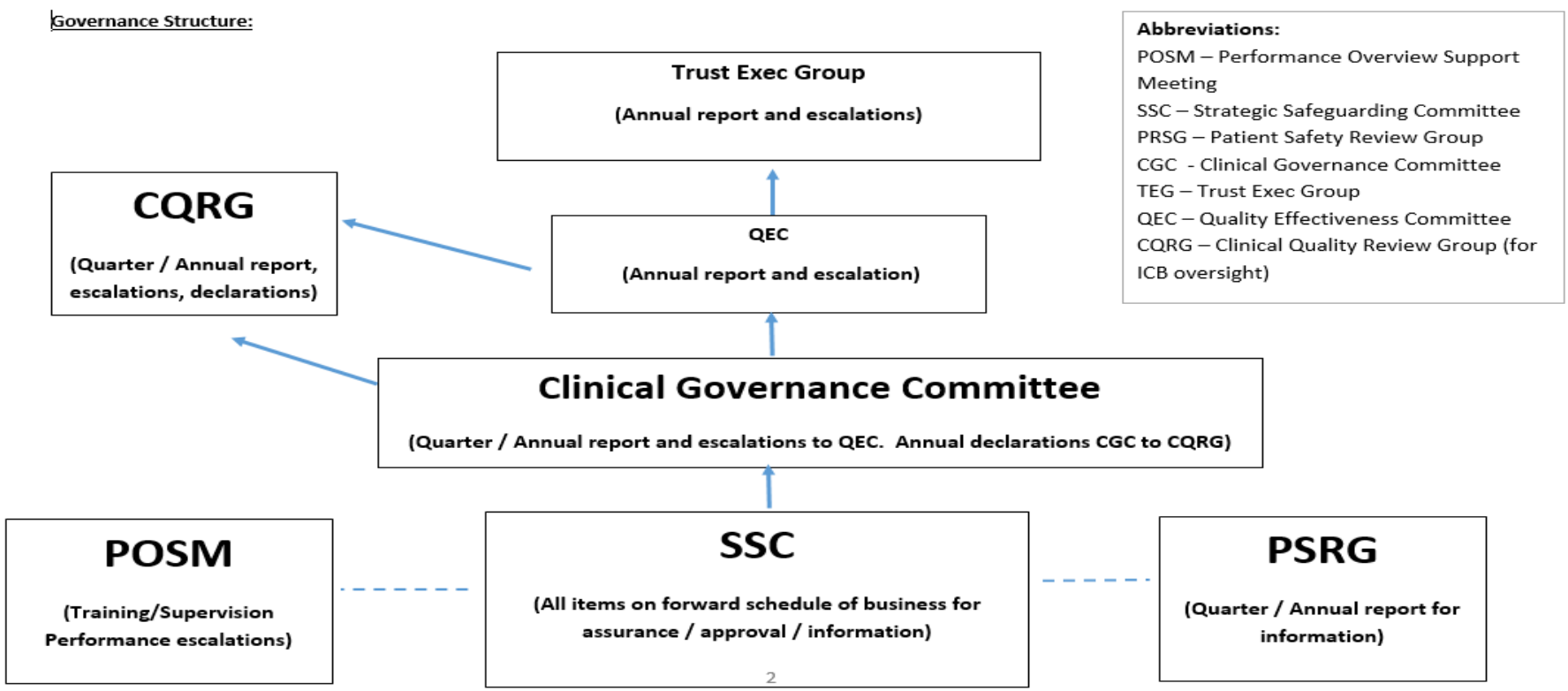


Figure 1 and 1.1 illustrates that there are clear lines of accountability in relation to roles, accountability and committee/board oversight within DBTH for Safeguarding. The safeguarding team provide specialist advice and support on all safeguarding matters Trust wide, to all colleagues. Of noting in the coming year the governance flow for the Trust has been streamlined and new arrangements will be outlined in 2024 – 2025 annual reporting. During this year the Strategic safeguarding committee's terms of reference and membership have been significantly reviewed to ensure divisional representation and refresh the agenda items being discussed. The strategic safeguarding committee (SSC), (renamed Strategic safeguarding group (SSG) from May 2024), remains the key meeting that oversights and coordinates safeguarding information with divisional and ICB members in attendance. **Appendix 1** provides an overview of how business was scheduled for discussion at the SSC throughout the reporting year. **Appendix 2** provides a year end summary of the safeguarding work plan. **Appendix 3** provides details of the safeguarding team members.

4. Overview of Safeguarding Activity:

One of the key indicators that we look at is the number of safeguarding referrals that are generated from Trust colleagues to social care, in relation to unborn babies, children and adults.

5. Safeguarding Referrals:

Figure 2: highlights the number of referrals made to social care, where abuse or harm was identified relating to patients accessing DBTH services:

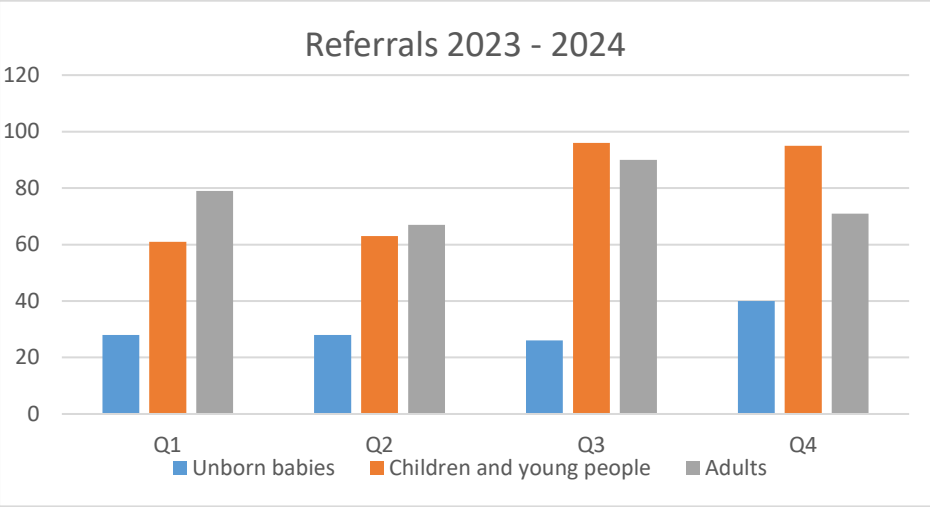


Figure 3: Highlighted comparison referral figures from the previous reporting year.

	Unborn babies	Children and Young people	Adults
Q1	28	61	79
Q2	28	63	67
Q3	26	96	90
Q4	40	95	71
Total 2023 - 2024	122	315	307
Comparison to 2022 - 2023	**281** (referrals were not previously split for unborn / children referrals for recording purposes)		**313**

The above data in **Figure 2 and 3** indicates an increase in activity for this reporting year across all areas of safeguarding, with a particular increase in referral activity noted in Q3 and Q4. In comparison to the previous year's reporting, it is evident there is significantly more referrals noted from children and unborn referrals, with a total of 437 children/unborn referrals this year in comparison to 281 from 2022 – 2023. Interestingly the safeguarding huddles commenced at the end of Q2, increasing opportunities for safeguarding discussions across paediatric

areas which may have contributed to a greater awareness of safeguarding impacting on increased safeguarding activity in Q3 and Q4; this will be an area of observation for the year ahead, made easier to oversight now the named midwives are part of the safeguarding team, providing a further opportunity for closer alignment with reporting mechanisms. Whilst referrals for Safeguarding adult referrals have largely remained comparable to 2022 – 2023, there has been a significant increase in the number of Deprivation of Liberty Safeguard (DOLS) applications that have been quality assured by the safeguarding adult nurse specialists in the team prior to submission to the relevant local authority.

Safeguarding Adults:

6. **Deprivation of Liberty Safeguards (DOLS):**

Figure 4: Deprivation of Liberty Safeguard (DOLS) Applications submitted

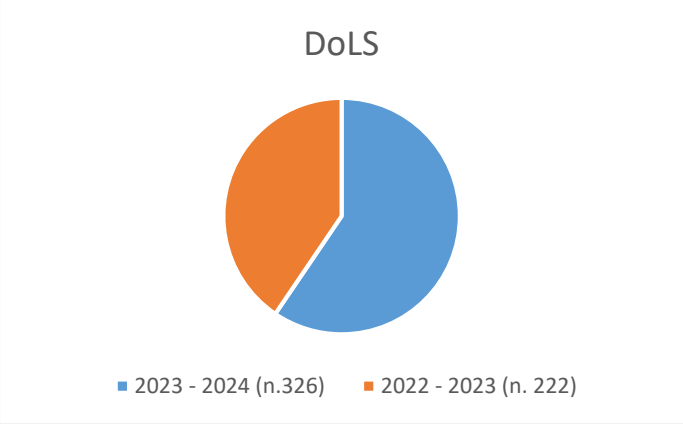


Figure 5: DOLS breakdown by reporting Quarter 2023 - 2024

2023 - 2024	DOLS applications referrals
Q1	63
Q2	61
Q3	92
Q4	110
Total	326

The above data in **Figures 4 and 5** provides an opportunity to compare the DOLS activity to the previous reporting year (2022 – 2023). There is a significant increase noted from 222 applications in the previous year to 326 applications in this year, evidencing an increase by 46%. Of particular note is the increase in activity in Q3 and Q4, anecdotally this could be attributed to the increase in safeguarding team capacity and the correlation that 2 safeguarding specialist adult nurses commenced in the team at the end of Q2 (September 2023) and the beginning of Q3 (October 2023); this will be an area of continued observation to monitor the activity trend for the year ahead.

7. Mental Capacity Act (2005): Embedding the framework:

During this reporting year, there has been an externally commissioned 360 Audit on Mental Capacity, with the final report being published in January 2024 (Q4). The focus of this audit was to provide an independent opinion on the systems and processes in place to support compliance with the Mental Capacity Act. For context, this audit was undertaken in August 2023 prior to the increased capacity in the Safeguarding team. There was already an organisational extreme risk opened, outlining the concerns regarding compliance to the Mental Capacity Act. This audit confirmed the concerns and provided an additional framework to progress improvements. There has been significant activity undertaken following this audit as outlined below:

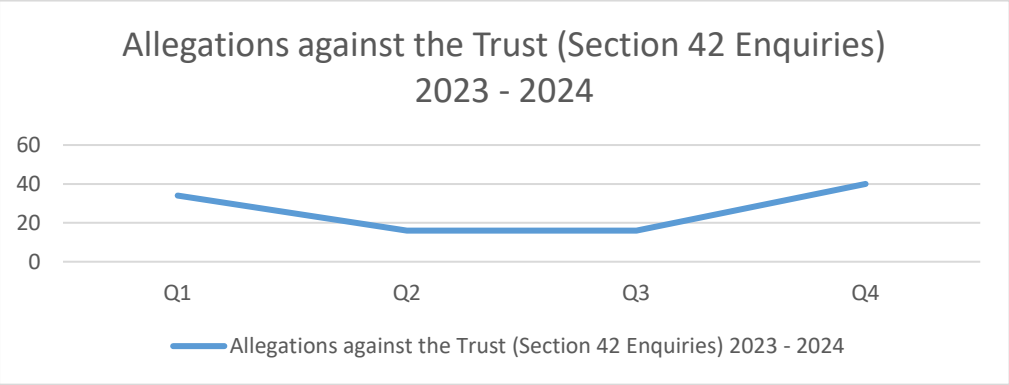
- Completed Quality Improvement project in preparation to implement a Trust Mental Capacity forum with divisional representation.
- Increase in Safeguarding Adult Nurse Specialists to support Trust colleagues in their responsibilities and legal duties in relation to MCA
- Review of the Strategic Safeguarding Committee to provide scrutiny and oversight responsibility for Trust MCA activity.
- A review of DBTH face to face training content, utilising 'gold standard' examples of MCA assessments and case studies to support practical application
- A review of the e-learning training offer to ensure robust content for any colleagues choosing this training route, and in line with e-learning for health resources.
- Development of bespoke drop in sessions on Mental Capacity and DOLS throughout Trust areas, driven by the newly appointed safeguarding adult nurse specialists
- Quality assurance of any MCA assessment prior to processing of any DOLS applications, to ensure robust content and an opportunity for learning and feedback to colleagues involved.
- Planning with DBTH Digital leads to develop patient electronic record options to support clear MCA assessment recording.
- Review of the MCA policy, to outline the planned quarterly audits to be routinely scheduled from Q1, 2024 – 2025, and to support further follow on from the previous scrutiny offered by the 360 audit.
- Completion of all 360 (Q4 - March 2024) actions with confirmation that auditors were assured of work undertaken and evidence provided. Significant ongoing progress is evident and will provide assurance on the remaining 360 actions that have a completion deadline of Q1 – June 2024. This will be further reported in the proceeding reporting year.
- Executive agreement to progress recruitment plans for a Trust MCA lead and supporting MCA Specialist advisors to continue with the drive and improvement plans.

8. Allegations against the Trust:

Allegations against the Trust (Section 42 Enquiry) are submitted via DBTH Safeguarding team. The safeguarding professionals will investigate the circumstances of the concern where possible, or they will direct the concern to the relevant Division for a response. All concerns are reported via the Trust DATIX reporting system.

Responses are returned to the Local Authority on completion with a clear outline of what actions have been taken by the Trust, where allegations are upheld.

Figure 6: provides details of allegations against the Trust that have been received for 2023 - 2024



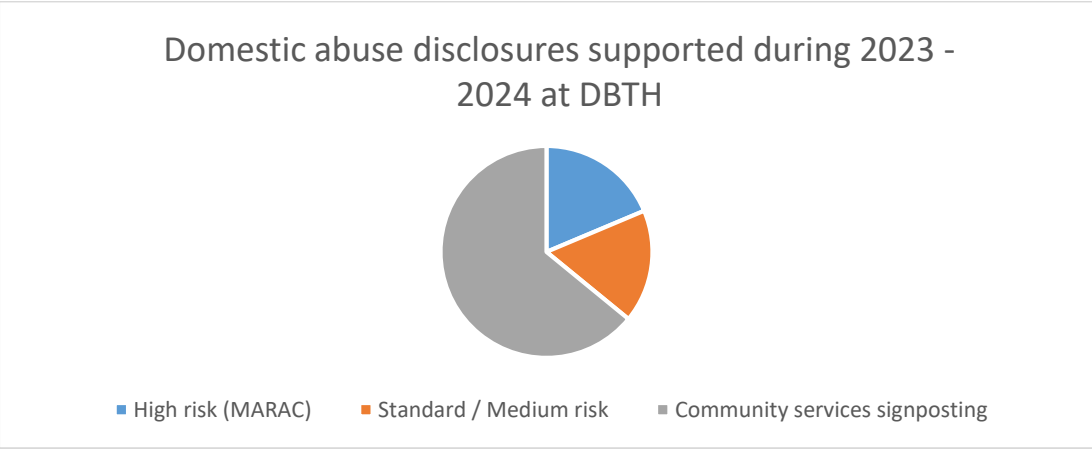
Q1	Q2	Q3	Q4
34	16	16	40

The common themes during this reporting year related to discharge concerns, neglect and medication concerns. Going forward, to support safeguarding investigations the team will be developing a bespoke training package, with supporting investigatory templates to enhance investigatory responses and support more timely returns to the Local Authority.

9. Domestic Abuse:

During this reporting year, our Domestic Abuse Liaison officers have supported 284 people who have disclosed domestic abuse. 53 of these have resulted in a referral to a Multi-Agency Risk Assessment Conference (MARAC) as risk has been deemed high. The purpose of MARACs are to prevent a domestic homicide and disrupt perpetrator behaviours, by providing a risk based response to keeping victims safe. Of the remaining disclosures, 49 cases were referred to the Doncaster Domestic Abuse Hub and the remaining 182 people were signposted to wider services within the community (adult / children's social care, mental health services, substance use services are some examples of community signposting actions that were undertaken.) We also collaborated with Doncaster Domestic Abuse Hub to provide relevant patients with personal alarms prior to discharge, where their circumstances supported this. This resulted in supporting patients experiencing domestic abuse, to feel safer on discharge home.

Figure 7: indicates the number of people supported by DBTHs Domestic Abuse (DA) liaison officers



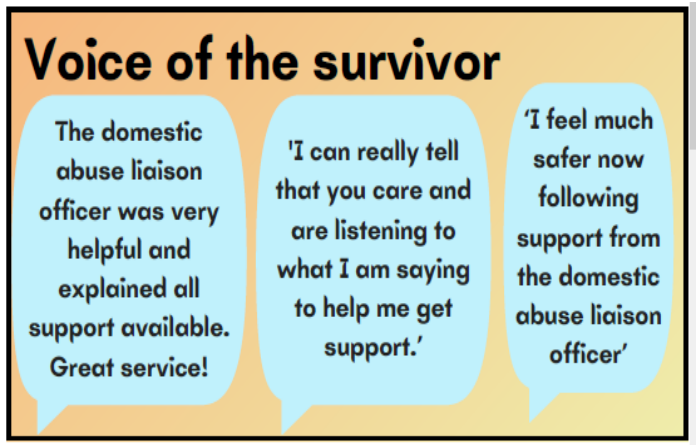
"Of these 284 disclosures, 101 referrals were made to the police to report a crime"

In addition to supporting disclosures, the domestic abuse liaison officers have successfully recruited a further 150 Trust colleagues to be 'domestic abuse champions', taking the running total of DBTH domestic abuse champions to over 400 colleagues. All domestic abuse champions have had additional training from our DA liaison officers to support them in how to ask the questions sensitively to support domestic abuse disclosure.

Importantly, it provides additional training to equip colleagues with the confidence to respond and understand how to enlist support from our specialist DA liaison officers following a disclosure. The DA officers have successfully developed a clear domestic abuse reporting flowchart to support Trust colleagues in escalating cases of concern. Additionally, they have worked closely this year to support all the Professional Nurse Advocates to receive additional training, whilst also ensuring they have supported sessions as part of preceptorship, induction, and international nurse recruitment sessions. These posts continue to be funded by the South Yorkshire Police Commissioner until March 2025. Sustaining this provision remains a key financial objective for the safeguarding team to ensure this essential resource is not lost, and this has been supported by the opportunity to deliver a presentation to the Board to outline how these roles are making a difference at DBTH. The contribution of these roles has also been significantly recognised from our wider partners in the Doncaster Safeguarding Adult Board, when our DA officers were presented with an award for their contribution in responding to Domestic Abuse and keeping the people of Doncaster safe:

Figure 7: shows our DA liaison officers proudly accepting their well-deserved award!

An important reminder of why these roles are so important:



Scan to access Doncaster reporting flowchart:

Scan to access Bassetlaw reporting flowchart:

Safeguarding unborn babies, children and young people:

10. Development of Safeguarding Huddles:

A key focus this year has been to develop 'safeguarding huddles' across paediatric areas of the Trust. Our safeguarding specialist nurse for children has been a key driver in scoping, developing, launching and embedding these across relevant areas of the Trust. This has increased the opportunities to support colleagues in having safeguarding conversations, assist in safeguarding escalations and referrals, whilst increasing the opportunities for safeguarding team members to be visible in key areas. Huddles have also been implemented in our emergency department with an 'all age' focus – to assist our colleagues to identify safeguarding concerns, be curious and ultimately support patients of any age to be safeguarded.

Looking forward, we recognise the increasing Trust implementation of wider 'Safety Huddles', as a team we have therefore decided to rebrand our 'Safeguarding Huddles' to ensure colleagues are not confused by the similar titles and we look forward to rebranding to 'safeguarding liaison meetings' as the new reporting year progresses. However, we want to recognise in this reporting year we have supported 370 Safeguarding huddles – outstanding!

Figure 8: Shows our specialist safeguarding Nurse Kim coordinating one of the first safeguarding huddles

11. Successful completion of the DBTH Management for Bruising or Injury in non-mobile infants and children pathway:

During Q1, a young baby was seen in our emergency department where several serious injuries were identified. One of the presenting features in this presentation was identification of bruises in a non-mobile baby. This case triggered a safeguarding rapid review and the multi-agency guidance and DBTH pathways were updated as a result. The safeguarding team has extensively supported the learning from this case by wide delivery of a presentation on 'Injury in non-mobile infants and children', development of a bespoke 7-minute briefing on non-mobile babies, and the development of a management flowchart to support future presentations in our emergency department. Resources related to this are on the Safeguarding HIVE pages: Presentation and bruising in non-mobile babies and infants.

12. ICON

During Q3 our Named Midwives and Specialist safeguarding nurse, joined forces to raise awareness of crying babies with the aim to support the reduction of abusive head trauma from babies being 'shaken' due to a care giver being triggered in response to the baby crying. ICON is a mnemonic that stands for **I** – Infant crying is normal, **C** – comfort methods can help, **O** – it's ok to walk away, **N** – Never, ever shake a baby. This is a national programme to support parents and care givers in how to respond when their baby cries, know what is normal crying to expect and understanding who can offer support. ICON

Figure 9: shows safeguarding team members raising the awareness of ICON across Trust departments. This picture was featured in the National ICON newsletter in October 2023 to recognise the fantastic work DBTH was doing.

Doncaster and Bassetlaw safeguarding team members speaking to parents in antenatal clinic about why babies cry and where to get support.

13. Pregnancy Liaison Meetings and Midwifery background checks:

Where potential safeguarding concerns emerge during pregnancy, DBTH work closely with our partner agencies to ensure proportionate information is shared and cases are discussed to provide support and ensure families are supported and unborn babies are safeguarded in preparation for birth. As part of this process multi-agency colleagues meet weekly as part of a 'Pregnancy Liaison Meeting - PLM' to proactively plan and support the identification of escalating safeguarding concerns, by completion of midwifery background checks to support risk-based decision making:

Figure 10: shows the number of PLMs and midwifery background checks completed during this reporting year

2023 - 2024	Number of patients discussed at PLMs	Number of midwifery multi-agency background checks completed
Q1	99	126
Q2	188	164
Q3	160	89
Q4	160	168
Total	**607**	**547**

14. Female Genital Mutilation (FGM):

The practice of FGM includes illegal procedures that intentionally alter or injure female genital organs for non-medical reasons. This practice is irreversible, has no health benefits and can cause serious injury or death (FGM Act, 2003). There is a national requirement to report cases of FGM via NHS Digital, health professionals can also add a FGM-IS tab on a female child's summary care record if they are deemed at risk of FGM – this allows for greater professional awareness to safeguarding female children at risk as they access health services. There is also a mandatory duty of regulated professionals to report known cases of FGM in under 18s to the police via 101. In Q2 the Trust FGM policy was reviewed to support the understanding of Trust responsibilities and a FGM lead was identified. For the Trust the FGM lead is Colleen Biltcliffe (Named Midwife for Safeguarding) and she will be driving forward future improvement plans as part of the safeguarding team's 2024 -2025 work plan. This will strengthen Trust arrangements on FGM and continue the collaborative working arrangements with our multi-agency partners to make risk based decision to safeguard women and girls at risk of FGM.

Figure 11: Indicates the FGM Trust data, which is now oversighted from Q4 by the Named Midwife

2023 - 2024	Number of FGM notifications (for adults)	Number of FGM-IS alerts progressed
Q1	0	2
Q2	5	2
Q3	0	2
Q4	13	0
Total	18	6

The above data in **Figure 11**, provides a quarterly overview of FGM activity known for patients accessing the Trust. In comparison to wider regional areas, Doncaster and Bassetlaw do not have high numbers of FGM. The recent transfer of the named midwives identified an opportunity for undertaking a gap analysis on FGM arrangements. The outcome of this triggered the addition of a Trust risk around notification processes (added outside of this reporting period – Q1 2024 -2025), it has also shaped actions on the safeguarding team work plan to progress additional scrutiny around the notification process and the development of a subsequent new monthly reporting oversight by the FGM lead looking at data from K2 to correlate with the number of FGM notifications received (K2 is the electronic system used in maternity). Following receipt of a notification the FGM lead now reviews the risk assessments undertaken, to ensure robust actions are in place; future work is also planned to increase additional awareness of FGM across wider Trust divisions, the detail of this is outlined in the forthcoming 2024 – 2025 safeguarding work plan. These actions will provide mitigations and a way forward to address the risk identified. Of noting, the appropriate risk assessments to the patient and any female baby or children had been undertaken on all prior FGM notifications. The risk triggered was around the systems in place for identifying the number of notifications for reporting to NHS Digital, the monthly reporting mechanism is the mitigation that has now been implemented.

15. Good practice (team award / gold standard safeguarding awards)

In Q1 the safeguarding team introduced the 'Gold standard safeguarding award'. This is a monthly award where colleagues are presented with a certificate and a love to shop voucher is provided, in recognition of their good safeguarding practice. Throughout this reporting year we have recognised the following colleagues for some great safeguarding practice:

- Michelle Shipley: Occupational Therapist
- Rebecca Rider / Sandra Rafferty: Paediatric Emergency Department
- Amymarie Tucker: Advanced Nurse Practitioner, Emergency Department

- Andrew Manroop: Staff Nurse, Medical Division
- Megan Naughton, Early Intervention and Inclusivity Lead Midwife
- Andrea Berry, Legal Services officer
- Claire Rogers and Jackie Jobling: Orthopaedic outpatients
- Laura Clarkson: Occupational Therapist
- Dr Aubrey Franco: Orthopaedic Registrar
- Charlotte Bellamy: Community Midwifery Support Worker

In Q4 the safeguarding team themselves were winners of the DBTH Star of the Month for the recognition to the continuation in providing vital support to Trust-wide colleagues:

Figure 12: shows Simon Brown, Deputy Chief Nurse presenting some of the safeguarding team members with their award

It was also good to capture the voices of safeguarding team members in the end of year work plan reflection session. Above are some of the comments captured on how it feels to be part of the safeguarding team one year on.

16. Safeguarding cases:

The team provide a detailed quarterly case update as part of the DBTH Strategic Safeguarding Committee on all ongoing activity related to child rapid reviews, child safeguarding practice reviews, safeguarding adult reviews, domestic homicides and other thematic safeguarding learning reviews that are initiated across Bassetlaw, (Nottinghamshire Children's Partnership and Adult Board) and Doncaster (Children's Partnership, Adult Board and Domestic Abuse Strategic Board). The activity remains high and the safeguarding team have responded within timescales to all information requests in this reporting year. Learning identified from reviews has included themes of the following:

- Bruising / injury in non-mobile children, including 'shaken baby' injuries
- Neglect, including not being brought to appointments
- Professional curiosity
- Exploitation (child sexual / criminal and financial)
- Unsafe sleep
- Suicide with links to domestic abuse experiences

Learning that is identified is shared via divisional representatives who attend the Strategic safeguarding committee. Key themes are also incorporated into the DBTH Safeguarding training and work streams are developed to respond to any specific relevant areas. Examples of DBTH responses include the pathway development for injuries / bruising in non-mobile babies, raising the awareness of abusive head trauma in babies, instilling professional curiosity as the underpinning ethos at safeguarding huddle discussions, progressing resources to recognise and respond to domestic abuse, working with our partners to respond to exploitation and neglect.

17. How we work with our partners:

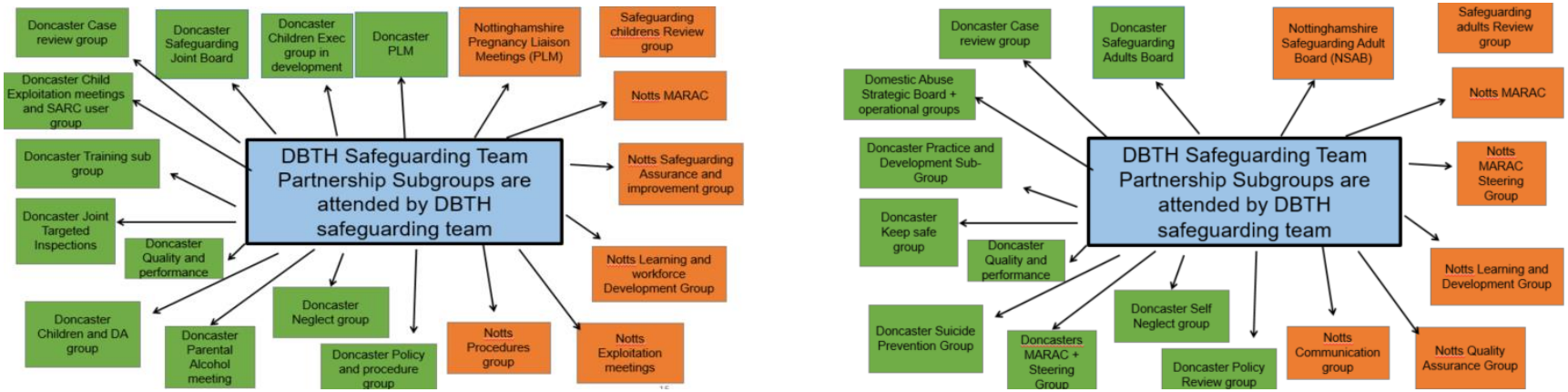
During this reporting year the team have undertaken a review of all partnership meetings across both Nottinghamshire and Doncaster (children and adult work streams), to ensure the voice of DBTH is represented and to support the opportunity to continue our active collaboration with local authorities, integrated care board (ICB) members and wider partner agencies.

As organisations we work together to share and have joint ownership to improve outcomes for children and adults.

This is achieved by:

1. Being able to challenge appropriately and hold one another to account
2. Early identification and analysis of emerging safeguarding risks
3. Learning being promoted in a way that as an organisation we can become more reflective and improve services for our patients and families

Figure 13: Provides an overview of key children and adult multi-agency meetings that the safeguarding team actively contribute to *(this is not an exhaustive list)*



18. Risks

The Deputy Chief Nurse and Head of Safeguarding continue to review the safeguarding risks as recorded on the DATIX risk register and at the frequency required for the risk grading. All safeguarding risks are reviewed in addition, each quarter at the strategic safeguarding committee that is chaired by the Deputy Chief Nurse. The position as of March 2024 identified 5 open risks that related to safeguarding functions, as outlined below:

1. Safeguarding training compliance
2. Safeguarding supervision
3. Capacity (resources) in the safeguarding team
4. MCA and DOLS: compliance
5. SABA Security and subcontract – behaviours of concern.

All risks have mitigations and actions in place to address the resolution. The annual safeguarding work plan additionally demonstrates significant progress to further respond to reducing the risks. The strategic safeguarding committee (now group) meetings provide a further opportunity for wider scrutiny by its members which includes divisional leads and integrated care board members from Doncaster and Nottinghamshire. A progress report on all outstanding risks is provided as a standing agenda item at each strategic safeguarding committee.

19. Training:

This year there has been a firm focus on increasing the safeguarding training compliance and ensuring all colleagues were correctly aligned to the appropriate level of safeguarding training. A full review of all 6000 plus roles was undertaken by the safeguarding team, to review the safeguarding training alignment as part of the foundation work on improving compliance, support was also provided from Education leads to address any re-alignments identified.

As a team we are now in a confident position that roles are appropriately aligned. Divisional leads have joined the team in collaborating to support colleagues to prioritise safeguarding training. This has resulted in a continued rise in compliance, the last remaining 'amber' (Children's Level 3), is now above 81% - from the starting Q1 position of the new reporting year (2024-2025) – all safeguarding training compliance will remain in continued focus for the year ahead.

In the Trust, we recognise that a low compliance in safeguarding training, can correlate with colleagues having reduced safeguarding knowledge, which directly impacts on a reduced capacity to recognise and respond to safeguarding concerns. This observation was also made by CQC during their inspection period, unfortunately during their visit to the Trust in August 2023, the safeguarding training data available was from June /July 2023 which was the lowest compliance. Whilst work had begun in earnest to improve this, time was needed to start to see an improved outcome. The results below demonstrate how this is now clearly evident, it provides an assured position that this area of concern is fully oversighted and progressing positively. Training compliance is discussed quarterly at the strategic safeguarding committee as part of the ongoing organisational risk and the target is to attain 90% compliance or above to achieve green 'RAG' status.

Of noting the Level 4 data from September 2023 to February 2024 was directly related to incorrect alignment of the adult safeguarding specialist's position numbers when they joined the team (incorrectly setting adult safeguarding colleagues with the same requirement as children's safeguarding colleagues) – this has now been rectified with new position numbers and compliance is now accurately presented.

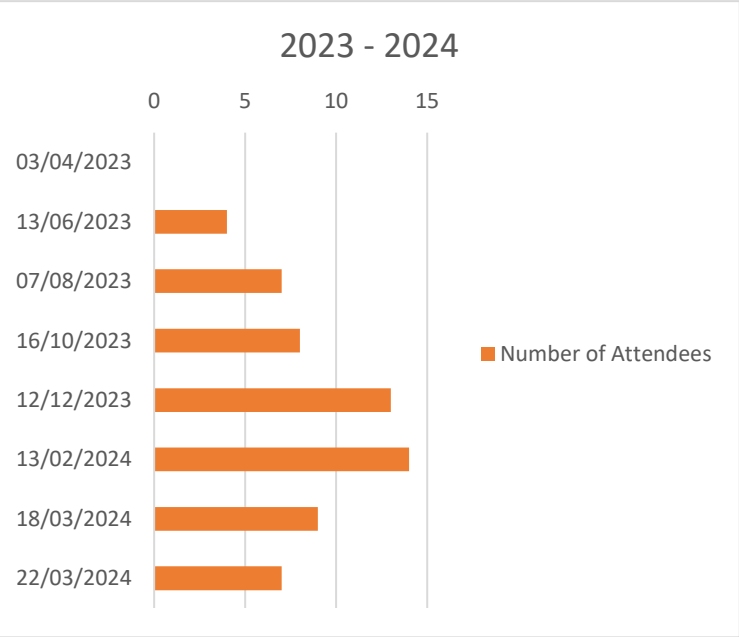
Figure 14: Provides monthly safeguarding training compliance % and highlights the year end position. Training figures have continued to evidence an improving picture.

	Level 1 - Children	Level 2 – Children	Level 3 – Children	Level 4 – Children	Level 1 – Adult	Level 2 - Adult	Prevent
April 2023	96.69	85.10	72.88	100	96.68	88.90	94.64
May 2023	96.40	86.97	73.91	100	96.40	90.06	94.91
June 2023	96.28	75.23	57.56	100	96.30	78.73	95.37
July 2023	95.48	76.56	59.94	100	95.59	78.68	95.47
August 2023	95.71	78.29	62.44	100	95.74	81.91	95.78
September 2023	95.99	81.47	64.39	75	96.02	84.50	96.05
October 2023	96.39	83.56	69.14	75	96.50	85.26	96.02
November 2023	96.37	85.29	70.01	75	96.49	86.83	95.00
December 2023	96.61	86.76	73.42	75 (3/4 com)	96.73	87.66	95.21
Training alignment role cleanse completed and submitted to education team: Each DBTH role was reviewed in line with Intercollegiate roles and responsibility guidance requirement on safeguarding training – this gave an assured position that all DBTH roles were correctly aligned.							
January 2024	96.80	88.37	74.25	75 (3/4 com)	96.88	89.24	95.70
February 2024	96.40	90.46	76.78	60 (3/5 com)	96.57	91.61	95.67
March 2024 (year-end position)	96.21	90.47	77.99	100	96.24	91.26	95.61

Data on training sessions provided:

Safeguarding Children Level 3 Training attendance:

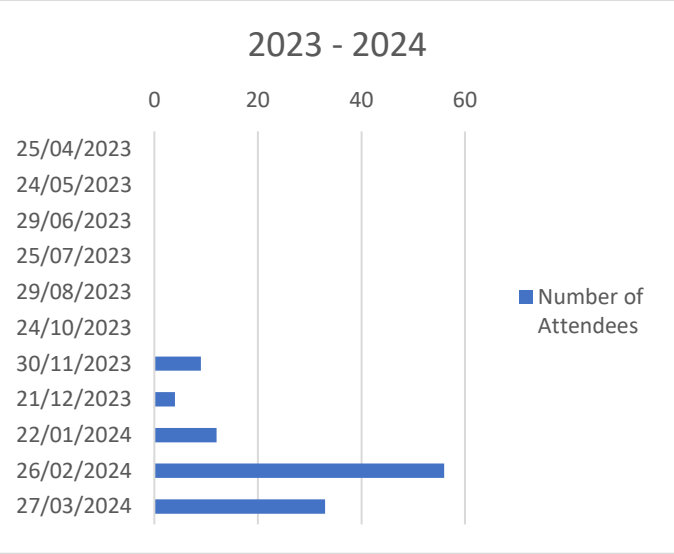
Figure 15: Indicates that during this reporting year there has been 8 offered Children's Level 3 safeguarding full day sessions scheduled. One session was cancelled due to no delegates (3/4/2023). The remaining sessions were completed with vacant spaces on all sessions except February 2024 when the session were booked to full capacity. In response to greater uptake on training from December 2023 the frequency of sessions were increased to respond to demand. The increase in demand correlates with increased focus from Divisional leads to support safeguarding training as a priority.



Date of training	Location of training	Room capacity	Delegates attended
03/04/2023	DRI – Learning Room 2 (Education Centre)	25	0
13/06/2023	BDGH – Blyth Room	14	4
07/08/2023	DRI – Learning Room 2 (Education Centre)	25	7
16/10/2023	DRI – Learning Room 4 (Education Centre)	18	8
12/12/2023	BDGH – Blyth Room	14	13
13/02/2024	DRI – Learning Room 1 (Education Centre)	14	14
18/03/2024	BDGH – Blyth Room	14	9
22/03/2024	DRI – Board Room	24	7

Safeguarding Adults and Children Level 2 Training Attendance

Figure 16: Indicates that during this reporting period 11 Level 2 (Joint Adult and Children's safeguarding) training sessions have been scheduled. The 6 sessions in grey in the table below were cancelled due to no delegate bookings. There has been a significant increase in attendance from Q3, again correlating with Divisional collaboration to prioritise attendance.



Date of training	Location of training	Room capacity	Delegates attended
25/04/2023	DRI – Lecture Theatre	140	0
24/05/2023	DRI – Lecture Theatre	140	0
29/06/2023	BDGH – Board Room	48	0
25/07/2023	DRI – Lecture Theatre	140	0
29/08/2023	DRI – Lecture Theatre	140	0
24/10/2023	DRI – Lecture Theatre	140	0
30/11/2023	DRI – Lecture Theatre	140	9
21/12/2023	BDGH – Board Room	48	4
22/01/2024	BDGH – Board Room	48	12
26/02/2024	DRI – Lecture Theatre	140	56
27/03/2024	DRI – Lecture Theatre	140	33

In addition to the mandatory safeguarding training sessions (Joint Level 2 children / adult and Level 3 Children), the team have also provided input to the preceptorship and international nurses sessions, with support also commencing on the foundation of care sessions in the coming year. They have also delivered 2 (Joint Level 2) sessions to the junior doctors, training 39 additional medical colleagues in total; this has provided additional safeguarding training opportunities. The team have also supported multi-agency partnerships with sessions during November 2023's safeguarding week when sessions on Bruising in non-mobile babies and ICON were delivered and attendance was offered to wider partnership colleagues.

Capturing the voice of our learners:

Below are some of the voices of our learners that have been captured during training evaluation:

20. Responding to NHS England's launch of the NHS Sexual Safety Charter:

In June 2023, NHS England contacted ICB and NHS Trust leads to highlight the increasing number of sexual safety incident reports relating to colleagues and patients across the NHS landscape. This triggered NHS England to launch the sexual safety charter in September 2023: setting out the clear ask for all NHS organisations to sign up and commit to embedding 10 zero tolerance principles by July 2024.

On behalf of the Trust our Chief Nurse signed the charter and the Safeguarding team has driven this work stream to ensure we are charter ready by July 2024. This has been an immense piece of work that has been supported with equal collaboration from our wider teams in People and Organisational Development, Patient Safety, Speak up Guardian, Education, Patient Experience, Equality and Diversity and Communications.

On reflection with other teams across the region, we are in a positive position and at year end we are prepared with a draft policy, reporting flowchart, expected standards of behaviour and training slides. Our focus has been on finalisation of the data capture via Datix, this is progressing and once completed will allow the policy / training slides to be finalised and communication plan to support the launch can then be progressed.

It has been useful to link with NHS England's Assistant Director for the Domestic Abuse and Sexual Violence Programme and show case our progress to date – of which positive recognition has been received.

21. Looking back on our 2023 – 2024 priorities

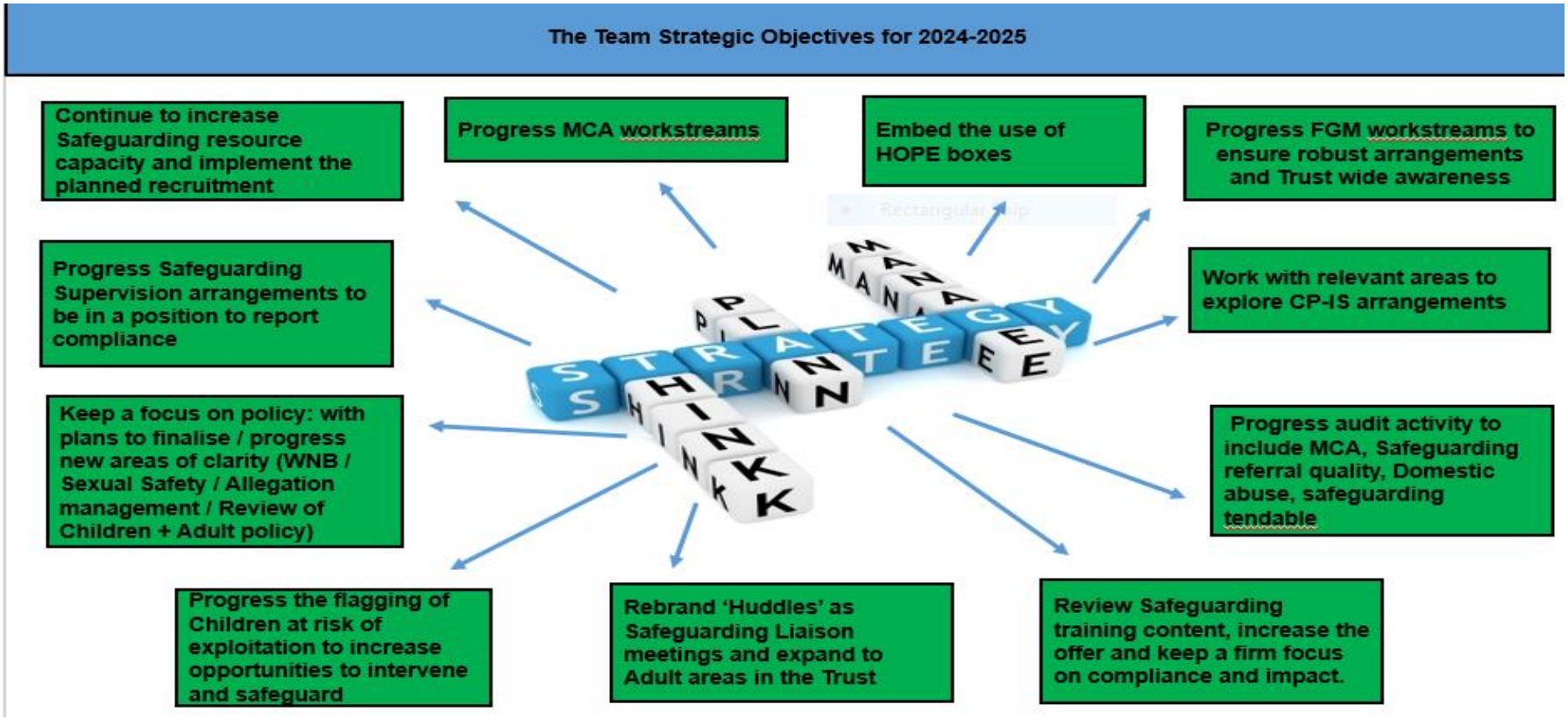
Figure 15: Provides a positive year end position with completion of all priorities that were outlined in the 2023 – 2024 annual report.

Safeguarding Priorities 2023 – 2024: How did we do?

Undertake a gap analysis, develop, and implement a safeguarding work plan to outline the identified priorities including a focus on audits, safeguarding supervision and training	✓
Develop and implement Safeguarding Huddles in order to increase visibility and embed safeguarding opportunities across DBTH.	✓
Recognise good practice and develop a 'Safeguarding Gold Standard Award' for DBTH colleagues who have demonstrated good examples of safeguarding our patients.	✓
Domestic abuse liaison officers to provide bespoke sessions for the preceptor programme (nurses and midwives) and international nurses and attend ED in order to raise awareness and embed professional curiosity.	✓
Review how requests for legal statements for Children's cases are currently managed by the team and align to Adult processes.	✓
Strengthen links with the Trust's Professional Nurse Advocates	✓
To refresh the quarterly and annual report format with the vision of purpose, readability and focusing on key headlines	✓
Progress the vision to increase the safeguarding team capacity.	✓
Review Trust Governance arrangements for Safeguarding.	✓

22. Looking forward to our 2024 – 2025 priorities

Figure 16: The safeguarding team have identified a number of key priorities for 2024 -2025 that will strengthen safeguarding arrangements for the Trust. The team work plan provides the ongoing oversight to ensure these priorities remain in focus, under the scrutiny of the Strategic Safeguarding Group.



23. Conclusion and closing remarks:

As we move forward into 2024, development of this annual report has been an opportunity to reflect on the DBTH safeguarding journey so far. It has allowed for recognition of our achievements and the opportunity to focus our efforts for the year ahead. This report provides assurance to the Trust, its patients and their families, and our partner agencies that safeguarding remains a key priority. During this year, our team has seen a growth in resources as part of our ongoing business planning. We have welcomed two safeguarding adult nurse specialists, a named nurse for safeguarding children, a safeguarding secretary, a deputy head of safeguarding and my own role as Head of Safeguarding.

In February 2024 we were also pleased to welcome our named safeguarding midwives, as they transferred from the maternity team to our safeguarding team. Expanding our resources will continue to be one of our priorities as we stride into another ambitious year ahead.

This report demonstrate the enhanced visibility of the team as our Trust safeguarding resources have expanded, and the impact this has had on increased safeguarding activity across Trust areas. The refreshed arrangements as part of the quarterly Strategic Safeguarding Group (formally known as Strategic Safeguarding Committee) has also contributed to robust Divisional collaboration and increased commitment to prioritise safeguarding training. The correlation between a workforce that has enhanced safeguarding knowledge and an increase in safeguarding referrals is also a clear observation that is outlined in this report. Colleagues' ability to recognise, respond and escalate safeguarding concerns has contributed to enhanced Trust safeguarding arrangements and a greater ability to keep our patients safe.

The priorities outlined for this reporting year have all been achieved and further ambitious priorities are outlined for the year ahead, underpinned by the finer detail outlined within the Trust's safeguarding team work plan. I am confident that the safeguarding team will have another productive and proactive year ahead, embedding practice to continuously improve the outcomes for children, young people and adults at risk.

Denise Phillip
Head of Safeguarding

Appendix 1: Strategic Safeguarding Committee (SSC) Forward Schedule of Business (April 2023 – March 2024)

DBTH SSC Forward Schedule of Business (April 2023 – March 2024)				
For Assurance	**Q1 April – June 2023**	**Q2 July – Sept 2023**	**Q3 Oct – Dec 2023**	**Q4 Jan – March 2024**
SG Quarterly report	✓	✓	✓	✓
Annual Report	✓			
Training Compliance		✓		✓
Safeguarding Self-Assessments	On Completion / when scheduled			
Audit outcomes / action plans	On Completion / when scheduled			
Update on SG risks	✓	✓	✓	✓
Update on SG cases	✓	✓	✓	✓
Good Practice	✓	✓	✓	✓
Outstanding Datix and Divisional responses	✓	✓	✓	✓
Looked after Children's update			✓	
SEND update			✓	
For Approval	**Q1 April – June 2023**	**Q2 July – Sept 2023**	**Q3 Oct – Dec 2023**	**Q4 Jan – March 2024**
Policies	On Completion / when scheduled			
ToR	✓			
Group Membership	✓			
Agree Forward schedule of Business	✓			
Audit action plans	On Completion / When scheduled			
For information	**Q1 April – June 2023**	**Q2 July – Sept 2023**	**Q3 Oct – Dec 2023**	**Q4 Jan – March 2024**
SG Briefings / newsletter	✓	✓	✓	✓
Key SG headlines regional/nation	When available			
Learning from other areas	When available			
Updates from ICB / DBTH Divisions	✓	✓	✓	✓

Appendix 2: 2023 – 2024 Work Plan summary

Safeguarding Work Plan: Position update and summary Feb 2024 – Denise Phillip (Head of Safeguarding)
This has been an ambitious work plan for 2023 – 2024, with key priorities and safeguarding work streams identified following the initial GAP analysis that was undertaken in May 2023. In total there were 23 work streams identified. **Current areas completed:** - **Safeguarding GAP analysis and benchmarking against the national Safeguarding Accountability framework:** this supported a clear understanding of gaps and risks. All risks identified as part of the gap analysis and SAAF benchmark are reflected in our organisation risk register. **(Action 1)** - **Refresh and reframe from Strategic Safeguarding People Board to the current Strategic Safeguarding Committee:** this committee is functioning well, good engagement across divisions that has supported divisional oversight and progression with safeguarding work across the Trust. **(Action 2)** - **Safeguarding meeting commitments:** an overview of all internal and external meeting have been mapped to create a database of commitments, clear representation and ensure work streams are covered. This exercise indicated the high number of commitments that the Safeguarding team have to partnership and organisational work streams. It maximises opportunities to champion safeguarding, share learning, receive good practice points from other areas and ensure the voice of DBTH is represented locally, regionally and nationally. **(Action 3).** - **Outline of all Safeguarding cases:** A live case matrix is now used for knowledge on the status of safeguarding cases – this supports key points of learning and information to be shared at SSC. **(Action 4).** - **Legal statement process for children and unborn babies:** This has been reviewed and DBTH legal team now oversight the requests, quality assurance and return of legal statements. This ensures we have a safe process within the Trust and has evidenced ongoing collaboration between Legal and Safeguarding teams in DBTH. **(Action 5)** - **Enhance SG team frameworks:** supportive frameworks and regular team meetings / 1-1's now established. **(Action 7)** - **DA Liaison officer work stream:** Significant work completed including: reporting flowcharts, links with PNA's, attendance at preceptor and international nurse programmes. Regular DA champion sessions and recruitment of DBTH DA champions increasing each month. Successful collaboration with Doncaster local authority to issue safety equipment from DBTH. Evaluation tool developed to seek feedback from colleagues on support of DA liaison officer in their professional roles and from colleagues personally using the DA support services. **(Action 8)** - **Safeguarding Huddles:** Established across DBTH sites with positive feedback and enhanced visibility of the SG team. **(Action 9)**

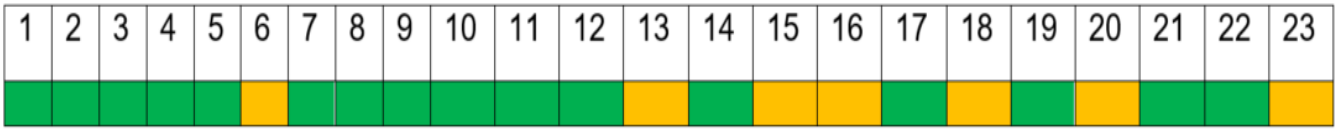
- **Raise the profile of SG across Trust sites:** A successful programme of work has been undertaken, including development of SG Gold Standard awards, huddles, monthly briefings, new style quarterly reporting. Presence at internal and external meetings. Stalls outside cafeteria. **(Action 10)**
- **Safeguarding standards:** The requested self – assessment was undertaken and completed for Doncaster ICB (continued oversight on areas that remain in progression). Yearly requirement for this submission. Notts Section 11 self – assessment will be submitted in 2024 **(Action 11)**
- **Audit schedule:** CP-IS / legal processes registered but decision made to pause until 2024 – 2025 due to change in Children's lead and colleagues in legal team. They will be added to 2024 – 2025 audit schedule. Decision made for FGM audit not to be progressed – for this to be a gap analysis instead (initial part of this commenced 8.2.24). ICON audit in progress, DA quarterly audit embedded and progressing well. MCA quarterly audit registration submitted to commence Q1. **(Action 12)**
- **MCA / DOLS:** the initial phases as identified have been completed, this has included enhancing SG adult team resources, commencing programmes of support and reviewing training content. This will continue to be on the 2024 – 2025 work plan as ongoing work required to support 360 action plan, outcomes of QI project and enhanced provision in the team with a specific focus on MCA/DoLS **(Action 17)**
- **Transition of Named Midwives for Safeguarding:** Transition date 27th Feb 2024 **(Action 19)**
- **Review of SG Secure Drives:** completed **(Action 21)**
- **Review of Intranet and External internet SG information:** External content updated to ensure SG team information is correct. Work progressing with review of intranet (this will be an ongoing piece of work of continual improvement and review). **(Action 22)**

Ongoing areas that will transfer to 2024 – 2025:

- **Safeguarding Supervision arrangements:** Significant progress made but this is an ongoing work stream. Successes in scoping, securing and funding SG supervisor training (3 cohorts will have been completed in total by year end of Q4 – increasing our SG supervisor capacity greatly. Compliance matrix developed and has been shared with relevant divisions to support Divisional data capture with ongoing work in progress for capturing compliance rates on ESR – this can only be progressed when the policy has been reviewed and frequency requirements of supervision agreed (update in progress). Next steps planning has been delayed to ensure our newly appointed Named Nurse for Children's safeguarding can lead this work stream, with wider SG team support. **(Action 6) Likely new target date will be set to Q2 2024 -2025.**
- **SG Policies for updating:** Good progress made on FGM / Prevent / Managing visiting dignitaries / Bruising pathways for non-mobile infants. Scoping completed on WNB, decision to progress this policy as a standalone (in final stages of drafting). Children's policy review date extended to include Bruising and FII/perplexing presentations and to support newly appt'd named nurse to oversight. Scoping undertaken for Sexual Safety policy – progress and in draft format. Decision made for LADO/PiPoT to be a stand-alone policy. Policy work transferred to 2024 – 2025 work streams will be: WNB / LADO and PiPoT / Children's Policy / Sexual safety (**Action 13**)
- **Flagging of children discussed at MARAC and children at risk of exploitation:** MARAC flagging SOP finalised and go live date finalised **(Action 14).** Exploitation flagging processes delayed to allow for new named nurse to induct into role. This will transfer to 2024 – 2025 work stream **(Action 15)**
- **Review of SG Training arrangements:** Significant progression made including increase across all levels of compliance (particular progression in L2/3 children and L2 adults. DERICK system allows for greater oversight of Trust compliance. Divisions have made significant efforts to engage colleagues to access training. Additional training sessions have been scheduled to support demand. MCA eLearning content reviewed and ReST approval panel has agreed progression with adoption of elfh packages, go live date awaited. Work ongoing to capture the 'job specific additional hours required for some roles with L3 requirements (additional 4 hours on top of core L3 training.) this will transfer to 2024 -2025 work stream. **(Action 16)**

- **FGM:** Trust lead identified and initial commencement of gap analysis. Meetings scheduled to look at wider partnership processes and gain assurances on current DBTH practice. Recommendation for Trust risk to be registered until assurances in place. Trust FGM lead will progress work streams into 2024 – 2025 work plan. **(Action 18)**
- **CP-IS:** Significant delay with this action but there has been limited national steer on next step changes. ICB (Notts) are linking with NHS E for further steer. Links made with CP-IS lead in Doncaster. Further work needed with ICB lead to understand multi-agency picture. Scoping and assurance needed on DBTH processes and this will form part of 2024 – 2025 work plan. **(Action 20)**
- **Sexual Safety: this action was added in September 2023.** Significant progress made in comparison to national and regional picture. DBTH working group established, draft policy / behaviour standards / reporting flowchart / training slides in development. Data capture work streams being explored. Target Trust implementation date is July 2025. When draft documents have been agreed by working group, next steps will include linking with Divisional leads. Action plan in place as part of working group**. (Action 23)**

Overarching key of Work plan completion – amber areas will transfer to 2024 – 2025:



Appendix 3 – Meet the DBTH Safeguarding team:

Meet the DBTH Safeguarding Team

Dr Lavleen Chadha
Named Doctor for Safeguarding Children

Denise Phillip
Head of Safeguarding

Amanda Timms
Deputy Head of Safeguarding

Dr Bushra Ismaiel
Designated Doctor for Safeguarding Children

Natalie Jacques
Specialist Nurse for Safeguarding Adults

TBC
Lead Nurse for Safeguarding Adults

Deborah Searson
Specialist Nurse for Safeguarding Adults

Sean Humphreys
Domestic Abuse Liaison Officer

Caitlyn Porter
Domestic Abuse Liaison Officer

Debbie Rees-Pollard
Named Midwife for Safeguarding

Colleen Biltcliffe
Named Midwife for Safeguarding

Kim Armistead
Specialist Nurse for Safeguarding Children

Vicki Baker
Named Nurse for Safeguarding Children

Anne Lundy
Specialist Nurse for Safeguarding Children

Susie Bullock
Safeguarding Secretary

What is our role?

As a Safeguarding team we provide safeguarding support, advice, safeguarding supervision and safeguarding training for colleagues working with adults and children (including maternity services) across Trust areas.

We ensure that safeguarding policies and procedures are in place in order to support safe practice to all patients whilst they are accessing care from service areas.

As a team we work closely with Partner agencies to ensure robust safeguarding arrangements are in place for children and adults in a 'think family' approach. We contribute as a Partner agency to shape and influence, local, regional and national safeguarding arrangements.

We work across South Yorkshire and Nottinghamshire to share practice, develop a shared safeguarding vision and champion a coordinated safeguarding response.

What do we offer?

The team's core hours of work are Monday – Friday (9-5pm). Outside of these hours safeguarding support resources can be found on the HIVE. We support the multi-agency safeguarding partnerships and boards to undertake reviews of serious safeguarding cases, domestic homicides and allegations that may have been made against our Trust; liaising with relevant Trust areas to provide and share information.

We support Trust colleagues with any Safeguarding advice or support that may be required to support care of an adult or child, answering any safeguarding questions that colleagues may have.

We provide Safeguarding training on a range of topics for Trust colleagues and opportunities to access safeguarding supervision.

We disseminate key local and national safeguarding information across Trust areas and signpost to internal and external safeguarding training opportunities.

We are the interface for partners and support safe sharing of safeguarding information when necessary to safeguard an unborn baby, child, young person or adult at risk.

2409 - E4 INFECTION, PREVENTION & CONTROL ANNUAL REPORT

Discussion Item | Karen Jessop, Chief Nurse & Dr Ken Agwuh, Director of IPC | 12:50

5 minutes

REFERENCES

Only PDFs are attached

- E4 - Infection Prevention and Control Annual Report.pdf
- E4 - IPC Annual Report 2023-2024.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**E4**
Report Title:	**Infection Prevention and Control Annual Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Ken Agwuh, Director of Infection Prevention and Control Mim Boyack, Lead Nurse Infection Prevention and Control		
Appendices:	n/a		

Report Summary

This report informs Trust Board of Directors of the infection prevention and control work undertaken in 2023-24 and provides assurance that the trust remains compliant with the Health and Social Care Act 2008 - Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance.

Key points:

- There were three Trust-apportioned methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases reported against the national zero tolerance.
- There were 55 HOHA and 10 COHA *Clostridium difficile* toxin (CDT) cases reported in total this year against a threshold of 42 cases, with four related to antibiotic use outside the guidelines.
- There were 40 HOHA and 10 COHA Trust-apportioned methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia. An increase by 11 cases compared to 2022/23 cases of 39 for all cases of HCAI MSSA bacteraemia.
- The Trust reported 96 *Escherichia coli* (*E. coli)* bacteraemia cases in total against a threshold of 80 cases. Of cases reported, 61 were HOHA and 35 cases of COHA. We increased our numbers by 5 cases when compared to submission in 2022/23.
- We reported 119 Vancomycin-resistant Enterococci (VRE) cases this year (17 from clinical samples, 70 from screening samples and 32 related to cross-infection in Trauma & Orthopaedic).
- There were 13 cases of carbapenemase-producing *Enterobacteriaceae* (CPE) in the Trust this year (8 from clinical samples and 5 from screen samples). We carried out 1876 screens for CPE in 2023/24 compared with 794 screens for CPE in 2022/23.

Recommendation:	Trust Board are asked to take assurance that the trust remains compliant with the Health and Social Care Act 2008 - Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all

Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*

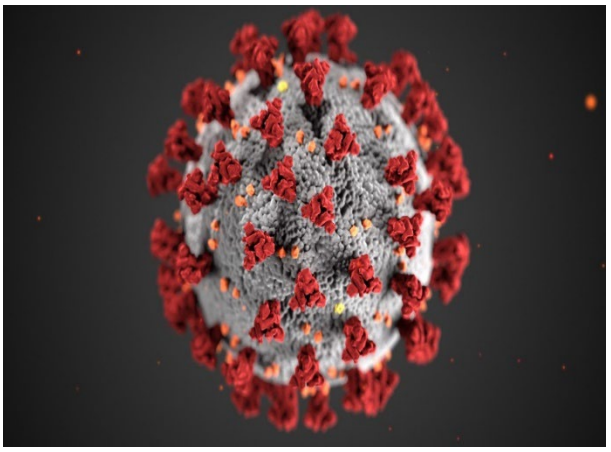
We believe this paper is aligned to the strategic direction of:	South Yorkshire ICS	NHS Nottingham & Nottinghamshire ICS
	Yes /~~No/ NA~~	Yes /~~No/ NA~~

Implications			
Relationship to Board assurance framework:	**x**	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
		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
		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
		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
		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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **~~YES~~/NO**		
Legal/ Regulation:	Health and Social Care Act and regulatory requirements (CQC). Could result in regulatory action if not achieved.		
Resources:	Nil		

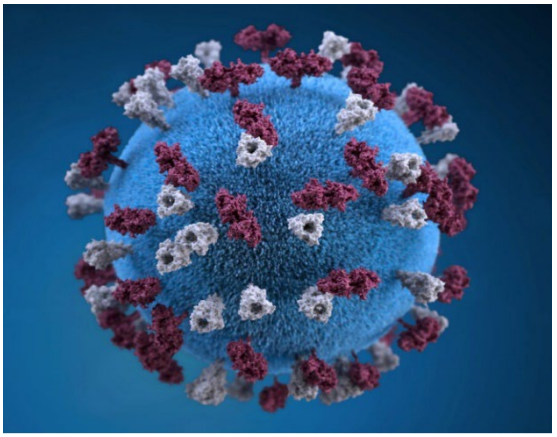
Assurance Route		
Previously considered by:		Infection Prevention and Control Committee
Date:	August 2024	
Any outcomes/next steps	Approved.	
Previously circulated reports to supplement this paper:	N/A	

NHS

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust



Sars-Cov 2 (WHO)



Measles virus (CDC)

Dr Ken Agwuh - Director of Infection Prevention and Control.
Miriam Boyack – Lead Nurse Infection Prevention and Control.

DBTH Infection Prevention and Control Team

Contents	Page

This report outlines a summary of the key infection prevention and control initiatives and activities in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) during the year April 2023 to March 2024. Delivering the values – We Care, some of our achievements in the last twelve months, include:

We always put the patient first.

- We achieved, more than 47% of all frontline staff received the influenza vaccine against an all NHS Trust average in England of 42.8%.
- We continue to support the use of point of care testing (in addition to confirmatory PCR tests) for diagnosis of COVID-19 and Influenza for all patients admitted with respiratory symptoms and for all patients if they developed respiratory symptoms during their admission.
- We provided 6150 PCR tests for COVID, Flu A/B and RSV for 2023/24

Everyone Counts – we treated each other with courtesy, honesty, respect and dignity.

- Our Escherichia coli bloodstream infections increased by 6.7% in 2023/24 compared with figures in 2022/23 (90 cases). We reported 96 cases, which was 20% above a reduced year's threshold of 80 Healthcare associated *E coli* bloodstream infection.
- The Trust surgical site infection surveillance (SSIS) in Orthopaedics for knee and hip revisions, which had been previously reported as a high outlier, is now within national averages.

Committed to quality and continuously improving patient experience.

- Despite missing our *Clostridioides difficile* trajectory by reporting 65(55%) against a reduced threshold of 42 cases. All cases received a post infection review to ensure lessons are learnt. We identified four cases as having a 'lapse in care' in relation to antibiotic prescriptions. There was no evidence of cross-infection despite the pandemic and shortages in isolation facilities due to COVID.
- We achieved 104 days of zero MRSA bloodstream infection towards the end of the financial year. Having previously achieving more than 811 days since the last case in 2021. We are committed to exceeding this achievement in 2024/25.
- Trust continues to participate in Infection in Critical Care Quality Improvement – Blood Stream Infection (ICCQIP-BSI) surveillance.
- The Infection Prevention and Control Team have commenced Surgical Site Infection Surveillance in other surgical specialties including Breast surgery, vascular surgery and gastro-intestinal surgery.

Always caring and compassionate.

- We continued promoting hand hygiene compliance of greater than 97%.
- Achieving improved ward environmental cleanliness scores of >97% in all patient care areas.
- Trust HCAI rate has fallen to 3.1% in 2023 from 3.9% in 2022 at the yearly Point Prevalence Surveillance (PPS).

Responsible and accountable for our actions – taking pride in our work.

- We missed our target to maintain our blood culture contamination rate of <3% as recommended by Department of Health. The Trust average was 4.5% down from 5.2% in 2022/23, a challenge we are working to improve.
- We continue to update our Trust antimicrobial guidelines based on NICE clinical guidelines, to effectively manage sepsis/infections, encourage antimicrobial stewardship (AMS) and reduce antimicrobial resistance (AMR)
- Better compliance with Water Quality for *Legionella spp* and *Pseudomonas aeruginosa* monitoring Trust-wide.

Encouraging, valuing our diverse staff, and rewarding ability.

- Continued development of IPC teaching packages for all staff within Trust.
- Maintain regular Infection Prevention communication during the COVID pandemic & other learning resources.
- We continue to work with the UKHSA and the Doncaster and Bassetlaw Places to manage effectively, the ongoing measles cases presenting to the Trust.

Challenges:

Continued promotion of good Infection Prevention and Control practices within the context of the resolving pandemic and living with COVID.

- The NHS Standard Contract for 2024/25 is yet to be released officially but we are working with our trajectory figures for 2023/24 to further reduce our Trust *Clostridioides difficile* and Gram-negative bloodstream infections. This further brings the challenge of improving on our performance from previous years.
- Working to prevent cases of nosocomial COVID and other respiratory viruses within the Trust. We recorded more than 20% of DBTH HCWs involved with direct patient care received their COVID -19 vaccine where COVID-19 vaccination data is available, we want to improve on this in 2024/25.
- Maintaining the Orthopaedic surgical site infection rates to below national averages and we have extended the surgical site infections surveillance to other surgical specialties for 2024/25.
- Work with our health economy partners to reduce the incidence of Gram-negative bloodstream infections.
- Maintaining MRSA bacteraemia against a zero case threshold and working with our UKHSA and CCG colleagues to investigate a growing prevalence of PVL MRSA infection/colonisation amongst intravenous Drug users within the health economy.
- Reducing the Trust acquired MRSA colonisation rate from last year.
- Improve teaching and training on blood cultures no touch technique to reduce our contamination rate to <3%
- Managing effectively the dental chairs water quality located at Mexborough Hospital.
- Managing the measles outbreak which is currently having significant impact in IPC within the region.

Introduction

The purpose of this report is to inform patients, members of the public, staff, the Trust Board of Directors, Council of Governors and South Yorkshire Integrated Care Board (Doncaster Place-Based partnership) and Nottingham & Nottinghamshire Integrated Care System (Bassetlaw Place – Based partnership), of the infection prevention and control work undertaken in 2023-24 and to provide assurance that the trust remains compliant with the Health and Social Care Act 2008 – Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance which sets out the criteria against which a registered provider demonstrates compliance with requirements relating to cleanliness and infection prevention and control.

This report is a record of activities relating to prevention and control of healthcare associated infection (HCAI) in Doncaster & Bassetlaw Teaching Hospitals NHS Trust (DBTH) during the year April 2023 to March 2024. The control of healthcare associated infection remains a top priority for the public, patients and staff; and remains one of the Trusts strategic objectives. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources, and affect antimicrobial resistance. Investment in infection prevention and control remains both necessary and cost effective in the long term.

Following the declaration of the COVID-19 pandemic by the World Health Organization in the winter months of 2019-20, the Trust had to join in the preparations for the workforce and environmental challenges that were to follow. The first positive case in the Trust was admitted on the 20th March 2020. In 2022, the Department Health released the living with COVID guidance that was geared at supporting the use of vaccination and supporting the NHS and social care sector to return to the pre-COVID era. In January 2024, the UKHSA released updated guidelines on COVID-19 with standardisation across other acute respiratory infection (ARI) viruses. This reduces the window period of 14 days to 5 days as for other respiratory viruses.

The months since have been exceptional for DBTH and continue to be, as we have moved through several waves of the pandemic and now to living with COVID;

- changes to guidance from the NHS England/UKHSA continue to be published on how to meet the demands of the pandemic now resolving as we live with COVID-19
- changes in PPE to be for the care of patients suspected or confirmed as having COVID
- changes to FIT mask testing; PPE supply and use for staff; supporting staff on IPC principles and practice
- changes in the patients care pathway back to pre-pandemic
- changes to testing for patients and staff with respiratory symptoms
- changes to laboratory testing and point of care testing
- Changes to outbreak management aligned with other acute respiratory viruses

Since October 2023, we have witnessed an outbreak of Measles in England with over 1109 laboratory confirmed cases with the vast majority identified in the West Midlands. We identified eleven cases since October 2023 linked to the Trust that prompted an incident management review and administration of HNIG where appropriate as per national guidelines. Infection prevention and control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. Success is the product of everyone getting everything right first time, every time. This annual report will demonstrate the challenges faced during living with COVID-19 and other emerging infectious diseases such as mpox, measles, pertussis and pulmonary tuberculosis. How we are performing will also be detailed, where we have done well and where we would like to do better.

1. Introduction and Purpose

The Trust has a statutory responsibility to be compliant with The Health and Social Care Act 2008 (DH, 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC). This report details the Infection Prevention and Control Team (IPCT) activity from April 2023 to March 2024. Performance targets generally set for the year were taken from the NHS Standard Contract 2023/24: Minimising *Clostridiodes difficile* and Gram-negative bloodstream infections published by NHS England.

Key Points:

- The Trust considers itself to be compliant with The Health and Social Care Act 2008 (DH, 2015) and the team continue to monitor this through the Infection Control Annual Plan.
- There was three Trust-apportioned methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases reported against the national zero tolerance.
- There were 55 HOHA and 10 COHA *Clostridium difficile* toxin (CDT) cases reported in total this year against a threshold of 42 cases, with four classified as having a lapse in care due to antibiotic use outside the guidelines.
- There were 40 HOHA and 10 COHA Trust-apportioned methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia. An increase by 11 cases compared to 2022/23 cases of 39 for all cases of HCAI MSSA bacteraemia.
- The Trust reported 96 *Escherichia coli* (*E. coli)* bacteraemia cases in total against a threshold of 80 cases. Of cases reported, 61 were HOHA and 35 cases of COHA. We increased our numbers by 5 cases when compared to submission in 2022/23.
- We reported between 1st April 2023 to 31st March 2024, 670 cases of confirmed COVID-19
- We reported between 1st April 2023 to 31st March 2024, 199 cases of influenza A and 12 cases of Influenza B admitted to hospital. We also reported 202 cases of confirmed Respiratory Syncytial Virus (RSV)
- Norovirus has been very limited this year with just a few cases identified on hospitalisation.
- We reported 119 Vancomycin-resistant Enterococci (VRE) cases this year (17 from clinical samples, 70 from screening samples and 32 related to cross-infection in Trauma & Orthopaedic).
- We reported zero cases of Mpox incident in the Trust in 2023/24
- There were 13 cases of carbapenemase-producing *Enterobacteriaceae* (CPE) in the Trust this year (8 from clinical samples and 5 from screen samples). We carried out 1876 screens for CPE in 2023/24 compared with 794 screens for CPE in 2022/23.
- We ensured all Trust antimicrobial policies are up to date
- We achieved an overall compliance score of 64% in our CQUIN target for 2022/23 focused on UTI diagnosis and management in inpatients.

- Hand hygiene and bare below the elbow compliance has previously been audited on a monthly basis by the infection control link practitioners as well as the Infection Prevention and Control Team. The Trust target for hand hygiene compliance remains at 97% (green). As the COVID-19 pandemic is residing, we have recommenced many aspects of routine auditing work, which had not been undertaken as the demand for other support for ward staff superseded this work during the pandemic.
- The Trust participates in the Surgical Site Infection Surveillance system (SSIs) for Trauma and Orthopaedic. We reported no cases of SSI involving the knee at Bassetlaw site throughout 2023/24 and two cases of SSI involving the hip at both DRI and Bassetlaw sites

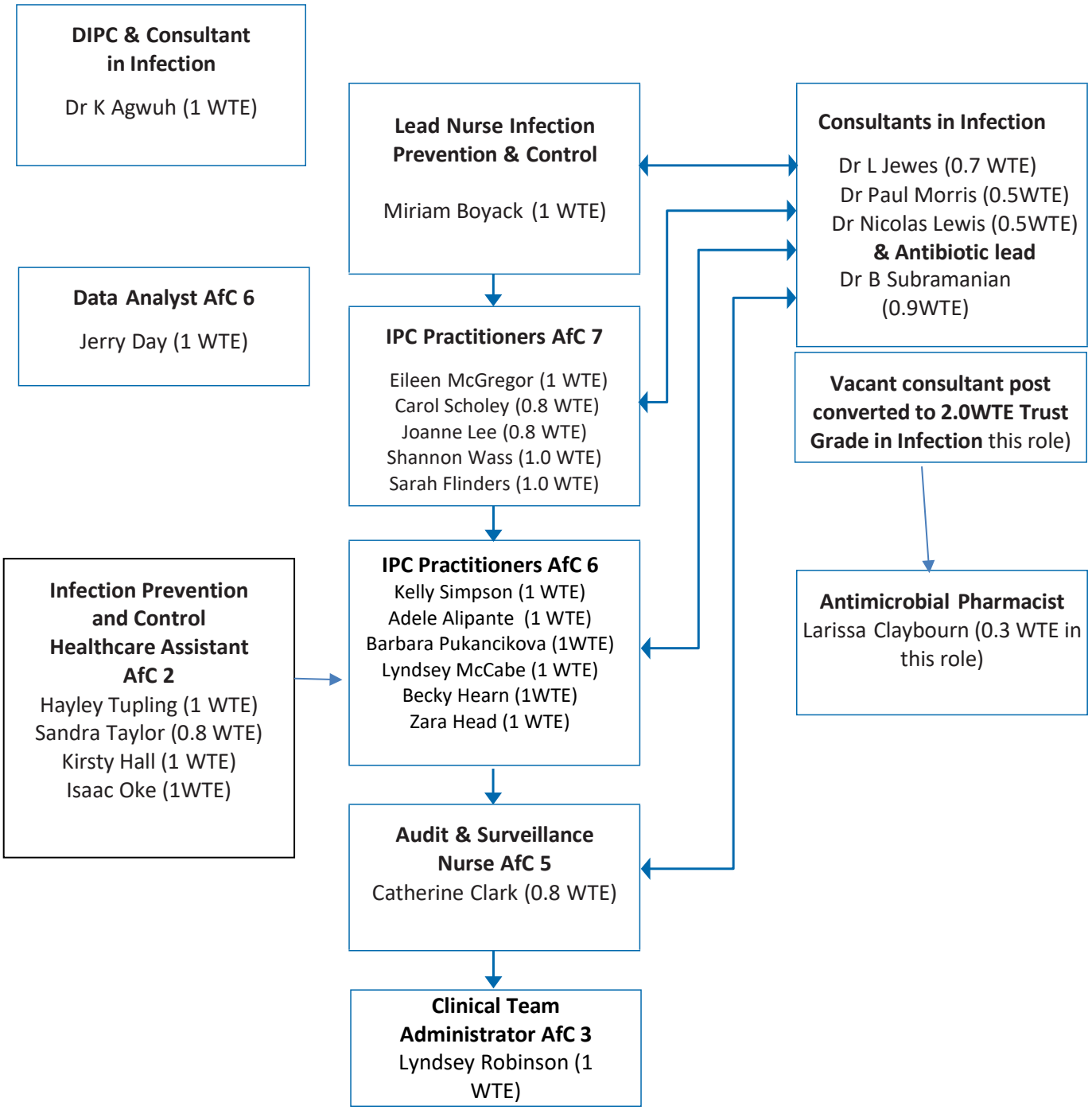
2. Infection Prevention & Control Arrangements

During 2022-2023, the proposed plan for a PLACE based Infection Prevention and Control Team was confirmed. With a collaborative approach to providing a service across organizational boundaries that would serve not only those patients in hospital, but wider members of the local population, funding was agreed and the Infection Prevention and Control Team was uplifted:

IPC Team	WTE	
Band 8a	1.0	
Band 7	4.6	
Band 6	6.0	
Band 5	0.8	
Band 6 data analyst	1.0	
Band 3 Clinical Team Administrator	1.0	
Band 2 Infection Prevention and Control Health care Assistant	3.8	
Microbiology Team		
Consultant in Infection Dr K Agwuh	1.0	DIPC
Consultant in Infection Dr L Jewes	0.7	
Consultant in Infection Dr B Subramanian	0.9	Antimicrobial Lead
Consultant in Infectious Disease & GIM Dr P Morris	0.5	
Consultant in Infectious Disease & GIM Dr N Lewis	0.5	
Trust grade doctors in Infection Dr A Abdulghani & Dr F Abraham	2.0	Fixed term post for 1 year

The Consultants in Infection work closely with the IPC nursing team to deliver the infection control service at DBTH. In addition to their work for the Trust, the Consultants in Infection provide specialist advice to Rotherham, Doncaster and South Humber Mental Health Trust (RDASH).

Infection Prevention & Control Team



Infection Prevention and Control Committee

INFECTION CONTROL COMMITTEE MEETING ATTENDANCE 2023-2024

Title	Apr 20	Jun 22	Aug 17	Oct 12	Dec 14	Feb 15	% Attendance
Antimicrobial Pharmacist	X	X	Cancelled	X	X	X	O
Bassetlaw CCG	√	√	Cancelled	√	√	√	100
CCDC UKHSA (Yorkshire and Humber)	√	√	Cancelled	√	√	√	100
CCDC UKHSA (North Notts)	√	X	Cancelled	X	X	X	20
Consultant Microbiologist (Antimicrobial Lead)	√	√	Cancelled	√	AP	√	80
Director of Infection Prevention and Control	√	√	Cancelled	√	√	√	100
Director of Nursing Services (Executive Lead for IPC)/ Deputy Director of Nursing (Representing Executive team) / Quality and Governance	√	AP	Cancelled	AP	√	X	40
Doncaster CCG	√	√	Cancelled	√	X	X	60
Hotel Services Manager /Estates and Facilities	√	X	Cancelled	√	√	√	80
Lead Nurse for Infection Prevention and Control	√	√	Cancelled	√	√	√	100
Trust Decontamination Manager	√	√	Cancelled	√	X	X	60
Occupational Health	√	X	Cancelled	√	√	√	80
Medical Division	X	X	Cancelled	√	√	√	60
Clinical Specialties Division	X	√	Cancelled	√	√	AP	60
Surgery and Cancer Division	√	√	Cancelled	√	√	√	100
Children and Families Division	√	√	Cancelled	√	√	√	100

AP = apologies (August meeting cancelled as not quorate due to annual leaves)

2023/2024 remained challenging due to continuing COVID-19 cases. In addition to this, DBTH saw an active Influenza season. This was within the context of other more familiar infections, including TB, MRSA and *Clostridioides difficile* and ones that have become more prevalent this year, such as Measles.

Ways of working, established throughout COVID have continued, for example; many meetings have taken place virtually, however, some have moved back to face to face where this adds value in facilitating discussion and building relationships.

The ICCM is held bimonthly and is responsible for ensuring appropriate implementation of national guidance and for monitoring of standards and that infection prevention and control policies are in place, regularly reviewed and compliance audited.

The annual infection control workstreams are monitored through this committee. The committee membership includes representatives from Health and Wellbeing, Consultants in Infection, Senior Infection Prevention and Control Practitioners, Senior Divisional Matrons and/or representatives, Pharmacist, ICB representatives, Estates and Facilities, Medical director or deputy and others co-opted as required.

Surveillance of Healthcare Associated Infection

One of the main elements of Infection Prevention work stream is undertaking active surveillance. Surveillance is more than just recording or reporting of infections. Data is collected in accordance with strict definitions and protocols to ensure consistency. Some surveillance data are only reported internally and other data are reported externally either as part of mandatory or voluntary surveillance schemes. All mandatory surveillance has continued to take place with the addition of Breast Surgery, Vascular and Gastrointestinal Surgery Surveillance.

However, the most important element of surveillance is feedback to clinicians. Feedback prompts review of, and where necessary, planned improvements to clinical practice. Where infections have been detected through surveillance, post infection review meetings have been undertaken to identify any learning themes.

During the COVID-19 pandemic PHE introduced case definitions for hospital onset of COVID-19.

- 0-2 days are defined as Community acquired infections
- 3-7 days after admission are defined as indeterminate acquired infections (ICI)
- 8-14 after admission are defined as probable healthcare associated infections (PCI)
- >15 days are defined as definite healthcare associated infections (DCI)

Cases identified as PCI or DCI, are reported on the Datix system. Post infection reviews have been undertaken on a large number of cases during 2023-2024. There have been no new learning themes identified during the Post Infection Reviews. The process for responding to cases classified as Probable or Definite hospital acquired infection was

therefore amended. In all cases where patients acquired COVID-19 in hospital, and have died, where COVID-19 is on part 1 or 2 of the death certificate, their next of kin/relatives have received a telephone call providing a verbal apology and a written letter of apology. This is undertaken by the Infection Prevention and Control Lead Nurse.

MRSA bacteraemia

Nationally, there remains a zero tolerance for preventable MRSA bacteraemia cases. As in previous years, every case of MRSA bacteraemia must undergo a rigorous Post Infection Review process to help identify any obvious root causes and to identify and learning.

We achieved more than 811 days of zero MRSA Bacteraemia attributed to the Trust between 2021 to March 2023 when reported an MRSA blood culture later identified as a contaminant. That same period we reported 11 cases of community associated MRSA BSI (cMRSA BSI) which was linked to a cluster of cases within the intravenous drug users (IVDU) within the Doncaster and Bassetlaw community. We carried out a major review with the support of UKHSA and our Doncaster Place colleagues to screen, decolonize and educate the IVDUs within the region on safe practices. In addition, we increased our surveillance within the Trust to ensure prompt identification of these subgroups and managed their infection effectively.

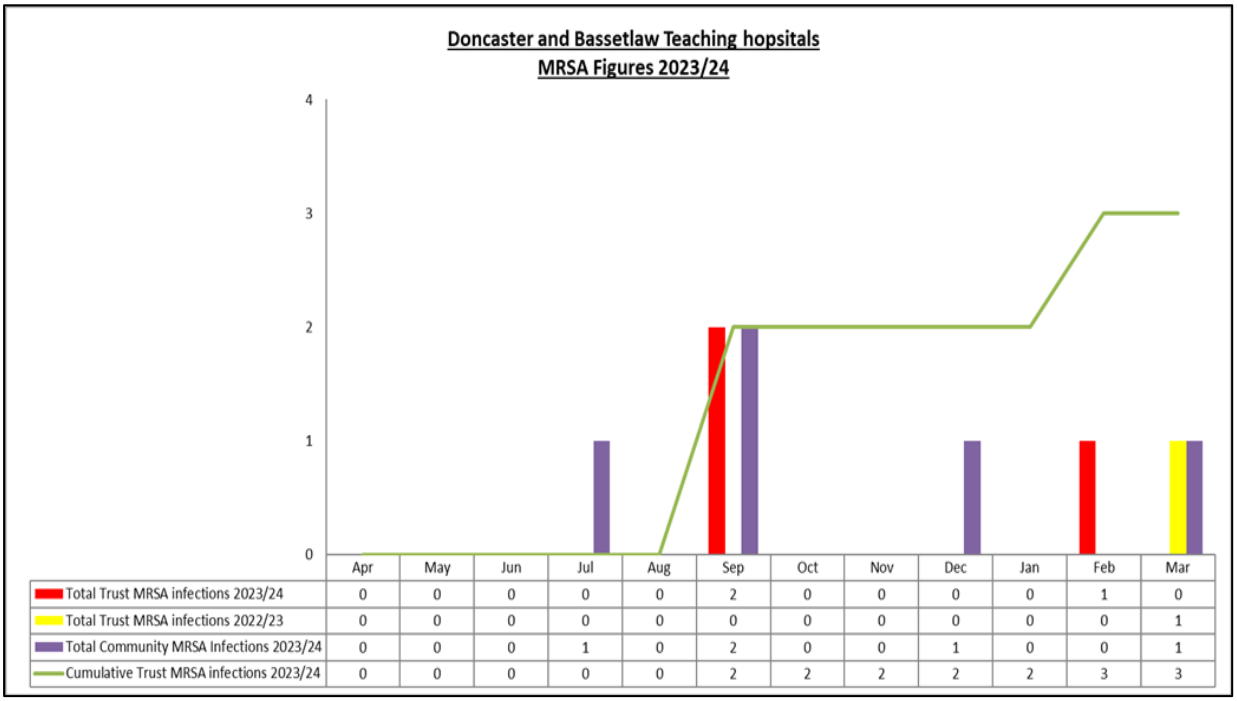
However, in 2023/24 we recorded three cases of Hospital associated MRSA BSI; all three cases would have been preventable but for delayed sepsis screens as these patients were colonized with MRSA from admission. Two of these were linked to the IVDU cluster, seen in previous years.

According to UKHSA review, the rate of community-onset community-associated (COCA) MRSA bacteraemia cases per 100,000 population in Doncaster and Bassetlaw was, 2.0 cases per 100,000, and was higher than the national average (1.6 cases per 100,000) at March 2024. While the MRSA bacteraemia cases counts of hospital-onsets as reported by the Trust as of March 2024 was 1.2 per 100,000 compared with national average of 1.0 per 100,000 population.

We have embarked on our ambition to continue to implement the 'Zero Tolerance to MRSA bacteraemia: 'Search and Destroy' campaign, and we ended the financial year by achieved 104 days of zero MRSA BSI.

Work continues to minimise the risk of MRSA Bacteraemia incidents through one to one specialist advice on decolonisation and risk reduction between the members of Infection Prevention and Control team and patients. Admitting teams are advised to perform a full sepsis screen on patients who are requiring antibiotics where they are from the high risk intravenous drug using group within Doncaster. The Consultants in Infection have a low threshold for advising anti-MRSA antibiotics for this groups of patients to minimise the risk of MRSA Bacteraemia developing.

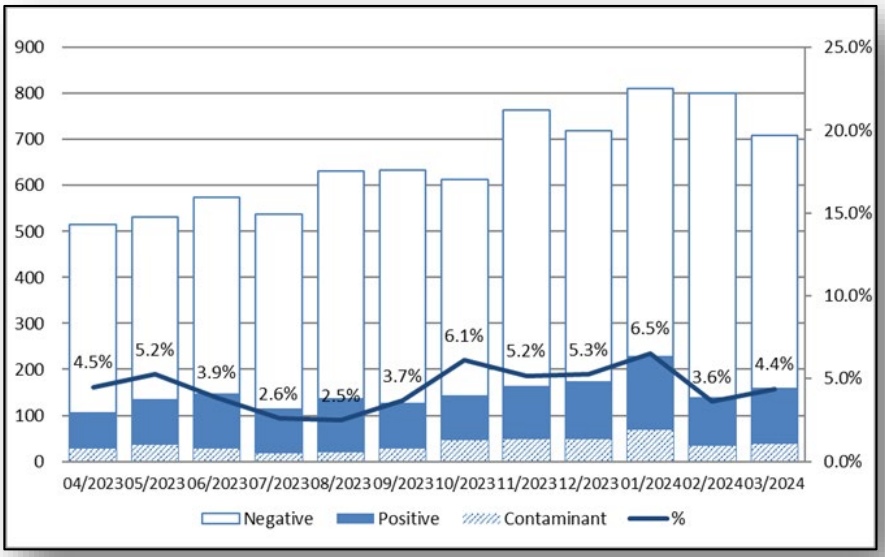
MRSA bacteremia cases 2023-24



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust MRSA infections 2023/24	0	0	0	0	0	2	0	0	0	0	1	0
Total Trust MRSA infections 2022/23	0	0	0	0	0	0	0	0	0	0	0	1
Total Community MRSA Infections 2023/24	0	0	0	1	0	2	0	0	1	0	0	1
Cumulative Trust MRSA infections 2023/24	0	0	0	0	0	2	2	2	2	2	3	3

Blood culture contamination rates

Average Blood culture contamination rate for 2023/24 was 4.5%, greater than the 3% national target but down from 5.2% from 2022/23. Overall, the number of blood cultures taken increased from 8,857 in 2022/23 to 9,620 for 2023/24. This figure is still low as our blood culture sets performed by the Trust is at 56.8 per 1,000 bed-days compared to an England average of 70.6 per 1,000 bed-days as of Q3 in 2023/24.



Education programs continue to target high-risk areas on improving blood culture techniques. A seven-minute video is shown at Doctors induction demonstrating the aseptic non-touch technique to use when obtaining blood cultures. Divisional directors are sent copies of blood cultures reported as contaminants. If staff on their units are involved in more than two episodes of blood cultures contaminants, they are investigated and if necessary referred for refresher training and assessment by the clinical skills team.

***Clostridioides difficile* infections**

Clostridioides difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. The NHS has made great strides in reducing the number of CDIs, but the rate of improvement has slowed over recent years and some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

The changes to the CDI reporting algorithm for this financial year are:

- Adding prior healthcare exposure element for community onset cases
- Reducing the number of days to apportion hospital-onset healthcare associated cases from three or more to two or more days following admission. The cases are reported onto the data capture system as:
    - **Hospital onset healthcare associated:** cases that are detected in the hospital two or more days after admission (HOHA)
    - **Community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)
    - **Community onset indeterminate association**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)

- **Community onset community associated**: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA).

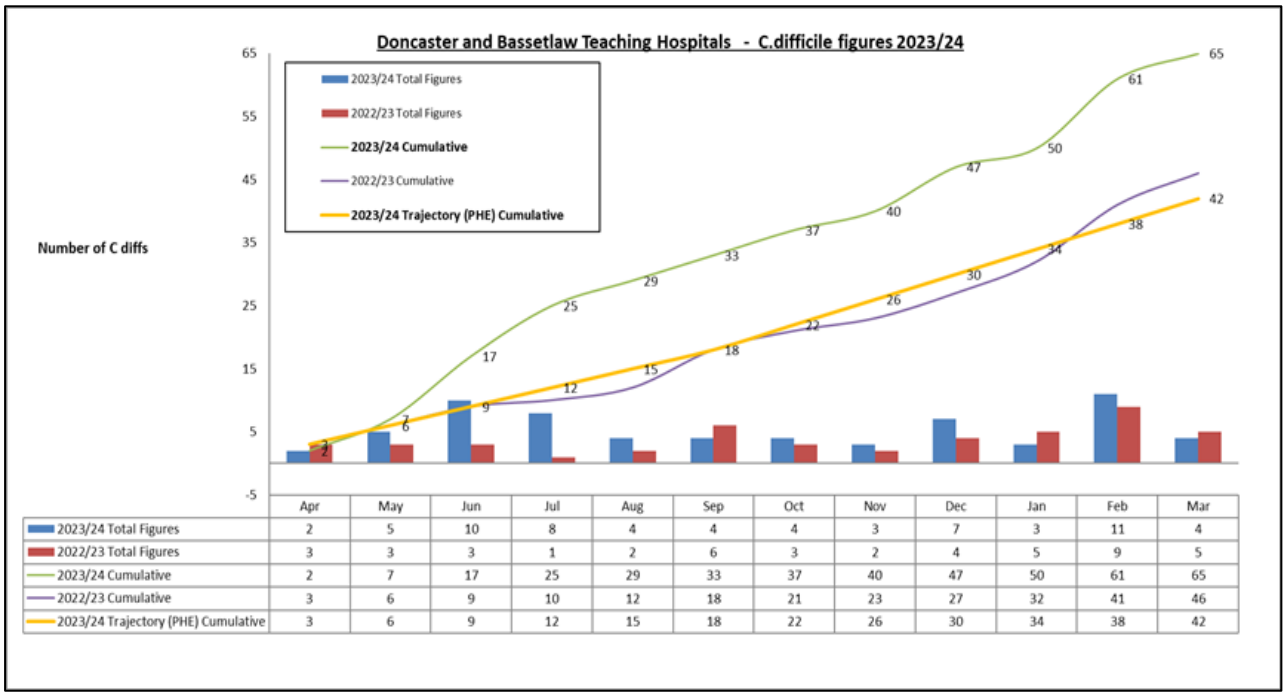
The acute trusts objectives use just two of these categories HOHA and COHA. The Trust had a reduced trajectory from 48 cases in 2022/23 to 42 cases in 2023/24. We ended the year on 65 cases (55% above our trajectory). Despite the rise in number of cases reported by the Trust for hospital onset-healthcare, associated cases, the rate of *C. difficile* overall for DBTH NHS FT was 21.7 per 100,000 bed days compared to an England average of 21 cases per 100,000 at the end of March 2024. Of interest is the significant reduction of *C. difficile* infection counts due to community onset-healthcare associated cases of 3.4 per 100,000 compared to an England average of 7.2 cases per 100,000 bed days. There were four lapses in care identified in all cases following the PIR. The trust PIR process is undertaken to investigate each CDI case, the most common findings being:

- Antibiotic usage
- Failure of treatments (previously identified and relapsed outside the timeframe).
- Patients on prolonged proton pump inhibitors (PPI)

Initiatives taken to reduce the risk of infection including CDI.

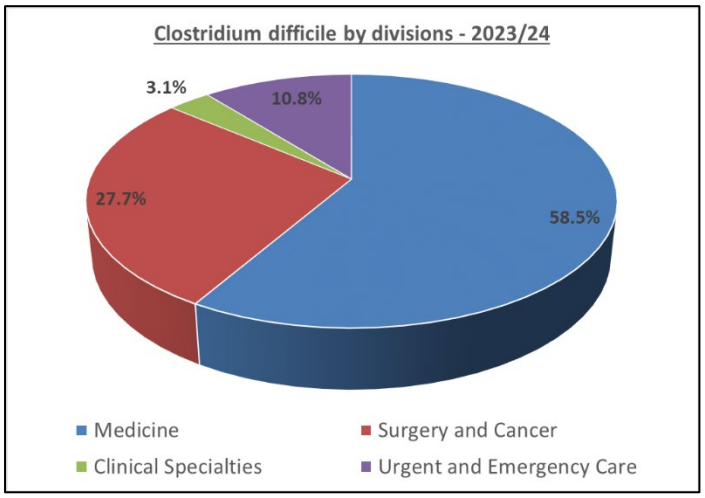
- Point prevalence surveillance (PPS), to identify any issues with invasive devices, antimicrobials and infection related issues
- Development of a RAG cleaning classification
- Continued monitoring of standards through Audit.
- Production and delivery of C Difficile teaching package in inpatient areas.

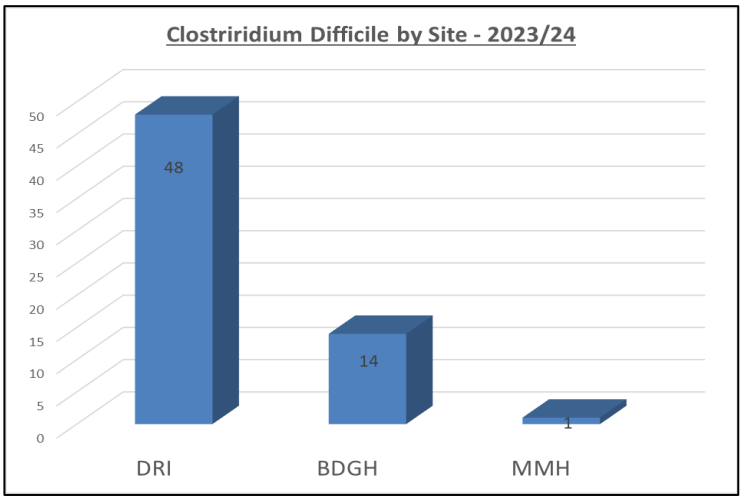
The challenge for the next year 2024-25 will be to keep within the CDI objective trajectory. We have planned a quality improvement exercise within the Trust and including our partners in Doncaster and Bassetlaw Places to review reasons for the significant rise this financial year. Also the Trust will be using the Patient Safety Incident Response Framework (PSIRF) that sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purposes of learning and improving patient safety.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/24 Total Figures	2	5	10	8	4	4	4	3	7	3	11	4
2022/23 Total Figures	3	3	3	1	2	6	3	2	4	5	9	5
2023/24 Cumulative	2	7	17	25	29	33	37	40	47	50	61	65
2022/23 Cumulative	3	6	9	10	12	18	21	23	27	32	41	46
2023/24 Trajectory (PHE) Cumulative	3	6	9	12	15	18	22	26	30	34	38	42

Trust-Attributed *C. difficile* cases by ward and divisions are shown in Appendix 3. Most infections occurred in medicine division where they had 38 (58.5%) cases in the year, Children and Families Division recorded 0 cases for 2023/24. The vast majority (22 cases) of the healthcare associated *C. difficile* occurred at DRI.

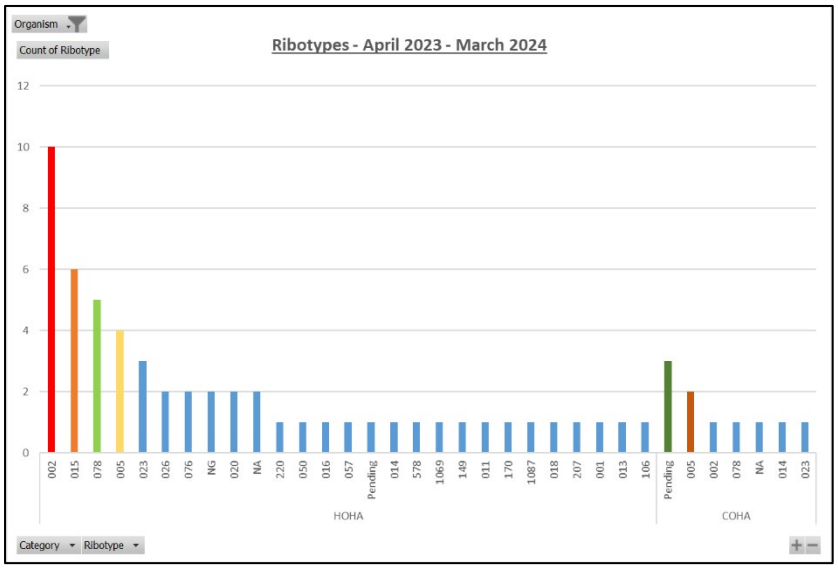




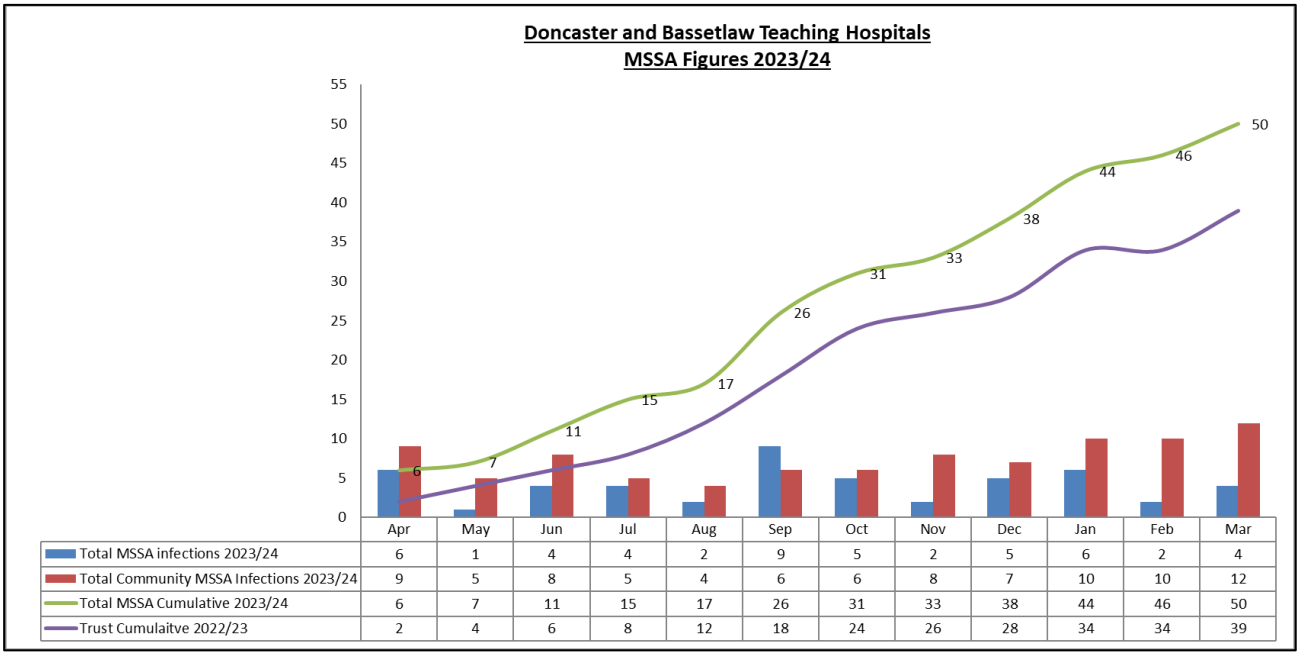
Ribotyping on *Clostridioides difficile* isolates from patients with *C. difficile* infection allows for the identification of certain strains such as 027 that can be difficult to control when causing outbreaks and/or may be associated with poor clinical outcomes. Ribotyping allows for identification of possible cross infection.

Common ribotypes at DBTH: CE0002 was the most frequently isolated (ten episodes) ribotype in 2023/24. The CE002 accounted for 15.3% of the total Trust cases. Other common ribotypes include CE015 – 6 times, CE078 – 5 times, CE005 – 4 times and CE023 – 3 times. There was no direct evidence of cross-infections despite the recurring ribotypes.

Ribotypes identified from samples submitted to reference laboratory



Methicillin sensitive *Staphylococcus aureus* bloodstream infection (MSSA BSI)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total MSSA infections 2023/24	6	1	4	4	2	9	5	2	5	6	2	4
Total Community MSSA Infections 2023/24	9	5	8	5	4	6	6	8	7	10	10	12
Total MSSA Cumulative 2023/24	6	7	11	15	17	26	31	33	38	44	46	50
Trust Cumulaitve 2022/23	2	4	6	8	12	18	24	26	28	34	34	39

Methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia has been included in the mandatory surveillance scheme since January 2011, with cases occurring more than 2 days after admission apportioned to acute Trusts. There were 140 MSSA BSI in 2023/24, an increase from 114 cases reported in 2022/23. We reported 50 cases attributed to the Trust for 2023/24 compared to 39 cases in 2022/23. There is an overall upward trend in MSSA bacteraemia cases counts but of the hospital-onset and community on-set cases of 15.8 versus 10.8 per 100,000 bed-days and 37.5 versus 26.8 per 100,000 bed-days respectively for hospital on-set and community on-set compared with England averages.

However, the Trust acknowledges that further improvement can be achieved in this infection as significant number of Trust attributed cases were catheter associated and increased emphasis on clinical practices using the VIP score and initiation of post infection reviews will assist in case reduction. Overall, Trust attributed MSSA by ward and Division are shown in Appendix.

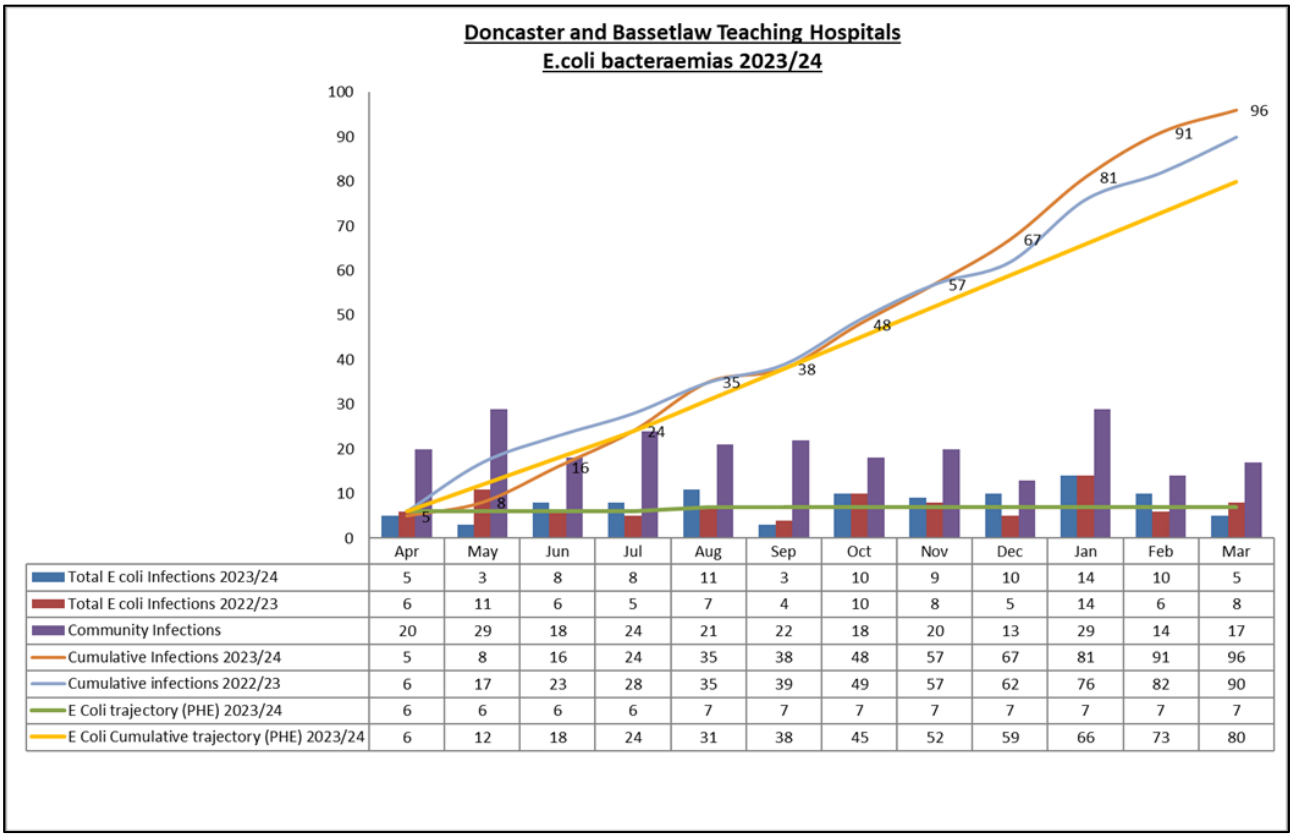
Gram-negative bloodstream infections surveillance

Public Heath England, in April 2017, introduced additional Gram-negative bloodstream infections surveillance. This was to enable NHS Trusts to report cases of bloodstream infections due to *Pseudomonas aeruginosa* and *Klebsiella spp* to the Healthcare Associated Infections Data Capture System (HCAI DCS).

This was further expanded by HM government publication in January 2019, tackling antimicrobial resistance 2019-2024: the UK's five-year national action plan. This includes the aim to reduce the incidence of specified drug-resistant infections in humans in the UK, halve the number of healthcare associated Gram-negative blood stream infections, reduce UK antimicrobial use in humans by 15% and report on the percentage of prescriptions supported by use if a diagnostic test or decision support tool.

This surveillance is expected to be in line with the existing *E. coli* bacteraemia surveillance.

E. coli bloodstream infection (*E. coli* BSI)



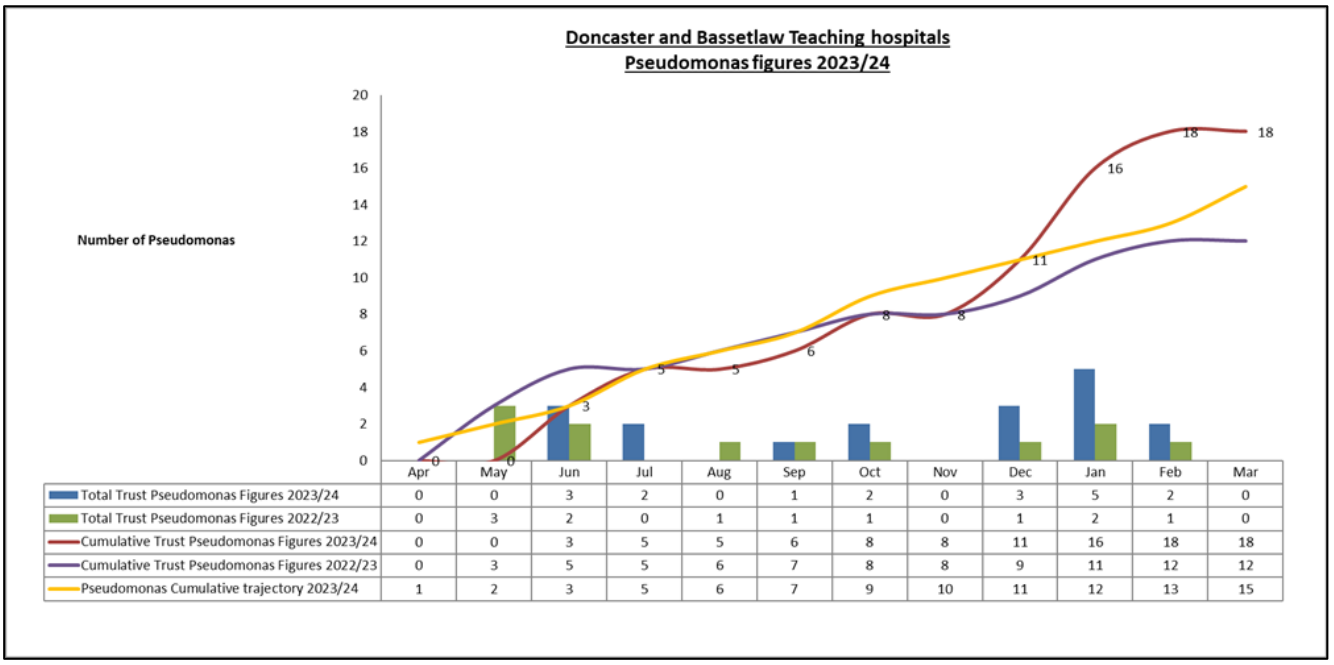
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total E coli Infections 2023/24	5	3	8	8	11	3	10	9	10	14	10	5
Total E coli Infections 2022/23	6	11	6	5	7	4	10	8	5	14	6	8
Community Infections	20	29	18	24	21	22	18	20	13	29	14	17
Cumulative Infections 2023/24	5	8	16	24	35	38	48	57	67	81	91	96
Cumulative infections 2022/23	6	17	23	28	35	39	49	57	62	76	82	90
E Coli trajectory (PHE) 2023/24	6	6	6	6	7	7	7	7	7	7	7	7
E Coli Cumulative trajectory (PHE) 2023/24	6	12	18	24	31	38	45	52	59	66	73	80

There were 341 *E. coli* bloodstream infections of which 96 (28%) occurred in patients more than two days after admission to hospital. The overall Trust attributed *E. coli* BSI cases have increased by 5 cases (5.2%) from 2022/23 submission.
There is an overall upward trend in the last few years in *E coli* bacteraemia cases counts, the hospital-onset and community on-set cases of *E coli* bacteraemia of 24.5 versus 22.7 per 100,000 bed-days and 110.1 versus 95.1 per 100,000 bed-days respectively for hospital on-set and community on-set compared with England averages.

Doncaster & Bassetlaw Teaching Hospitals NHS Trust has been working with Doncaster Place-Based partnership in South Yorkshire Integrated Care Board and Nottingham & Bassetlaw Place – Based partnership in Nottinghamshire Integrated Care System to minimise rates of Gram-negative bloodstream infections so they are no higher than the threshold levels set by NHS England. Cases occurring more than two days after admission are shown by ward and Divisions in Appendix 5. Most E coli bacteremia occurred in patients aged 65 or over, with a median age of 76 years for hospital associated cases. The majority of *E. coli* BSI relate to urinary tract or hepato-biliary infection, which account for around three-quarters of infections.

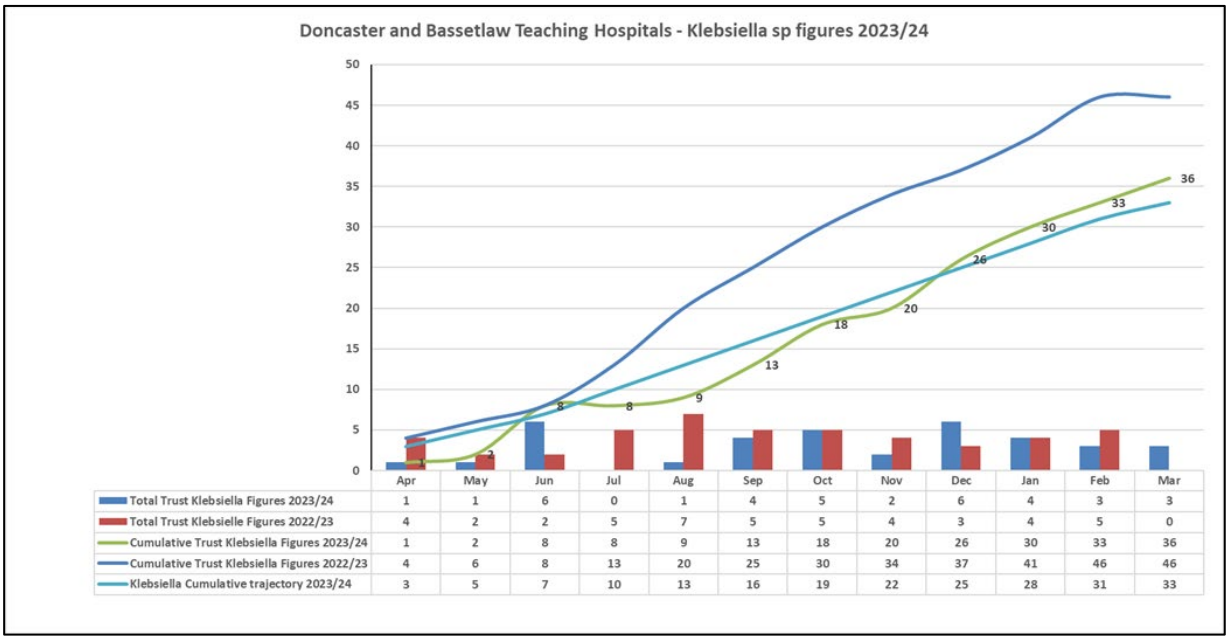
Over the last decade there has also been an increase in extended-spectrum beta- lactamase (ESBL) producing E. coli and other antibiotic resistant strains. There were 10 (10.4%) ESBL-producing or other multi-resistant E coli in 96 blood cultures attributed to Trust as healthcare associated and 19 (8.2%) in 245 blood cultures taken after the second day of admission to hospital and with no recent admission within 28 days to hospital.

Pseudomonas aeruginosa & Klebsiella spp



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust Pseudomonas Figures 2023/24	0	0	3	2	0	1	2	0	3	5	2	0
Total Trust Pseudomonas Figures 2022/23	0	3	2	0	1	1	1	0	1	2	1	0
Cumulative Trust Pseudomonas Figures 2023/24	0	0	3	5	5	6	8	8	11	16	18	18
Cumulative Trust Pseudomonas Figures 2022/23	0	3	5	5	6	7	8	8	9	11	12	12
Pseudomonas Cumulative trajectory 2023/24	1	2	3	5	6	7	9	10	11	12	13	15

Twenty-seven *Pseudomonas aeruginosa* bloodstream infections, an increase of one case (4%) from 2022/23 were reported to the HCAI DCS for 2023/24, 18 were in patients greater than 48 hours from admission, demonstrating an increase by 33% from 12 cases reported as healthcare associated infection in 2022/23. We exceeded our trajectory of 15 cases by three (20%) cases of *P. aeruginosa* BSI. There is an overall downward trend in the last few years in *Pseudomonas aeruginosa* bacteraemia cases counts, the hospital-onset and community on-set cases of *P. aeruginosa* bacteraemia of 3.9 versus 4.8 per 100,000 bed-days and 7.1 versus 7.7 per 100,000 bed-days respectively for hospital on-set and community on-set compared with England averages.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust Klebsiella Figures 2023/24	1	1	6	0	1	4	5	2	6	4	3	3
Total Trust Klebsielle Figures 2022/23	4	2	2	5	7	5	5	4	3	4	5	0
Cumulative Trust Klebsiella Figures 2023/24	1	2	8	8	9	13	18	20	26	30	33	36
Cumulative Trust Klebsiella Figures 2022/23	4	6	8	13	20	25	30	34	37	41	46	46
Klebsiella Cumulative trajectory 2023/24	3	5	7	10	13	16	19	22	25	28	31	33

Of the 100 *Klebsiella spp* bloodstream infections reported, an increase of 8% to the HCAI DCS for 2023/24 from previous financial year. The Trust reported 64 and 36 cases for community associated & hospital associated *Klebsiella* infections respectively. We exceeded our threshold of 33 cases by 9.1%. The vast majority approximately 75% of these being *Klebsiella pneumoniae*.
There is a downward trend in *Klebsiella spp* bacteraemia cases counts for hospital-onset versus England average of 9.5 per 100,000 bed-days, while we observed an upward trend for community on-set cases of *Klebsiella spp bacteraemia* of 30.8 versus 25.4 per 100,000 bed-days for community on-set compared with England averages.

Cases occurring more than two days (for *Pseudomonas aeruginosa and Klebsiella spp*) after admission are shown by ward and Divisions in Appendix 5.

Surgical site infection surveillance:

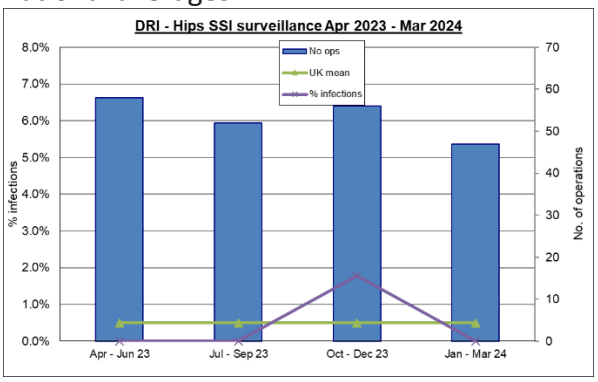
The United Kingdom Health Security Agency (UKHSA) Surgical Site Infection (SSI) surveillance service assesses specialty specific surgical site infections, on a quarterly basis. The Trust participates in this surveillance using the standard case definitions and surveillance methodology.

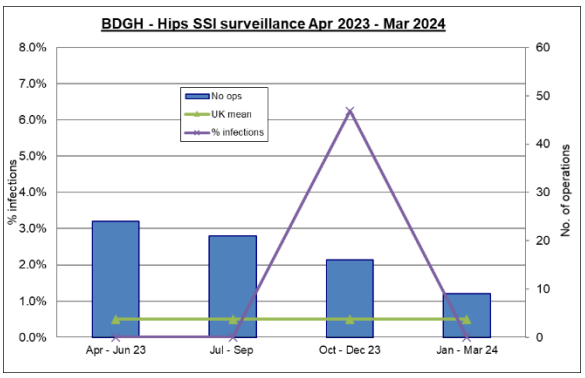
The reporting of Orthopaedic SSI cases became compulsory in 2006. Other components of the scheme remain voluntary.

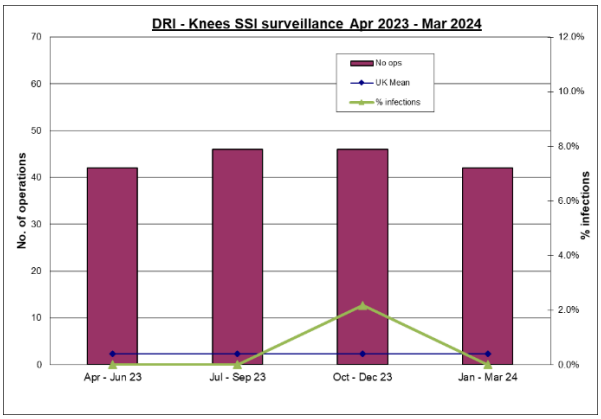
The reports produced by the UKHSA enable Trusts to benchmark their performance against other hospitals. Information is extrapolated from Bluespier, patient's notes, discussion with clinicians, patients and post-discharge telephone surveillance within 30 days of the procedure, or via follow-up appointments or on readmission.

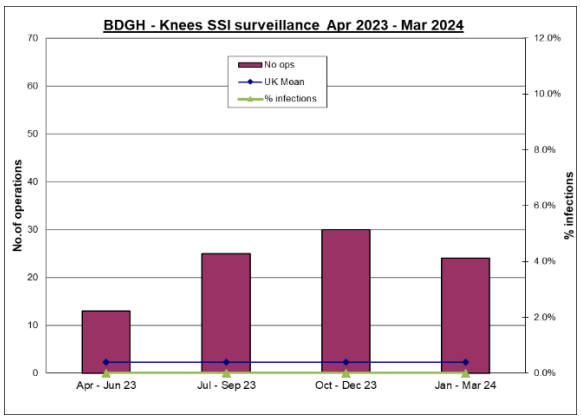
Infection rates are reported monthly to the board through the Trust PSRG and governance. The SSI rate of infection for Primary Knee Surgery at DRI and BDGH was 0.6% and 3.2% respectively against a UK mean of 0.6%. While the SSI rate for Primary Hip Surgery for 2023/24 at DRI and BDGH was, 0.4% and 0.3% respectively against a UK mean of 0.4%. The reported infection in Q3 was one case in a TKR at DRI and two cases each reported in Q3 was due to deep infection post THR in a DRI and DBGH sites. No lapse in care was identified during the Post Infection review (PIR.)

The graphs below show surgical activities and deep infection cases compared with national averages.









Infection in Critical Care Quality Improvement Programme (ICCQIP):

The Trust joined the Infection in Critical Care Quality Improvement Programme, which carries out ICU bloodstream infection surveillance in England. The graph below shows the progress made by our Adult critical care unit at the Doncaster Royal Infirmary in reducing our ICU-associated bloodstream infection and catheter associated bloodstream infection respectively. We will be extending the surveillance and any learning to the Bassetlaw General Hospital Intensive care unit.
Central Venous Line Infection in Critical Care, referred to as Catheter related blood stream infections (CRBSI), are monitored and reported via Public Health England (now known as the UKHSA). This is mandatory surveillance for all critical care units in England.
The infection rate peaked during the COVID pandemic and has remained higher than baseline nationally as well as at DBTH. This is likely due to higher morbidity in the case mix in critical care, in hospital and in the population generally.

In the year 2023-24 there were 2 central line related infections (CRBSI) as shown in chart 1. The infection rate has remained around the national average (2 CRBSIs per 1000 catheter days) for the last 2 years. The utilisation of Central lines in critical care in DBTH is significantly below the national average, which means we keep utilisation, and thus risk, to a minimum.

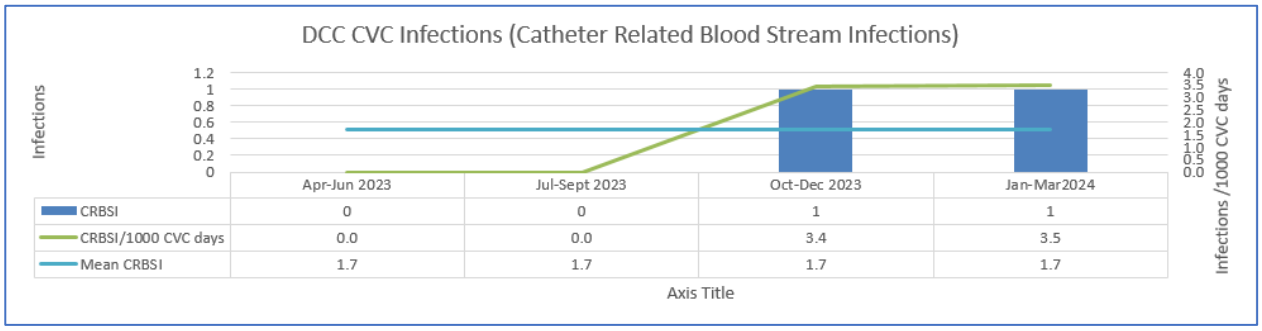
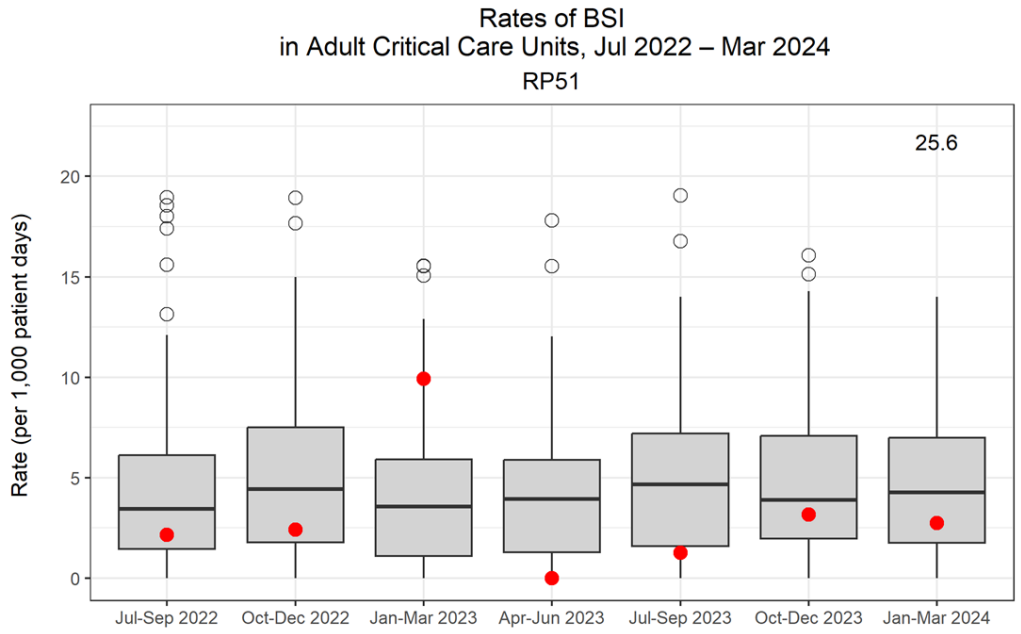
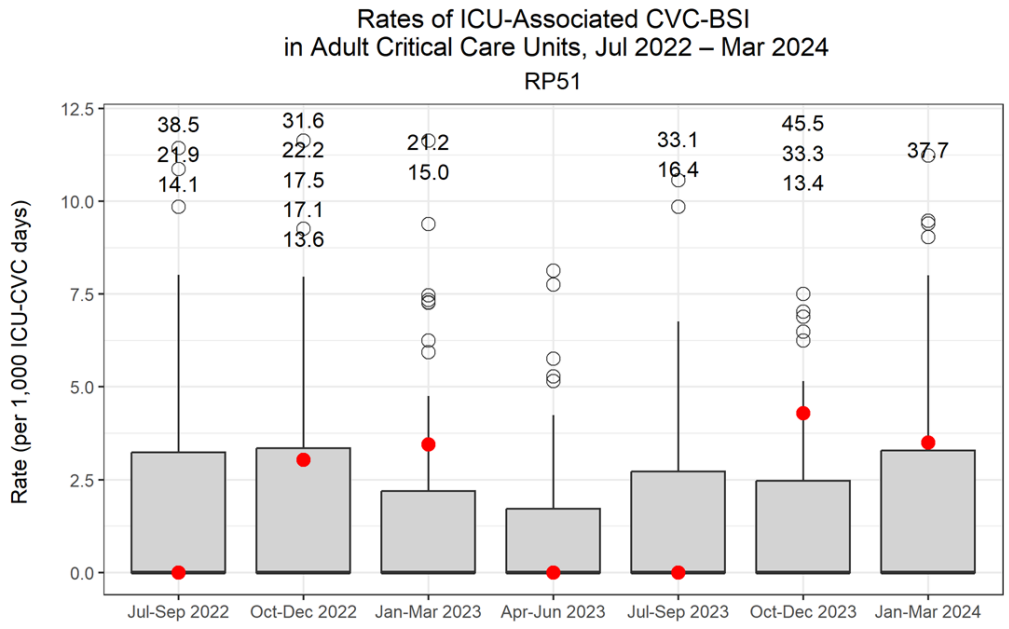


Chart 1. CRBSI at DBTH in Critical Care

Each infection is investigated to help us learn lessons about how to continuously improve. The recent implementation of a digital patient record in critical care has significant helped in the delivery and monitoring of Central line insertion and care ensuring we deliver evidence-based standards.



The red dots on the box and whisker plots represent the rates for your unit. If the red dot is missing from any of the plots, it is because rates could not be calculated for your unit due to non-participation, missing data or zeros entered for denominators.



The red dots on the box and whisker plots represent the rates for your unit. If the red dot is missing from any of the plots, it is because rates could not be calculated for your unit due to non-participation, missing data or zeros entered for denominators.

Influenza virus infection

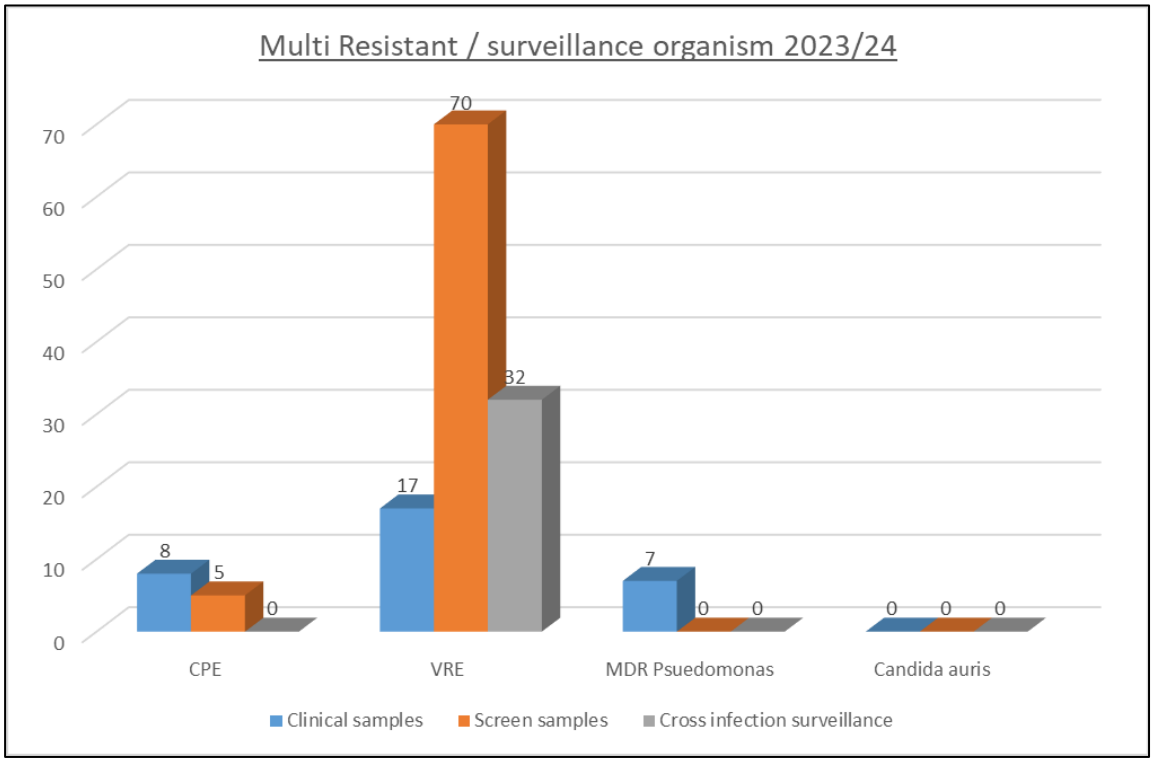
Influenza season was significantly higher in 2022-2023 with 605 cases of Flu A and 42 cases of Flu B, than in 2023/24 where we recorded 199 confirmed Flu A and 12 Flu B. As COVID-19 precautionary measures in the wider community were gradually stood down, Influenza season cases were prominent in the winter pressure months.

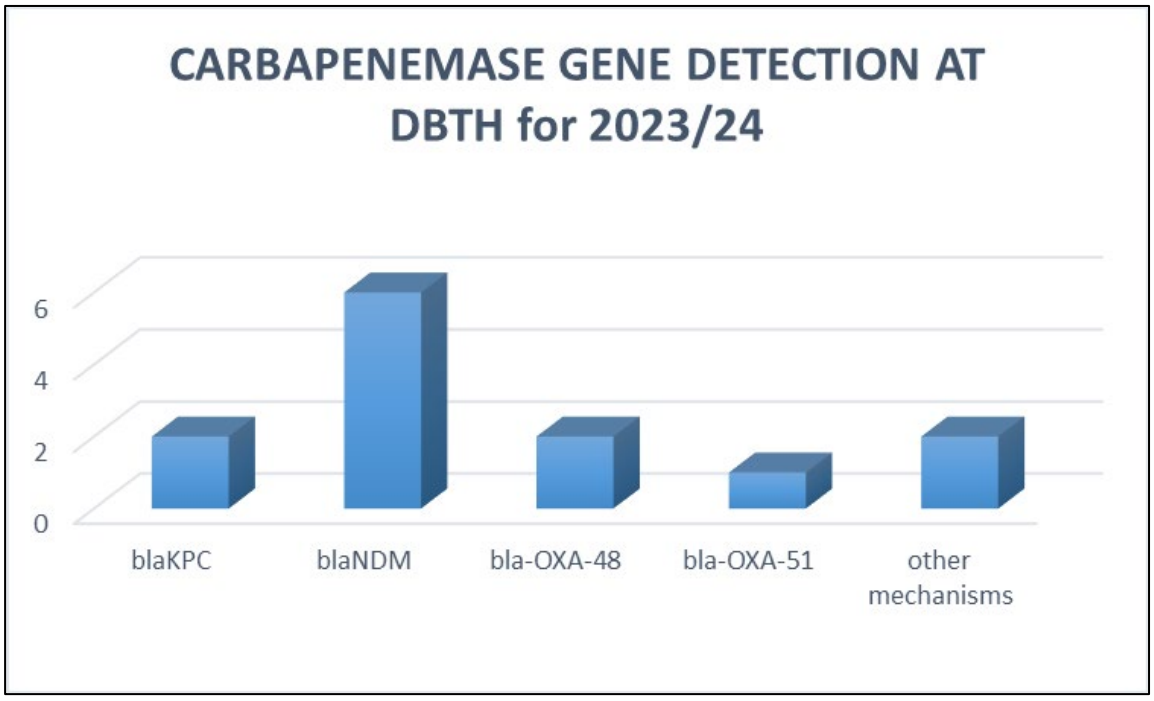
The figures below show that since the withdrawal of COVID 19 restrictions, patients admitted with influenza continued to decline significantly.

Month	Influenza A	Influenza B
April 2023	4	7
May 2023	1	1
June 2023	7	0
August 2023	1	0
September 2023	2	0
October 2023	0	0
November 2023	3	0
December 2023	45	0
January 2024	65	3
February 2024	50	0
March 2024	21	0

More than 47% of all frontline staff received the influenza vaccine against an all NHS Trust average in England of 42.8%. Whilst it is acknowledged that the number of staff within DBTH who have had their Influenza vaccination is above the England average, DBTH strive for much higher vaccination rates.

Multi-resistant organisms & Carbapenemase-Producing Organisms





Carbapenemase-producing Enterobacteriaceae (CPE) is a group of bacteria that are highly resistant to many antimicrobials, including Carbapenems (Meropenem, Imipenem). Some isolates are resistant to all currently available antibiotics. Many of these bacteria usually live harmlessly as part of the gut flora and play an important role in the digestion of food. In September 2020 Public Health England (now UKHSA), issued a framework of actions to contain Carbapenemase-producing Enterobacterales; these organisms spread rapidly in healthcare settings and lead to poor clinical outcomes due to limited antimicrobial options available to treat. The recommendations from this updated framework include active screening for CPE, surveillance systems required for rapid detection and monitoring, standard infection control and contact precautions, antimicrobial stewardship, laboratory methods to enable early detection of the four major types (KPC, OXA-48-like, NDM and VIM), effective outbreak and cluster management and organizational responsibilities.

We reported thirteen cases of CPE for 2023/24 compared to ten cases of CPE in 2022/23, this is partly due to an increase in CPE screening due to the updated guidelines. Of the cases identified in the Trust 6 of the screens were identified as blaNDM, and the other screens identified 2 cases each of the blaOXA-48 & blaKPC respectively, and one case of bla-OXA51, while 2 others had other carbapenemase activities. The devastating impact of CPE in these health economies highlights the importance of the Trust having robust infection prevention and control practices in place consistently to prevent the spread of these bacteria.

We have continued to isolate multi-drug resistant *Pseudomonas aeruginosa* (MDR – Pseudomonas), we reported in 2023/24, 7 cases isolated from clinical samples such as urine, sputum, tissue and wound swabs.
No further cases of MDR-Pseudomonas linked to an initial uretero-scope linked cross-infection in 2017 have been reported in 2023/24 as in 2022/23.

We reported 119 cases of Vancomycin Resistant Enterococcus (VRE) in 2023/24, which was a significant rise from 31 cases reported in 2022/23. Seventeen of the reported cases were identified from clinical samples, while seventy were from screening samples, with thirty-two related to cross-infection, which was identified in our trauma and Orthopaedic wards. The vast majority of these isolates were Glycopeptide resistant.

Following identification of increased cases within orthopaedic cases within the trauma and orthopaedic wards, the IPC team and the clinical teams met regularly over several months to review practices in relation to being bare below the Elbows. In addition the wards were thoroughly deep cleaned, followed up with enhanced cleaning and weekly Ultra Violet treatment in toilet areas. The clinical environment was decluttered. Patients were screened weekly to facilitate timely isolation and management of cases to bring the outbreak to a close.

We have not reported or isolated *Candida auris* in 2023/24 as was the case in previous years.

Point Prevalence Survey

National Point Prevalence Survey (PPS) of Healthcare-Associated Infections

The Trust participated in the National Point Prevalence Survey (PPS) on Healthcare-associated infections (HCAIs), Antimicrobial Use (AMU), and Antimicrobial Stewardship (AMS) 2023 in England.

The 2023 survey is the sixth national point prevalent survey (PPS) on healthcare-associated infections (HCAI) and the third national PPS on antimicrobial use (AMU). This PPS is the first national PPS post-COVID survey and will provide important information on prevalence of HCAI and AMU following the pandemic. DBTH NHS FT was one of the 124 Trusts/ independent sector providers who contributed to the 2023 PPS with data on more than 55,000 patients.

The survey included all three major sites of the Trust, Doncaster Royal Infirmary, Bassetlaw District General Hospital and Montagu Hospital.

A total of 779 patients were surveyed, there were 25 patients with HCAIs, 253 patients having AMU, 40 patients with a CVC and 154 patients with a urinary catheter in situ.

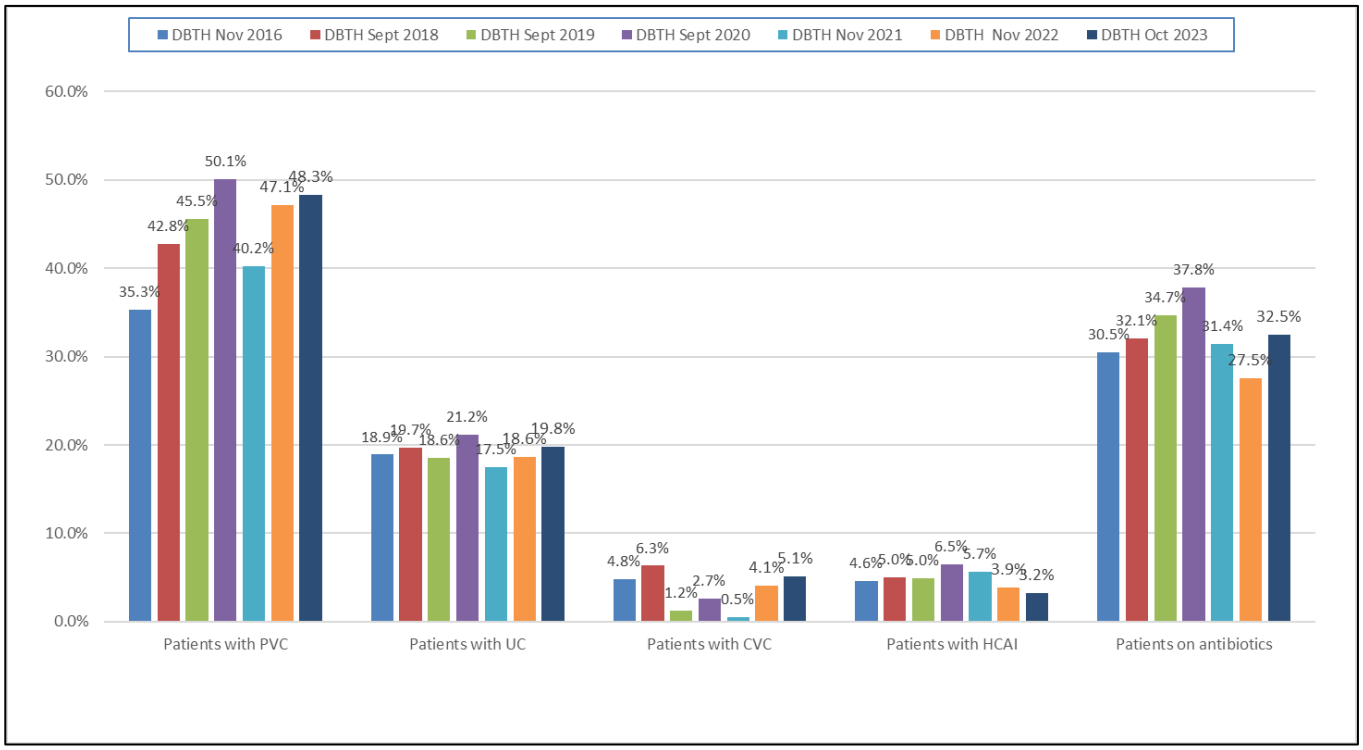
Hospital/ Trust	Total patients (N)	Patients with HCAI (n)	HCAI prevalence (%)	Patients with AMU (n)	AMU prevalence (%)	Patients with CVC (n)	Patients with PVC (n)	Patients with Urinary catheter (n)	Patients with Intubation (n)
Doncaster And Bassetlaw Teaching Hospitals Nhs Foundation Trust (overall)	779	25	3.2	253	32.5	40	376	154	7
Bassetlaw District General Hospital	144	1	0.7	44	30.6	9	67	25	1
Doncaster Royal Infirmary	593	22	3.7	206	34.7	31	308	120	6
Montagu Hospital	42	2	4.8	3	7.1	0	1	9	0

There are now seven years of data – National PPS November 2016 (reported 2017), local PPS September 2018, September 2019, September 2020, November 2021, November 2022 and 2023 upon which to benchmark for improvement.

HCAI prevalence has decreased to 3.2% compared to 3.9% last year and is below the national average of 6.6% in 2016, we are still awaiting National averages for 2023.

															National	
Measure	DBTH Sep 2023		DBTH Nov 2022		DBTH Nov 2021		DBTH Sept 2020		DBTH Sept 2019		DBTH Sept 2018		DBTH Nov 2016		Nov-16	Nov-16
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Patients surveyed	779		414		423		415		404		458		476		48312	
Patients with PVC	376	48.3%	195	47.1%	170	40.2%	208	50.1%	184	45.5%	196	42.8%	168	35.3%	20675	42.8%
Patients with UC	154	19.8%	77	18.6%	74	17.5%	88	21.2%	75	18.6%	90	19.7%	90	18.9%	9724	20.1%
Patients with CVC	40	5.1%	17	4.1%	2	0.5%	11	2.7%	5	1.2%	29	6.3%	23	4.8%	3183	6.6%
Patients with HCAI	25	3.2%	16	3.9%	24	5.7%	27	6.5%	20	5.0%	23	5.0%	22	4.6%	3174	6.6%
Patients on antibiotics	253	32.5%	114	27.5%	133	31.4%	157	37.8%	140	34.7%	147	32.1%	145	30.5%	17884	37.0%

	DBTH Nov 2016	DBTH Sept 2018	DBTH Sept 2019	DBTH Sept 2020	DBTH Nov 2021	DBTH Nov 2022	DBTH Oct 2023
Patients with PVC	35.3%	42.8%	45.5%	50.1%	40.2%	47.1%	48.3%
Patients with UC	18.9%	19.7%	18.6%	21.2%	17.5%	18.6%	19.8%
Patients with CVC	4.8%	6.3%	1.2%	2.7%	0.5%	4.1%	5.1%
Patients with HCAI	4.6%	5.0%	5.0%	6.5%	5.7%	3.9%	3.2%
Patients on antibioti	30.5%	32.1%	34.7%	37.8%	31.4%	27.5%	32.5%



2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Facilities – Deep Clean

Enhanced Cleaning

During the course of 2023/24 our FM teams provided enhanced cleaning across Leger wards due to an outbreak and continuing transmission and evidence of GRE present on wards.

National Standards of Healthcare Cleanliness

A revision to the National Standards of Healthcare Cleanliness 2007 were published in April 2021. The 2021 standards reflect modern methods of cleaning, changes in infection prevention and control and important considerations for cleaning services during a pandemic. The new standards focus on a need for a collaborative approach to cleaning and aim to emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

As part of compliance with the new cleaning standards, all organisations are required to display the commitment to cleanliness charter. The charter demonstrates the organisation is serious about providing a safe, clean environment by referencing the new star rating which reflects the cleanliness of the whole area.

All areas within the Trust have been assessed with IPC and assigned one of six functional risk categories. The functional risk categories then apply the frequency of cleaning, the cleaning standards to be achieved, the monitoring and auditing frequency, and audit target scores that will then be reflected in the star rating.

The current cleaning model at DBTH does not fully comply with the revised 2021 standards and a business case to fund the resource that is required has been submitted. Due to financial conditions, the additional funding requested to bridge the gap has not yet been approved.

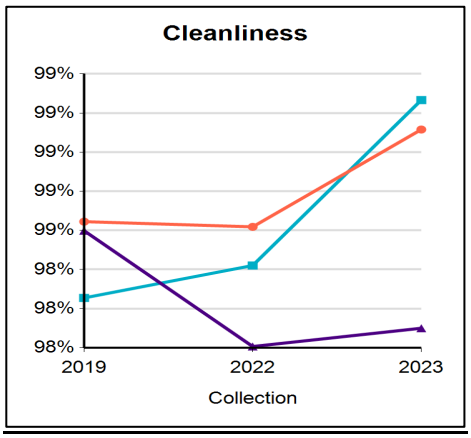
Window cleaning took place throughout the Trust in October and November 2023. DBTH are not yet in a position to sign up and display the cleanliness charter until all the gaps in service have been fully addressed.

PLACE inspections

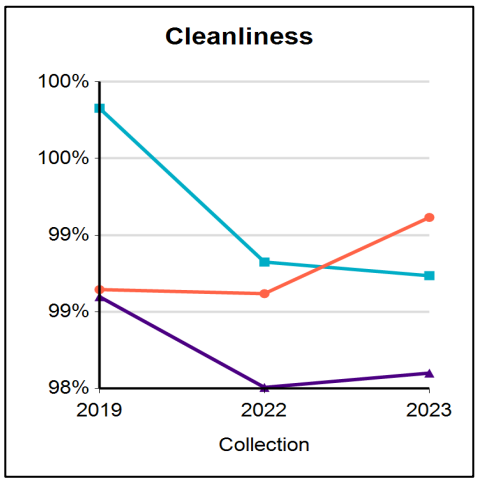
The Facilities teams supported the Patient Lead Assessment of the Care Environment data

collection exercise undertaken in October 2023. The three main sites of the Trust were assessed in the various domains of the inspection including cleanliness. The results demonstrate a cleanliness result above the organisation average across all three sites as shown.

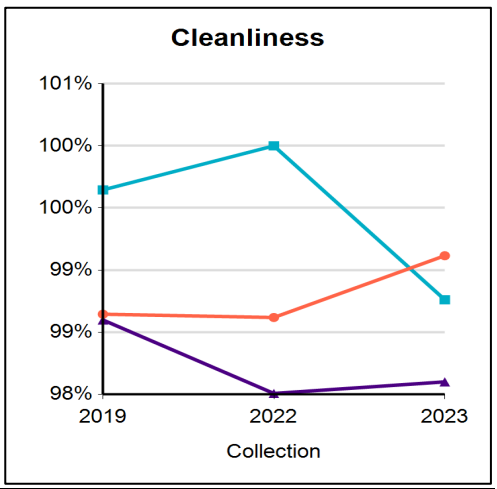
DRI Site PLACE Cleanliness Score



BDGH Site PLACE Cleanliness Score



MMH Site PLACE Cleanliness Score



Site Scores **Organisation Average** **National Average**

Deep Clean Update 23-24

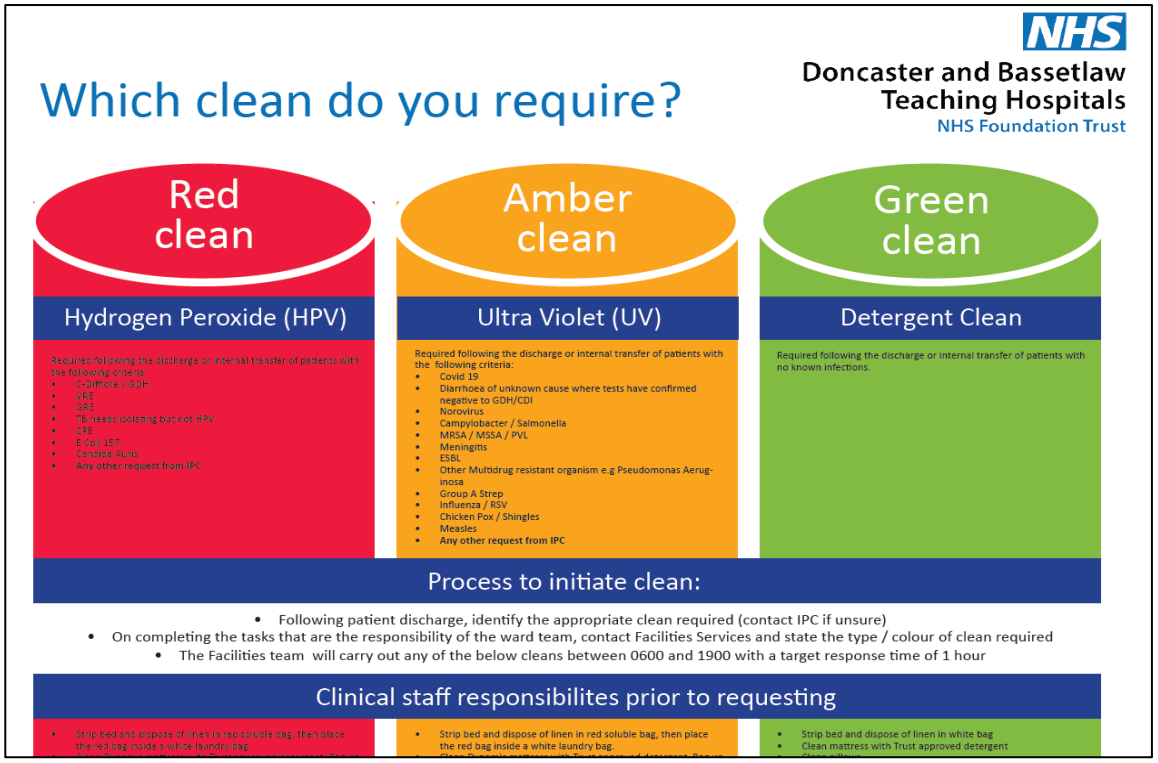
The Deep Clean program has had success in working through a pre-planned annual schedule which has been supported by the IPC team, Head of Patient Flow, and the Deputy Chief Nurse.
Where access has not been possible due to activity or patient capacity issues, the team

have looked at opportunities outside of the schedule – for example Theatres, and at functional areas on other sites.
Whilst some HCA infections have risen in the Trust during 2023/24, the teams have been able to deliver decontamination services to affected functional areas prior to admitting new patients without limiting patient flow.

A summary of completed scheduled deep cleaned functional areas are shown below.

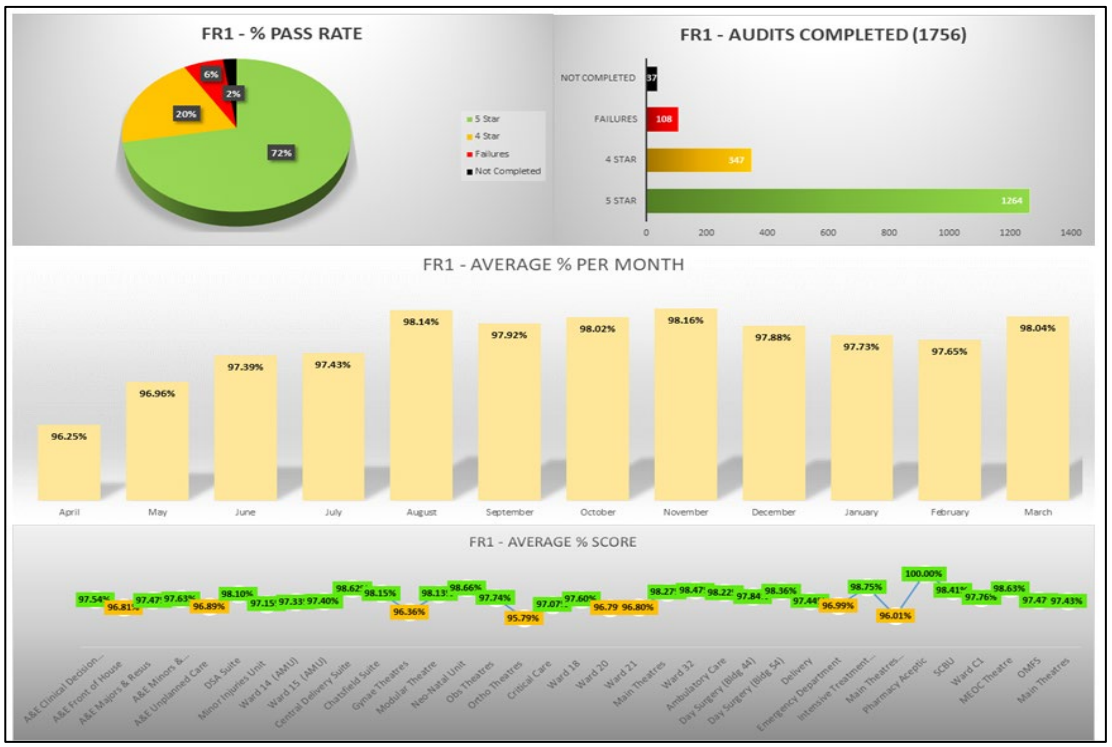
Site	FR Rati	Division	Area	Details of Clean	Clean Comme	Clean Comple
DRI	FR2	Surgery & Cancer	Ward 27	Corridor Oustanding	05/06/2023	12/07/2023
DRI	FR2	Surgery & Cancer	Ward 26	Completed in Full	19/06/2023	30/06/2023
DRI	FR2	Medicine	Ward 25	SR6, SR7, SR9, SR10, SR11 Outstanding	13/07/2023	10/08/2023
DRI	FR2	Medicine	Ward 24	Bay 14-17, SR19, SR20,SR30 Oustanding	07/08/2023	15/08/2023
DRI	FR2		Ward 22	Completed in Full	21/08/2023	07/09/2023
DRI	FR1	Medicine	Ward 20 (Respiratory) (Augmented)	SR6, SR7, SR8, SR23, and Corridor Outstanding	04/09/2023	04/12/2023
DRI	FR1	Medicine	Ward 21 (Respiratory) (Augmented)	SR5, SR18, SR19, SR20, SR21, SR22, SR23 Oustanding	04/12/2023	08/12/2023
DRI	FR2	Medicine	Ward 19	Completed in Full	11/12/2023	15/12/2024
DRI	FR2	Medicine	Ward 16			
DRI	FR2	Medicine	Ward 17	Completed in Full		
DRI	FR1	Medicine	Ward 14 (AMU)		20/05/2024	25/05/2024
DRI	FR1	Medicine	Ward 15 (AMU)		20/05/2024	25/05/2024
DRI	FR1	Medicine	Ward 32 (Renal) (Augmented)	SR1, SR2 and SR21 Oustanding	03/07/2023	26/07/2023
DRI	FR2	Surgery & Cancer	Ward S12	EC Checking if was FULL Deep Clean	23/10/2023	23/10/2023
DRI	FR2	Surgery & Cancer	Ward S11	SR 7 Oustanding	27/12/2023	08/01/2024
DRI	FR2	Surgery & Cancer	Orthopaedic Elective Ward (Modular Lower)	Completed in Full	18/09/2023	22/09/2023
DRI	FR1	Surgery & Cancer	Theatre Orthopeadic (Theatre Recovery)			
DRI	FR1	Surgery & Cancer	Theatres Main	Completed in Full	02/10/2023	03/10/2023
DRI	FR2	Surgery & Cancer	Ward 1	Completed in Full	20/07/2023	20/07/2023
DRI	FR2	Surgery & Cancer	Ward 3	Completed in Full	19/07/2023	19/07/2023
BDGH	FR2	Clinical Speciality Services	Elective Short Stay (ESSU / B6)	Completed in Full	16/10/2023	20/10/2023
DRI	FR2	Medicine	Ward Kingfisher	Underway		
DRI	FR2	Medicine	Ward Kestrel	Underway		
DRI	FR1	Surgery & Cancer	Theatres Womens	Completed in Full	20/11/2023	24/11/2023
DRI	FR2	Children's and Families	Ward Children	Completed in Full	25/09/2023	13/10/2023
DRI	FR2	Children's and Families	Ward Children's observation	Completed in Full	05/10/2023	13/10/2023
BDGH	FR1		Ward B3 (Augmented care)	Completed in Full	02/11/2023	03/11/2023
DRI	FR2	Surgery & Cancer	Ward 7 (St Ledger)	Completed in Full	17/07/2023	17/07/2023
DRI	FR2	Surgery & Cancer	Ward 8 (St Ledger)	Completed in Full	25/07/2023	25/07/2023
DRI	FR2	Surgery & Cancer	Ward 9 (St Ledger)	Completed in Full	18/07/2023	18/07/2023
			Ward 6 (Tacu)	Completed in Full	21/07/2023	21/07/2023

The FM team in collaboration with the IPC team introduced a reference RAG poster to advise which type of clean to request for individual circumstances. An excerpt of the poster is shown on the next page.



Cleanliness Audits

The Facilities team continue to audit cleanliness outcomes based on the requirements of the National Specification of Cleanliness 2007.
During 2023/24 the service audited 1756 functional areas with the highest risk rating.
The service audits in excess of 3000 wards and departments every year.
We report our performance monthly to our internal POSM meetings for assurance.



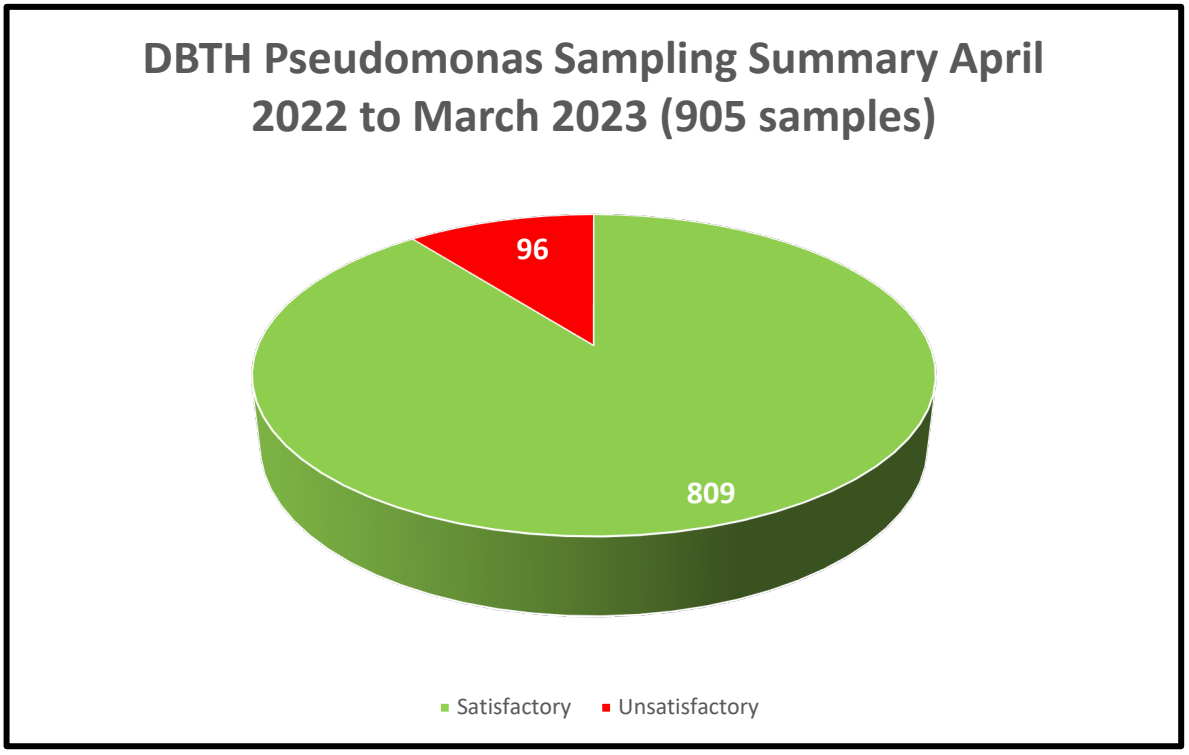
Water Safety Group:

Water hygiene sampling for Pseudomonas Aeruginosa and Legionella species is carried out proactively to monitor water quality within Trust premises. Sampling is also implemented reactively in response to any potential failures in water quality control strategies for assurance.

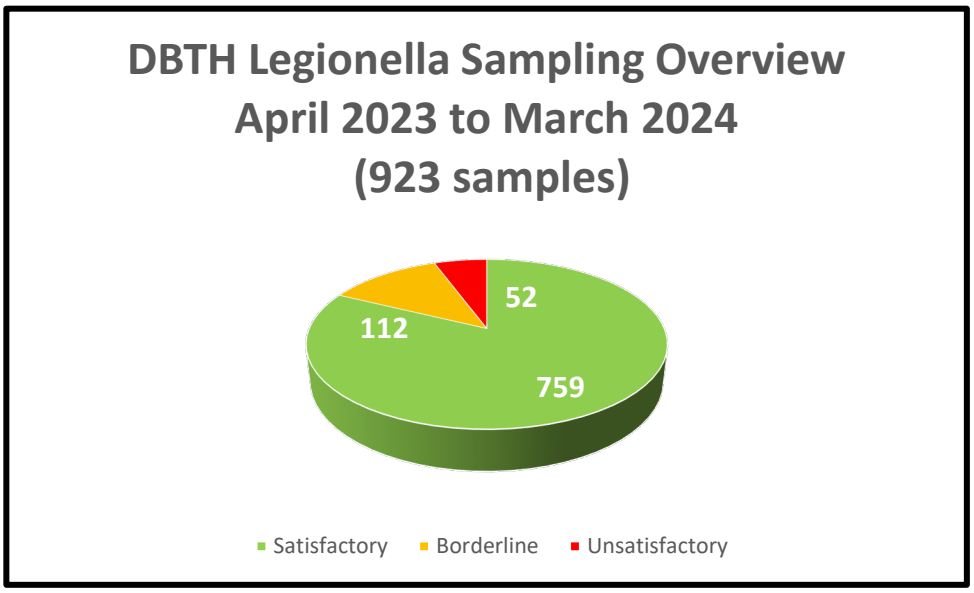
Routine sampling is carried out on a monthly basis across the 3 sites, the sampling is made up of repeat testing of any failures from the previous month and a set of samples. The sampling strategy is agreed jointly between IPC and the Estates team at the Water Safety Group (WSG) which meets every 3 months.

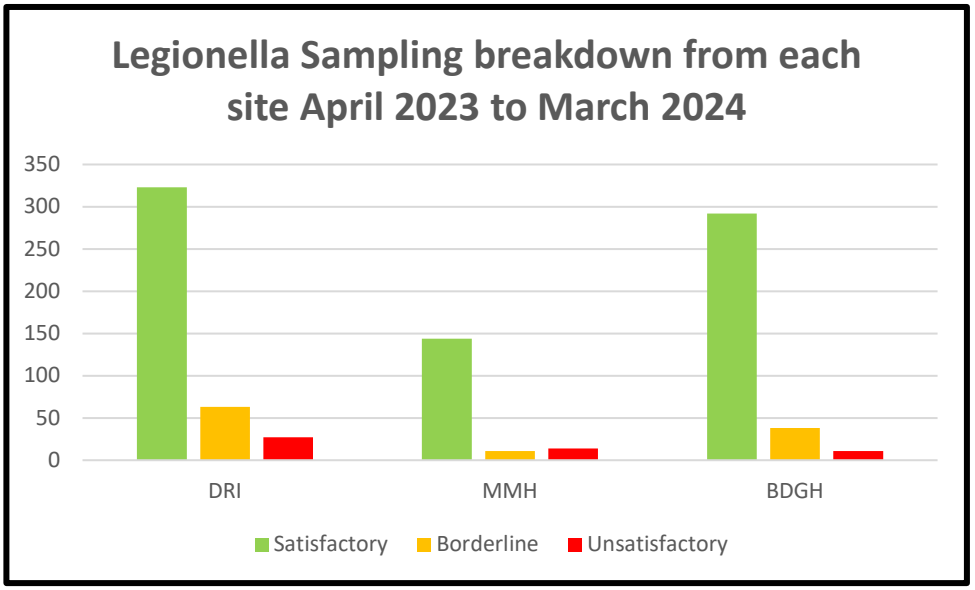
HTM 04-01 'Safe Water in Healthcare Premises' advises that all outlets in augmented care areas should be sampled for Pseudomonas Aeruginosa on a 6 monthly basis. A third party water quality service provider is contracted to conduct this sampling on behalf of the Trust they carry out a number of samples across the sites for Pseudomonas. Below are the Pseudomonas results for 2023/24

Pseudomonas Aeruginosa sampling has decreased slightly over this period and we have sampled 905 times a decrease of 87 samples due to an audit of the augmented care areas, the overwhelming majority been clear sample result with only 96 returning a positive result, any positive result is then actioned appropriately to rectify the issues.



Legionella sampling similarly has decreased slightly in 2023/24 from 1320 to 923, the vast majority of sample returned a satisfactory result, any unsatisfactory results are investigated for non-conformities and rectified and resampled.





IPC and Estates continue to work in close collaboration to monitor sampling data and coordinate responses to positive sample results as required. Water sampling data is also reported to the Trust Water Safety Group and Infection Control Committee routinely for assurance. Any trends, themes or concerns emerging from this data are then discussed so that actions to manage the risk may be agreed accordingly.

3. Provide suitable accurate information on infections to service users and their visitors.

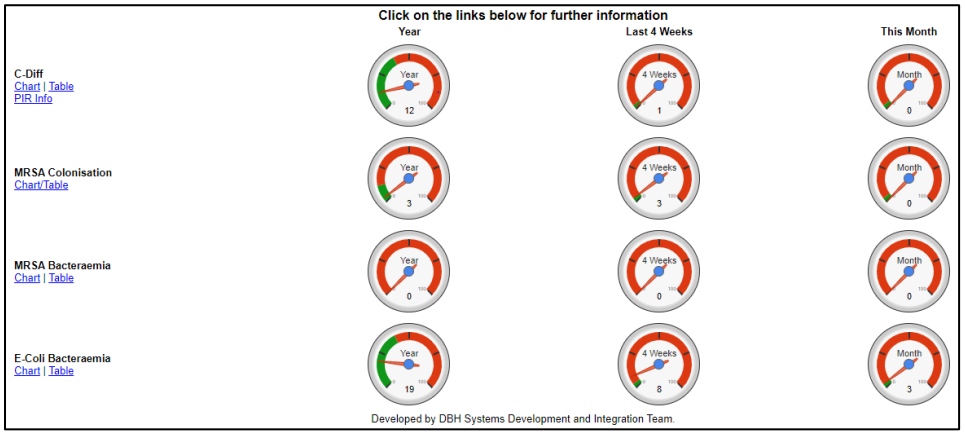
Patient information

General patient information is available on the Trust's internet site, which includes up to date information on respiratory viral infection following advice from UKHSA (UK Health Security Agency) and access to Hospital services. Patient information leaflets are available on different organisms, explaining what they are and what measures may be put in place while the patient is in hospital.

4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

Performance dashboard

The intranet site for most of the year displayed a number of key clinical indicators available to managers and clinical staff.



These dials provided a quick visual assessment on how the Trust is performing against key performance indicators, and clicking on the dials gave access to further detailed information.

The performance dials are also interactive allowing Divisions to visually review their performance against key IPC indicators. The processes of accessing these HCAI dials involves taking multiple steps on the Trust HIVE system and are thus, not as accessable as they were with the previous intranet site.

There has been a recognition over the past year that the current Intranet site is outdated. As the Trust moves to using Nerve Centre, the IPC team have worked with the Digital Transformation team to develop an IPC profile on Nerve Centre to provide live information that can be inputted remotely and seen by the clinical teams immediately on the hand held devices in the clinical area and on Desktops. Over the coming year, the current IPC information dashboard will not be supported and will become obsolete. Work to identify a replacement system as been underway since August 2022, however, financial constraints within the organization has prevented this from moving forward.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

Covid-19 Pandemic focus

Over the year 2023-2024, the organisation continued to see activity in relation to SARS-CoV-2 and COVID-19.

Key elements of the IPCT continued response over the year 2023-2024 are listed below:

- Review and application of all national guidance across all areas and responding appropriately to any risks identified.
- Continued reinforcement of PPE guidance including how to don and doff safely when required.
- Close contact with communications colleagues to ensure clear messages are disseminated across the organisation.
- Production of educational material and guidance documents/flowcharts in relation to all IPC measures.
- Frequent close contact with clinical services to support clinical practice and patient management in terms of IPC practices and in clinical aspects by Consultants in Infection and the Infection Prevention and Control Team.
- Continued attendance at internal and external meetings/groups with partners, ICB, NHSE/I, PHE (UKHSA) and national teams.
- Review and completion of the Board Assurance Framework at intervals.
- Continued provision of the IPC service across the Trust and across the Doncaster borough covering all CQC registered older persons care homes, Learning Disabilities care homes, Supported Living facilities, two Specialist Healthcare Placements, five Extra Care facilities and the team are also a point of contact for domiciliary care providers as and when required.
- Conducting environmental audits commensurate with local authority and provider contracts.
- COVID-19 outbreak management within the DBTH and in community services covered by the team.

Patient Management/cohorting

There have been 411 patients who have acquired COVID-19 within DBTH from day 8 of their admission onwards during 2023-2024.

Patients with COVID-19 continue to be isolated or cohorted during their infectious period to minimise the risk of transmission of infection. However, the risk cannot be eliminated and there have been cases where patients have been incubating the infection when they present to our services, without any symptoms who have then become infectious and transmission to others has occurred. With the lifting of all COVID-19 related restrictions, minimising spread within the hospital has been challenging.

There have been 14 cases where patients contracted COVID-19 whilst in hospital, who have died and had COVID-19 annotated on Part 1 or Part 2 of the Death Certificate. This is against 144 deaths since April 2020 and March 2022 and 20 between April 2022 and March 2023. Patient safety is still paramount and the management of patients, staff and visitors into hospital remains a high priority for all infectious cases, not just COVID-19 cases.

The IPC team participate daily in the Daily Operational meetings, where senior leaders support patient flow through services as safely as possible with advice given by the IPC team and Consultants in Infection.

The ability to test for COVID-19 and have timely results has continued to be key in minimising the spread of COVID-19 in our hospitals. Screening protocols for timely identification of patients with symptoms of COVID-19 continue and are in accordance with national guidance.

The Infection Prevention and Control (IPC) Team coordinated with clinical staff, site managers and senior leaders to provide advice and guidance on testing and on acting on test results in a timely manner to ensure that patients were segregated at the earliest possible opportunity.

PPE

Mask Fit testing remains a key priority for DBTH as it now forms part of the Emergency Preparation Resilience and Response (EPRR) Core standards which mandates that any member of staff that is likely to be exposed to patients who may have an infection where FFP3 masks are required (e.g Influenza, COVID-19, TB) must be Fit tested on at least two masks every two years. Fit tests should be carried out by a competent person in accordance with Health and Safety Executive.

The resource required to meet the standard is not in place. The IPC team have provided ad hoc FIT testing on staff and the Education Team are Fit testing new starters during induction, if the staff member's role means that they may come into close contact with a patient with an infection that requires the wearing of FFP3 masks.

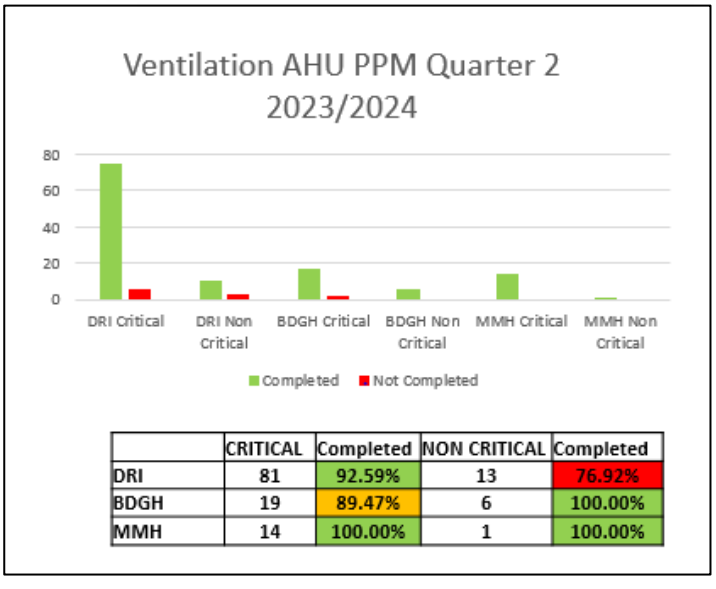
Ventilation

Poor ventilation continues to be a challenging issue throughout the Trust's estates. This is managed by the Ventilation Safety Group, which meets every six months to review the latest ventilation reports for both critical and non-critical ventilation systems.

The Trust allocated £200K of capital funds to improve ventilation across the estate. The Ventilation Safety Group decided to use the funds to begin replacing the main supply and extract fans in the two tower blocks, East Ward and Women's and Children's. This project is expected to have the most significant impact on clinical spaces, including the Department of Critical Care and Respiratory, which are classified as critical ventilation areas under the Health Technical Memorandum.

All the fans were purchased within the financial year, and the plan is to install them in the next financial year to complete the work. Additionally, the Ventilation Safety Group agreed to collect all unused air scrubbers purchased during COVID-19. These are now stored with the Estates department for use as directed by the Infection Prevention and Control (IPC) team.

An Air Scrubber located in emergency department at DRI site



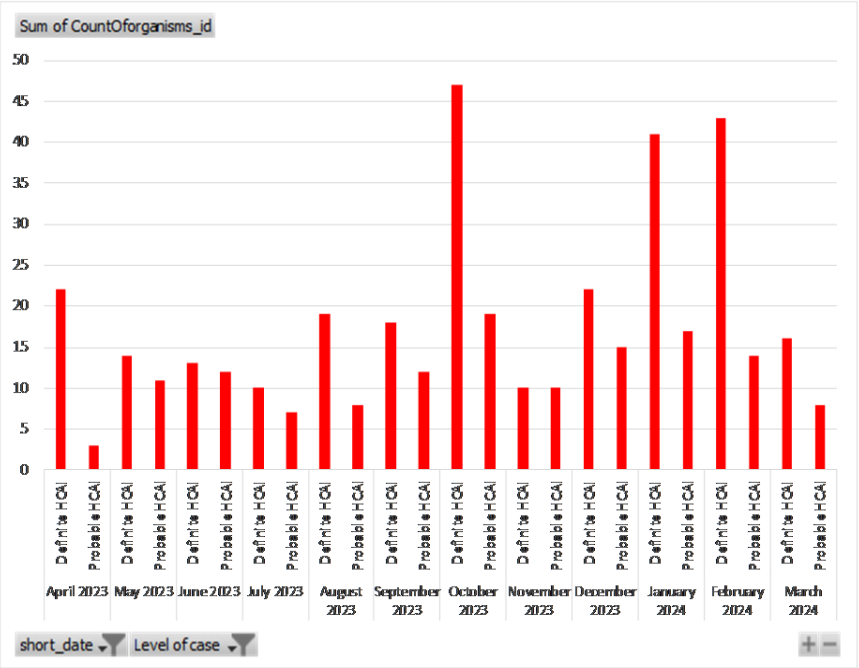
	CRITICAL	Completed	NON CRITICAL	Completed
DRI	81	92.59%	13	76.92%
BDGH	19	89.47%	6	100.00%
MMH	14	100.00%	1	100.00%

All PPM's for BDGH & MMH in both quarters have been completed, only 1 outstanding PPM remains for DRI QTR 2 in 2023/24

Classification of nosocomial infections

Numbers of Definite and Probable Hospital acquired COVID-19 infections

short_date	Level of case	Total
April 2023	Definite HCAI	22
	Probable HCAI	3
May 2023	Definite HCAI	14
	Probable HCAI	11
June 2023	Definite HCAI	13
	Probable HCAI	12
July 2023	Definite HCAI	10
	Probable HCAI	7
August 2023	Definite HCAI	19
	Probable HCAI	8
September 2023	Definite HCAI	18
	Probable HCAI	12
October 2023	Definite HCAI	47
	Probable HCAI	19
November 2023	Definite HCAI	10
	Probable HCAI	10
December 2023	Definite HCAI	22
	Probable HCAI	15
January 2024	Definite HCAI	41
	Probable HCAI	17
February 2024	Definite HCAI	43
	Probable HCAI	14
March 2024	Definite HCAI	16
	Probable HCAI	8
Grand Total		411



Outbreaks

Outbreaks that have occurred throughout 2023-2024 are listed below. On identification of an outbreak the IPC Team have deployed, rapidly reviewing the areas and identifying areas for improvement. The IPC Team have also audited PPE use and IPC practice proactively outside of outbreaks situations. Themes of learning identified through outbreak control reviews have been hand hygiene and bare below the elbow compliance, cleanliness of equipment and the environment. General clutter of environments. COVID-19 restrictions were not in place during this period.

Date	Department	Causative Organism	Number of patients involved	Number of staff involved	Outcome	Comments
May 2023	T&O Unit	GRE	31	0	Resolved after 6 months	Considered to have commenced following extensive construction work. Spread occurred due to environmental issues as well as suboptimal IPC practices.
July 2023	Ward 32	Clostridioides difficile	4	0	Resolved within a month	Ribotyping of each case, all different and therefore not linked
August 2023	Rehab 1	SARS-CoV-2	8	9	Resolved within 4 weeks	Suspected that staff inadvertently introduced to the unit
September 2023	Gresley Unit	SARS-CoV-2	9	4	Resolved within 4 weeks	Suspected that staff inadvertently introduced to the unit
October 2023	B5	SARS-CoV-2	10	7	Resolved within 4 weeks	Suspected that staff/visitors or patients incubating on admission inadvertently introduced to the unit
November 2023	Mallard	SARS-CoV-2	5	4	Resolved within 4 weeks	Suspected that two relatives inadvertently introduced to the unit
December 2023	Rehab 1	Influenza	5	0	Resolved Within 2 weeks	Suspected that staff or visitors were the source of infection which then spread
January 2024	Ward 22	Influenza	3	0	Resolved within 2 weeks	Complex, confused patient admitted with Influenza that could not be isolated from others
January 2024	Rehab 2	SARS-CoV-2	11	9	Resolved within 4 weeks	Suspected that staff or visitors were the source of infection, which then spread. There had been more visitors over the Christmas period.

Antimicrobial management:

The DBTH antimicrobial stewardship activity in 2023/24 has focused around a number of key priorities - IVOS CQUIN, restricting fluoroquinolone use, regional paediatric AMS initiative, reducing *C. difficile* infection and improving antibiotic stewardship through specialty ward rounds and MDTs.

AMS team and service

The AMS agenda is delivered through teamwork from Consultants in Infection, Trust grade doctors, Antimicrobial Pharmacist and IPC nurse team. Our clinical service comprises phone consults, e-consults from GPs, bacteraemia reviews, infectious disease consults, daily ICU ward rounds and specialty antibiotic ward rounds in a number of specialties. This includes weekly haematology, orthopaedics, renal and the addition of vascular ward rounds in 2023/2024. We also contribute to regular MDTs in prosthetic joint infections, spinal infections and regional South Yorkshire infective endocarditis.

IVOS CQUIN

Much of the AMS efforts in 2023/24 has centered on the IVOS CQUIN. The CQUIN target was set at less than 40% of patients still being on IV antibiotics at the point of meeting UKHSA IVOS criteria. At the outset, we published a new IVOS guideline for DBTH using the ACED tool in line with UKHSA recommendations. We raised awareness of the CQUIN and new guideline through data sharing at ICC and AMT meetings, social media and hospital communications. We submitted the required 100 patient data for each quarter and met the target for all quarters – see graph below. We demonstrated additional AMS benefits through undertaking the CQUIN work by other AMS interventions made by the audit team, increased ward presence by the Infection team and the financial benefit to the Trust by achieving the target.

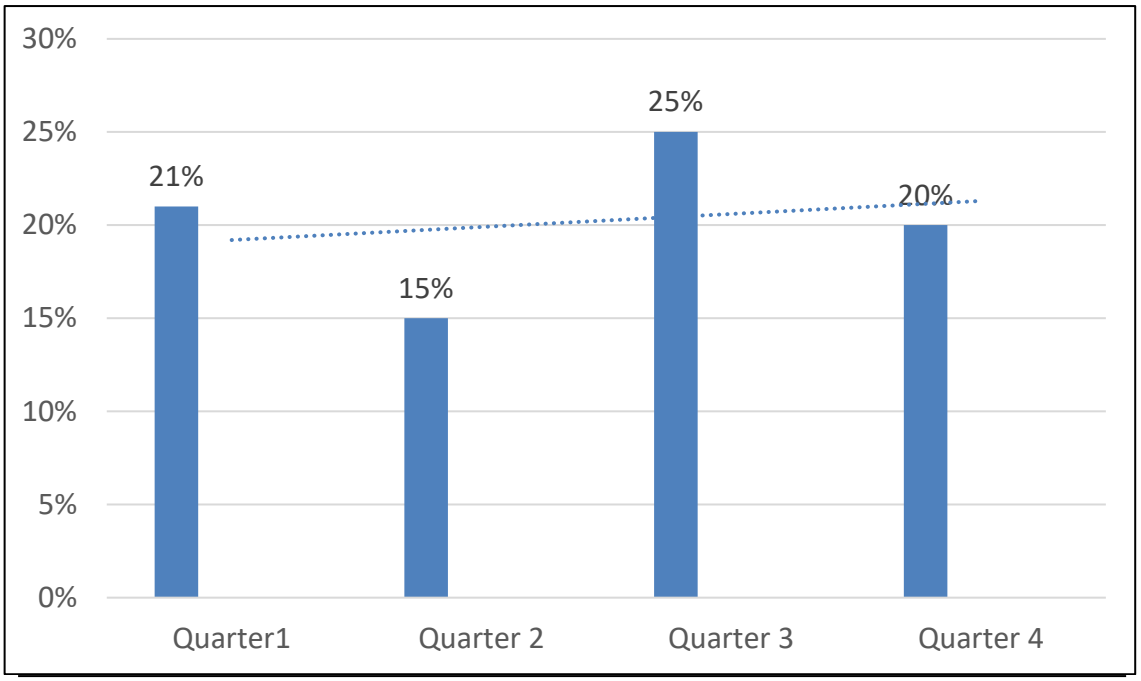


Figure 1 Proportion of DBTH patients still on IV antibiotics at point of meeting IVOS switching criteria (Target < 40%)

Restricting fluoroquinolone use

In January 2024, MHRA warning was released as follows: *Fluoroquinolone antibiotics given systemically (by mouth, injection, or inhalation) must only be administered when no other antibiotics are appropriate for use, the Medicines and Healthcare products Regulatory Agency (MHRA) has announced. This means that fluoroquinolones should only be prescribed when other recommended antibiotics have failed, will not work due to resistance, or are unsafe to use in an individual patient*.

We have delivered an educational lecture to clinicians at a Patient Safety Seminar and recorded webinar to promote awareness of the fluoroquinolone risks and changes to prescribing.

Currently the use of ciprofloxacin (and some other quinolones including levofloxacin) is already restricted at DBTH. Microbiology restricted codes are required for most fluoroquinolone prescribing which is outside of our Trust guidelines – this is to ensure appropriateness, given the side effect profile, and to advise that discussions occur between the prescribing doctor and patient about the risks and benefits of the antibiotic selected.

We have also minimised use of quinolones in our guidelines. Where possible, we have replaced with other oral antibiotics with similar efficacy, such as cotrimoxazole. Where ciprofloxacin had previously been advised in surgical prophylaxis options, this has been replaced with gentamicin where appropriate.

Where quinolones remain the most effective treatment option, these should be prescribed with informed patient consent and with the patient information leaflet provided. We have now added the MHRA warning and patient information leaflet in the Trust Antimicrobial webpage and any updated DBTH guidelines now include links to these resources. We have also worked with GU physicians to mitigate the use of ofloxacin in this setting.

Regional Paediatric AMS strategy

We have seen the launch of a regional paediatric AMS initiative led by Dr Charlotte Fuller, Leadership Fellow in Paediatric AMS. This has been a strategic project involving DBTH, Sheffield Teaching Hospitals, Sheffield Children's Hospital, Barnsely and Rotherham Hospitals to improve paediatric AMS awareness, education, audits and policy decisions across our region. It has been acknowledged nationally as the first initiative of its kind in the country. This work has led to an increase in AMS activity, such as bimonthly point prevalence studies, bronchiolitis audit, launch of meningitis/encephalitis audit and educational sessions for paediatric junior doctors.

AMS Ward rounds

There has been a re-introduction in AMS ward rounds involving Antimicrobial Pharmacist and Trust Antimicrobial lead. We have aimed to alternate between medical and surgical specialties to capture data on current prescribing practice and areas that require further intervention. Data from AMS ward rounds and IVOS CQUIN has been shared regularly at Infection Control Committee Meetings and Antimicrobial Management Team meetings to raise awareness and trigger improvement.

Antimicrobial Management Team (AMT)

The Antibiotic management team was reconfigured last year to include both Nursing and Medical representation from each of the Divisions. A new Terms of Reference (TOR) and agenda were drawn up in August 2023 with aims as below:

- Communicate group decisions where appropriate through DTC, ICC, clinical specialty governance meetings
- Ensure trust antimicrobial guidelines are in place and reviewed regularly or when new evidence is

published

- Monitor the Trust's compliance and benchmarking for antimicrobial stewardship, learning from others to improve our stewardship
- Report a regular formal review of the Trust's retrospective antibiotic consumption data, especially broad-spectrum antibiotics
- Identify actions to address non-compliance with Trust guidelines, general antimicrobial stewardship issues and other prescribing issues.
- Provide guidance on how antimicrobial stewardship can be delivered in a ward and outpatient environment

Although engagement has improved compared to previous years, engagement across some of the specialty areas is still lacking.

Trust Antimicrobial policies

The antimicrobial policies are updated and reviewed in monthly Drugs and Therapeutics Committee meetings. See table below for overview of guidelines reviewed in 2023/2024. Our Trust performance in infection audits, point prevalence studies and antibiotic consumption data is shared at the bimonthly Infection Control Committee meetings.

Table 1 Guideline updated and approved April 2023- April 2024

Guidelines	Date of approval
Antimicrobial Management of Urinary Tract Infections	May 2023
Teicoplanin Dosing and Monitoring Guideline	June 2023
IV to PO Switch and 5-day Stop Policy	June 2023
Guideline for the initial investigation and diagnosis of Infective Endocarditis in Adults	October 2023
Clostridium difficile Infection (CDI) Policy	December 2023
Gastrointestinal Tract Infections – Antimicrobial Management	April 2024

Reducing MSSA bacteraemia in renal

Over the last couple of years, we have noted an increase in MSSA bloodstream infections within the renal unit. We have continued to undertake post infection reviews to identify learning to help reduce these infections amongst the dialysis cohort. We have continued to promote MSSA screening for patients with tunnel lines and to encourage the daily long term use of Prontoderm foam. With the help of the Renal Development Sister, there has been a push to improve staff training and competencies from an infection control perspective when accessing lines. More recently, we have started a QI project to review new dressing type in patients who are intolerant of the standard chlorhexidine dressings.

Infection Virtual Wards

In the 2023/24 financial year, we have also enhanced the AMS work through introduction of the Infection Virtual Ward and the Orthopaedic IV Antibiotic Virtual Ward. The aim of these services is to improve patient outcome, facilitate early hospital discharge, reduce risk of hospital-associated infection and improve patient experience.

Addressing C.difficile and MRSA infections

The IPC nursing team undertake regular antibiotic audits for inpatients at DBTH. Patients who are identified as high risk of developing *C. difficile* infection or MRSA infection are flagged up to the Consultants in Infection for intervention and review of high risk antibiotic use.

Weekly PIRs for *Clostridioides difficile* infections were conducted in 2023/24 to identify areas that require improvement in relation to antimicrobial prescribing. These meetings include representation from the clinical team, executive team, pharmacy, microbiology, infection prevention and control and facilities and are aimed at raising awareness and improving antimicrobial stewardship and infection control practices within the Trust.

AMS Education during World Antimicrobial Resistance Awareness Week (WARAW) 2023

As part of our activities for WARAW in November 2023, we undertook the following activities:

- Friday 17th November - Seminar session in Main Lecture theatre DRI to kick start WARAW. Three short presentations on different topics.
- Saturday 18th November - Official launch of World Antimicrobial Resistance Awareness Week.
- Infection Prevention DRI 20th & Bassetlaw 21st November - IPC presence on wards and outside the Canteen (DRI) and main entrance at Bassetlaw. Raised awareness of hand hygiene, sepsis tools and vaccinations.
- Thursday 9th & Tuesday 21st November – PPE drop in session in the Education centre DRI.
- Antimicrobial allergies – are they really allergic? Tuesday 21st November BDGH Dining Hall. Wednesday 22nd November DRI Canteen.
- Antimicrobials in clinical practice DRI 22nd & Bassetlaw 23rd November - Microbiology, IPC and Pharmacy colleagues promoting awareness of antimicrobial resistance and IVOS. Posters illustrating audit performance from national IV to oral switch CQUIN.
- 'Sepsis Day & Optimising Diagnostics' Friday 24th November Bassetlaw & Wednesday 29th DRI. Raised awareness of sepsis diagnostics and management.

6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

Ward Accreditation scheme

The formal IPC accreditation Scheme has been paused through 2023-2024 as the service and the organisation has navigated through the PSIRF process and the DBTH Care Excellence Framework. Whilst the scheme has been halted the individual elements/standards that are worked towards remain in place.

The wards and department teams are required to achieve defined standards in audits of hand hygiene, patient's environment, Link Practitioner activities and the cascade of information. In addition, appropriate observations and feedback are undertaken which reinforce practical actions that clinical staff must undertake every time they carry out a procedure to reduce the risk of HCAI. These include:

- Preventing surgical site infection
- Urinary Catheter care
- Peripheral line care
- Central Venous Catheter Care
- Ventilator care
- *Clostridioides difficile*.

Hand Hygiene

Hand hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team have continued to promote hand hygiene compliance incorporating the WHO five moments tool but simplifying the moments to enable staff to concentrate on aspects that can easily influence hand hygiene compliance. Hand hygiene compliance including bare below the elbows is an expectation for all clinical staff.

Hand Hygiene observations are recorded on Tendable.

Where alert infections had been identified, for example, C Difficile and MRSA cases, IPC have monitored compliance with general practices through Snapshot auditing and feedback.

Enhanced surveillance was undertaken where an outbreak of infection was being considered, this included environmental audits, hand hygiene compliance, glove wearing and correct PPE. It also included the screening of staff and patients to investigate the extent of the outbreak.

World Health Organisation (WHO) hand hygiene

- Moment 1: before patient contact
- Moment 2: before a clean/aseptic procedure
- Moment 3: after body fluid exposure risk
- Moment 4: after patient contact
- Moment 5: after contact with patient surroundings.

Banners of staff placed at the entrance to the hospital and wards have been distributed to encourage and remind staff of the need to clean their hands.

7. Secure adequate access to laboratory support as appropriate.

Microbiology laboratory

The Microbiology laboratory continues to work closely with the IPC team, to ensure appropriate testing of samples and rapid communication of results, particularly with regard to SARS-COV-2, Influenza virus and RSV, *Clostridioides difficile*, norovirus, Group A Streptococcus, *Mycobacterium tuberculosis,* and MRSA screening and other "alert" organisms such as CPE and VRE. There is a line list of alert organisms generated regularly even before results are authorised to assist the Infection Prevention and Control team to act proactively in managing isolation and thus preventing healthcare associated infection. The microbiology laboratory also assist in facilitating the collection/packaging/forwarding of high risk sample such as measles, pertussis, mpox, viral hemorrhagic fever, CJD to mention but a few to be tested in other specialized reference centers across the United Kingdom, and facilitating results back to the consultants in Infection and IPC team.

The laboratory is fully UKAS accredited, and the laboratory is now providing an extended day service In addition to a seven days working, both of which has improved turnaround of results and prompt action on isolates.

As discussed earlier, resistance in gram-negative organisms continues to evolve and the laboratory has introduced protocols for screening for Carbapenemase-producing Enterobacteriaceae (CPE) to support PHE guidance. Film-Array is now fully validated within the laboratory, as a tool for early identification of bacterial and viral infections in cerebrospinal fluids. Work is completed in ensuing that Communicable Diseases Report (CDR) and Antimicrobial Resistance Reports (AMR) are transferred from the pathology LIMS and sent safely to the Second Generation Surveillance System (SGSS). The consultations within the region for a South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) pathology laboratory network is now completed, as the Microbiology department at DRI is now part of the Sheffield Teaching Hospitals, based at DRI. There is a rollout of the SYB Pathology Oracle Cerner PathNet LIMS expected to commence from April 2024 to completion in February 2026.

The COVID-19 PCR lab in microbiology at Doncaster Royal Infirmary

8. Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.

Infection Prevention and Control Policies

The following policies were updated and approved by the Infection Prevention and Control committee during 2023-2024.

Policy title	Policy number	Date approved ICCM
Asplenic Patients Policy – Management of Patients with Absent or Dysfunctional Spleen	PAT/IC 2 v.8	April 2023
Hand Hygiene	PAT/IC 5 v.9	April 2023
Tuberculosis – Care of the Patient with Pulmonary or Laryngeal Tuberculosis in Hospital	PAT/IC 23 v.8	June 2023
Clostridioides difficile Infection (CDI) Policy	PAT/IC 26 v.7	December 2023
Scabies – Guidance on Management	PAT/IC 7 v.9	December 2023
Surveillance Policy	PAT/IC 31 v.6	December 2023
Standard Infection Prevention and Control Precautions Policy	PAT/IC 19 v.9	December 2024 (finalized April 2024)

9. Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Staff influenza vaccination

INFLUENZA VACCINATION SUMMARY MARCH 2024

Org L2	Headcount	Influenza Vaccination Headcount	Influenza Vaccination Headcount %
272 Chief Executive Directorate	27	17	62.96%
272 Children & Families Division	756	390	51.59%
272 Clinical Specialties Division	1728	888	51.39%
272 Education and Research Directorate	95	61	64.21%
272 Estates & Facilities	660	275	41.67%
272 Finance & Healthcare Contracting Directorate	83	41	49.40%
272 Medical Director Directorate	14	5	35.71%
272 Medicine Division	1266	565	44.63%
272 Nursing Services Directorate	119	70	58.82%
272 People & Organisational Directorate	94	48	51.06%
272 Performance Directorate	240	107	44.58%
272 Restoration, Innovation and Transformation Division	170	104	61.18%
272 Surgery and Cancer Division	1122	508	45.28%
272 Urgent and Emergency Care Division	613	231	37.68%
Grand Total	**6987**	**3310**	**47.37%**

BCG Vaccination

Due to the changes in TB vaccination requirements and the change in supply, vaccine shortage has prevented full vaccination of HCW since approximately 2018. Current guidance continues to suggest that Healthcare workers (HCW) or laboratory workers with direct TB patient contact or contact with infectious materials, should be vaccinated with BCG. As vaccine supply became available again in 2021, the Occupational Health Department has started to use QuantiFERON testing for TB screening and BCG vaccination for new starters to the Trust In addition, DBTH has a planned program of identification and vaccination for those staff who work at the trust who were not able to receive the vaccine previously.

BCG (TB) VACCINATION SUMMARY MARCH 2024

BCG Vaccination 23/24	Total Identified	Total Attended	DNA Letter sent to Manager/Employee	Total Remaining no response	% of Declined/ no response
Q1	485	266	55	219	56.49%
Q2	463	261	36	202	51.40%
Q3	324	155	35	169	57.63%
Q4	261	154	6	107	43.30%
Total	**1533**	**836**	**132**	**697**	**53.04%**

Training and education

It is widely recognised that ongoing education in infection control is required in order to improve healthcare workers compliance with infection prevention and control practices.

The infection prevention and control computer based learning (SET and eLearning) packages are accessible for all staff via the Trust Intranet site. The Infection Prevention and Control Team have contributed to provide formal and informal teaching sessions within the clinical areas and where appropriate in face to face forums as with the international nurses' induction programme. This has included IPC practices with regard to COVID-19 and other alert organisms.

In response to higher than expected cases of *Clostridioides difficile* infections, a training package is being reinforced with clinical staff.

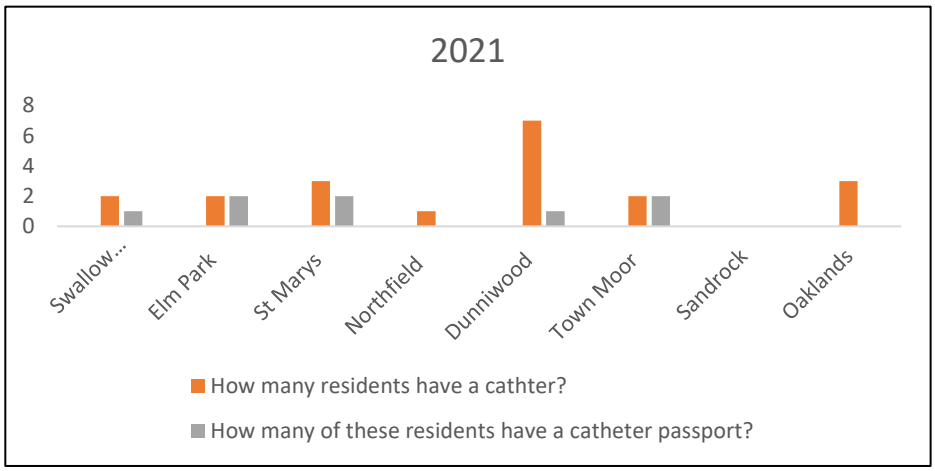
IPC Education has been delivered on the Foundations of Care programme for Healthcare Support Workers, International Nurses programme and the link nurse education/training meetings have continued throughout the year.

Audit

Infection Prevention and Control elements are included in the weekly and monthly auditing undertaken by ward/Department managers and matrons via the Tendable system. The Infection Prevention and Control Team undertake regular auditing of the Environment and elements relating to care via the Tendable System. These include monthly hand hygiene audits, VIP scores, PICC line surveillance, PPE, Urinary catheter care and Antibiotic audits. All clinical areas received an environmental audit in 2023-2024.

Other activities include:

The IPC team worked with a local company in 2022-2023 to trial port free cannulae in order to implement in 2023-2024. Implementation is currently underway.

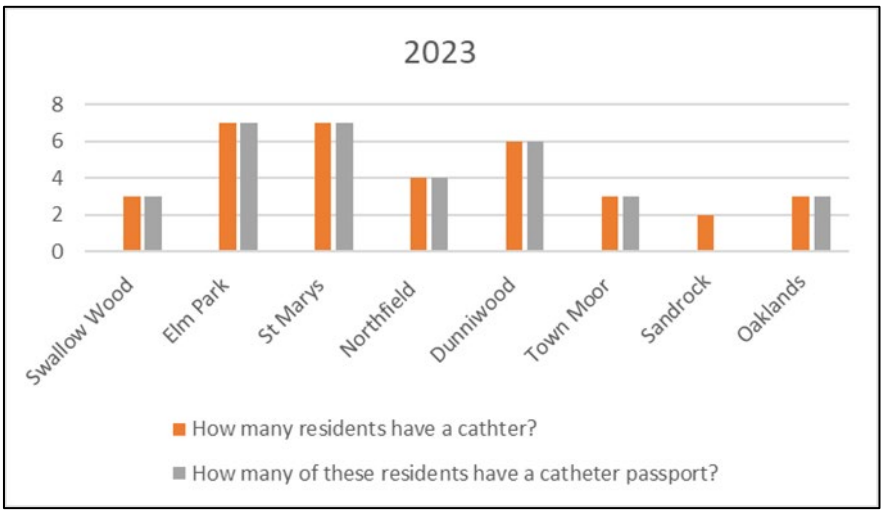


In 2021, DBTH IPC team started a project to help relaunch the catheter passport across acute and community settings with the hope of improving communications between professionals with regards to catheter care and the aim of reducing urinary tract infections. The passport was officially re launched in April 2022, along with input from RDASH colleagues and has remained a focus through 2023-2024.

In 2021, the IPC team found only one ward across the DBTH sites to have a supply and stock of Catheter Passports. In 2023, when re auditing, the IPC team found that 20 areas across DBTH had ordered Catheter Passports over the year since the re-launch, with some areas ordering more than one supply

as they stock and supply to several areas.

When looking at care homes, to re audit the IPC team focused on 8 homes, 4 nursing homes and 4 residential homes. Some findings are as follows:



Following notification from the UKHSA in July 2023 that Measles was circulating, DBTH began preparations in case of a higher number of cases being seen in the Doncaster area. The Occupational Health Team began reviewing all staff records for evidence of Measles vaccination or immunity. Where there was no evidence, clinics were set up for staff to receive their vaccine. Action cards and publications/posters to raise awareness were put together and disseminated across the organsation.

Working together with local partners (UKHSA City of Doncaster Council, Doncaster Place ICB team and other providers) the IPC service has investgated 10 cases of suspected Measles, four of which have been confirmed as having Measles. This has had significant implications in relation to contact tracing across Doncaster.

The IPC team have supported Trust wide hydration improvement and have supported hydration improvement across the community services that are covered by the service. This is in relation to supporting reduction in gram negative blood stream infections.

In order to promote sustainability and appropriate use of resources, the Infection Prevention and Control Team have undertaken an evaluation of antimicrobial curtains in 2023-2024. They have also advised on various procurement projects including Sharps management.

Summary

This report has provided the Trust Board with evidence of the measures in place that make a significant contribution to improving infection prevention and control practices across the Trust through a year of increased demand and pressure on the NHS and the Trust. The report has detailed the continuing progress against the Action Plan for 2023/24 in reducing HCAI rates for the Trust and the key priorities include:

- Continued focus on the reduction of all reportable Trust HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices to continue to prevent HCAIs and as we continue to live with COVID-19 and other Acute Respiratory Viruses.
- Continued focus on antimicrobial stewardship (AMS), reducing the impact of antimicrobial resistance (AMR), and ensuring our Trust antimicrobial guidelines are regularly updated in reflects NICE clinical guidelines.
- Continued strategy in reduction in Gram-negative blood stream infections and in particulars those associated with indwelling urinary catheter.
- Continue to implement strategy and effective antimicrobial stewardship geared towards reduction *Clostridioides difficile* infections and risk of contamination of hospital environments.
- Continued to monitor other high risk infectious disease alert pathogens such as *Mycobacterium tuberculosis*, mpox, measles, pertussis, viral hemorrhagic fever, CJD and thus reduce the risk to patients and HCWs
- Monitor decontamination services and reducing the risk of infection or transmission especially with the dental chairs situation at Montagu Hospital.
- Continue to monitor and manage water safety Trust-wide.
- Continue to improve and sustain the works of the ventilation safety group within the trust to meet the challenges of air exchange quality and in preventing transmission of respiratory viruses in clinical care areas and changes in care pathways across the Trust.
- Sustain progress with education, training and audit relating to infection prevention and control practices, and ensure all trust IPC policies are up to date.
- Maintaining a clean and safe environment for patients and staff by collaborative working with Estates and Facilities team to ensure optimal cleaning schedules, deep cleaning, waste management, medical technology, transport, linen services and Health & Safety within the Trust.

Appendix 1: Breakdown of Trust acquired C. difficile cases by ward and division 2023-24

Duplicate	FALSE
Year	2023/24
MESS Organisn	C.diff

ount of Episod			Month												
Category	Division	Location	2023/04	2023/05	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	Grand Total
HOHA	Surgery and Cancer	DR26	2		1					1					4
		DR9						1							1
		DRS11						1			3				4
		DR19		1			1						1		3
	Surgery and Cancer Total		2	1	1		1	2		1	3		1		12
	Clinical Specialities	DRDCC		1	1										2
	Clinical Specialities Total			1	1										2
	Medicine	CCUC2							1						1
		DGA4							1			2		1	4
		DGA5									1		1		2
		DGC1						1	1	1				1	4
		DR16				1						1			2
		DR17				1		1							2
		DR18			1										1
		DR20				2									2
		DR22			1	1									2
		DR24									2			1	3
		DR25		1	1										2
		DR32			3	1									4
		DRASSM												1	1
		DRKIN								1					1
		MALL			1										1
		RHB1									1				1
		STIR		1											1
		DRKES											1		1
	Medicine Total			2	7	6		2	3	2	4	3	2	4	35
	Urgent and Emergency Care	DGATC					1								1
		DRASSM				1	2		1				1		5
	Urgent and Emergency Care Total					1	3		1				1		6
HOHA Total			2	4	9	7	4	4	4	3	7	3	4	4	55
COHA	Surgery and Cancer	DGB5		1											1
		DR26			1								1		2
		DRS12											1		1
		DR19											1		1
		DR7				1									1
	Surgery and Cancer Total			1	1	1							3		6
	Medicine	DGC1											1		1
		DR21											1		1
		DR22											1		1
	Medicine Total												3		3
	Urgent and Emergency Care	DRASSM											1		1
	Urgent and Emergency Care Total												1		1
COHA Total				1	1	1							7		10
Grand Total			2	5	10	8	4	4	4	3	7	3	11	4	65

Appendix 2: Trust-attributed MSSA BSI cases by ward and division for 2023/24

Trust Infections

Duplicate	FALSE
Year	2023/24
MESS Organism	MSSA

Count of Episode			Mont											
Category	Division	Locati	2023/04	2023/05	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	Grand Total
HOHA	Medicine	CCUC2				1									1
		DGA4						1							1
		DGA5	1												1
		DGC1	1	1				1					1		4
		DR17				1						1			2
		DR18												1	1
		DR20						1			1				2
		DR21						2							2
		DR24	2							1					3
		DR25				1									1
		DR32	1		1				1		1				4
		DRCCU			1				1						2
		DRKIN						1							1
		KEST												1	1
		MALL					1								1
		STIR								1					1
	Medicine Total		5	1	2	3	1	6	2	2	2	1	1	2	28
	Surgery and Cancer	DR26										2			2
		DR27							1						1
		DR8							1						1
		DR9			1	1									2
		DRS10						1					1		2
		DRS12										1			1
		DR7									1	1			2
	Surgery and Cancer Total				1	1		1	2		1	4	1		11
	Urgent and Emergency Care	DRASSM						1							1
	Urgent and Emergency Care Total							1							1
HOHA Total			5	1	3	4	1	8	4	2	3	5	2	2	40
COHA	Medicine	DGA4									1				1
		DR18												1	1
		DR32									1			1	2
		MALL										1			1
	Medicine Total										2	1		2	5
	Surgery and Cancer	DR26					1								1
	Surgery and Cancer Total						1								1
	Urgent and Emergency Care	DGATC						1	1						2
		DRAE	1		1										2
	Urgent and Emergency Care Total		1		1			1	1						4
COHA Total			1		1		1	1	1		2	1		2	10
Grand Total			6	1	4	4	2	9	5	2	5	6	2	4	50

Appendix 3: Gram-negative Bloodstream infection >2 days after admission by ward and division

Year	2023/24
MESS Organism	Pseudomonas aeruginosa

Count of Episode			Mont												
Category	Division	Location	2023/04	2023/05	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	Grand Total
HOHA	Clinical Specialities	DRDCC				1									1
	Clinical Specialities Total					1									1
	Surgery and Cancer	DR26									1				1
		DRS11									1				1
		DR19			1							1			2
	Surgery and Cancer Total				1						2	1			4
	Medicine	DRCCU							1						1
		RHB2			1										1
		DR18										1	1		2
	Medicine Total				1				1			1	1		4
	Urgent and Emergency Care	DRASSM						1							1
	Urgent and Emergency Care Total							1							1
HOHA Total					2	1		1	1		2	2	1		10
COHA	Surgery and Cancer	DR26				1									1
	Surgery and Cancer Total					1									1
	Medicine	DGA4										1			1
		DR18										2	1		3
	Medicine Total											3	1		4
	Urgent and Emergency Care	DRAE									1				1
		DRASSM			1				1						2
	Urgent and Emergency Care Total				1				1		1				3
COHA Total					1	1			1		1	3	1		8
Grand Total					3	2		1	2		3	5	2		18

Year	2023/24
MESS Organism	Klebsiella sp

Count of Division			Mont												
Category	Division	Location	2023/04	2023/05	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	Grand Total
HOHA	Clinical Specialities	DRDCC						2			2				4
		DGITU			1										1
	Clinical Specialities Total				1			2			2				5
	Surgery and Cancer	DR26								1	2	1			4
		DR27											1		1
		DR19			1										1
	Surgery and Cancer Total				1					1	2	1	1		6
	Children and Families	DRMB										1			1
	Children and Families Total											1			1
	Medicine	DR24											1		1
		DR21												1	1
		DR32								1		1			2
		DGA4							1						1
		DR25									1				1
		KEST	1						1						2
		CCUC2			1										1
		DGA5			1										1
	Medicine Total		1		2				2	1	1	1	1	1	10
	Urgent and Emergency Care	DRASSM			1						1		1		3
		DGATC						1							1
	Urgent and Emergency Care Total				1			1			1		1		4
HOHA Total			1		5			3	2	2	6	3	3	1	26
COHA	Surgery and Cancer	DRAE												1	1
		DRS10			1										1
		DR26		1											1
		DRS12						1							1
	Surgery and Cancer Total			1	1			1						1	4
	Children and Families	DRG5										1			1
	Children and Families Total											1			1
	Medicine	DGAE												1	1
		DR24							1						1
		STIR					1								1
		KEST							1						1
	Medicine Total						1		2					1	4
	Urgent and Emergency Care	DRAE							1						1
	Urgent and Emergency Care Total								1						1
COHA Total				1	1		1	1	3			1		2	10
Grand Total			1	1	6		1	4	5	2	6	4	3	3	36

Appendix 4 - Hospital acquired MRSA colonisation cases detected 2023-24.

how_acquired	Hospital Acquired Infection
description	MRSA Colonisation

Count of description		hort_c												
division_name	WardName	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	Grand Total
Children and Families	NEONATAL UNIT DRI				1									1
Children and Families Total					1									1
Medicine	Ward A4						1							1
	Ward A5									1				1
	Ward 17										1			1
	Ward 18 - HAEMATOLOGY								1					1
	Ward 25										1			1
	REHAB 1										1			1
Medicine Total							1		1	1	3			6
Surgery and Cancer	ST LEGER WARD (Wards 7, 8 and 9)						1							1
	Ward 20		1	1										2
	Ward 22			1						1				2
Surgery and Cancer Total			1	2			1			1				5
Clinical Specialties	DEPT OF CRITICAL CARE			1								1		2
Clinical Specialties Total				1								1		2
Grand Total			1	3	1		2		1	2	3	1		14

Appendix 5 - Hospital acquired *E. coli* bloodstream infection (*E. coli* BSI) 2023-24.

Year	2023/24
MESS Organism	E.coli

Count of Episode			Mont												
Category	Division	Location	2023/04	2023/05	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	Grand Total
HOHA	Children and Families	DGA2	1												1
		DRG5	1												1
		DRM2							1						1
	Children and Families Total		2						1						3
	Clinical Specialities	DGITU							1		1				2
	Clinical Specialities Total								1		1				2
	Medicine	DGA5						1			1	2			4
		DR16					1						1		2
		DR17						1		1				1	3
		DR18					1		1				1		3
		DR20										1			1
		DR21									1		1		2
		DR24								3					3
		DR25		1								1			2
		DR32					1								1
		DRKIN				1	1			1					3
		KEST	1										1		2
		RHB1												1	1
		RHB2									1				1
		DRKES												1	1
	Medicine Total		1	1		1	4	2	1	5	3	4	4	3	29
	Surgery and Cancer	DR1											1	1	2
		DR25							1						1
		DR26				1				1	1	3			6
		DR27			1					1					2
		DR3				1									1
		DR9			1										1
		DRS10									1	1			2
		DRS11										1			1
		DRS12	1			1		1							3
		DR19					1				1				2
	Surgery and Cancer Total		1		2	3	1	1	1	2	3	5	1	1	21
	Urgent and Emergency Care	DGATC					1								1
		DRASSM			2		1					2			5
	Urgent and Emergency Care Total				2		2					2			6
HOHA Total			4	1	4	4	7	3	4	7	7	11	5	4	61
COHA	Medicine	DGA4		1									1		2
		DGA5											1		1
		DGAE												1	1
		DGC1							1						1
		DR17											1		1
		DR20									1				1
		DR24							2			1			3
		DR32										1			1
		DRKIN	1				1		1						3
		MALL										1			1
		RHB2							1						1
		STIR		1			1								2
	Medicine Total		1	2			2		5		1	3	3	1	18
	Surgery and Cancer	DGB5											1		1
		DR26											1		1
		DR27			1										1
		DR19				1			1		1				3
	Surgery and Cancer Total				1	1			1		1		2		6
	Urgent and Emergency Care	DGAE				1	1								2
		DGATC								1					1
		DRAE			3	2	1			1	1				8
	Urgent and Emergency Care Total				3	3	2			2	1				11
COHA Total			1	2	4	4	4		6	2	3	3	5	1	35
Grand Total			5	3	8	8	11	3	10	9	10	14	10	5	96

Glossary of terms

Antimicrobials	Antibiotics
AWaRe	Access, Watch and Reserve Antibiotics category in the WHO essential medicines list
Bacteraemia	The presence of bacteria in the blood
COVID-19	Coronavirus respiratory infection, highly contagious, high mortality.
C. difficile	The organism most frequently identified as the cause of antibiotic- associated diarrhoea
CLABSI	Central Line Associated Bloodstream Infection
CR-BSI	Catheter Related Bloodstream Infection
Colonisation	The presence of a bacteria on or in the body without causing infection
Dashboard	A way of presenting data in a visual format.
ESBL	Extended-Spectrum Beta-Lactamases are enzymes produced by bacteria, making them resistant to broad-spectrum antibiotics.
MRSA	Methicillin resistant Staphylococcus aureus is a bacterium that is resistant to commonly used antibiotics such as Flucloxacillin.
PIR	Post Infection Review is a systematic review of an incident to determine why it happened and lessons to be learnt.

2409 - F INFORMATION

2409 - F1 BOARD OF DIRECTORS WORK PLAN

Information Item | Rebecca Allen, Director of Strategy, Partnerships & Governance | 12:55

REFERENCES

Only PDFs are attached

F1 - BoD Workplan Live.pdf

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
ANNUAL WORK PROGRAMME FOR THE BOARD OF DIRECTORS

AGENDA ITEM/ACTION	LEAD PERSON / DOCUMENT ORIGINATOR	FREQUENCY	NEXT DUE	07/05/2024	02/07/2024	03/09/2024	05/11/2024	07/01/2025	04/03/2025	COMMENTS
OPENING ITEMS										
Welcome, apologies for absence and declarations of interest	Chair of the Board	Every Meeting	Every Meeting							
Actions from Previous Meetings	Chair of the Board	Every Meeting	Every Meeting							
Chair's Report	Chair of the Board	Every Meeting	Every Meeting							
Chief Executive's Report	Chief Executive	Every Meeting	Every Meeting							
BOARD LEARNING & REFLECTION										
Various (topics to be agreed by Executive Team)	Executive Lead & Presenter	As Req'd	As Req'd	H&WB		Wendy's Story				
STRATEGY, PLANNING & PARTNERSHIPS										
Winter Plan	Chief Operating Officer	Annual	Sep-24							
Annual Business Plan	Chief Financial Officer	Annual	Mar-25							
Financial Plan	Chief Financial Officer	Annual	May-25							
~~(Annual Corporate Objectives for Approval)~~ 2024/2025 Strategic Priorities Success Measures	Deputy Chief Executive	Annual	Jul-24							
~~Corporate Objectives - Quarterly Outcomes~~ Delivery Update 2024/25 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	Sep-24							Change in reporting from Exec Directors Qtly Objectives to Strategic Priorities Success Measures
Board Risk Appetite	Deputy Chief Executive	Annual	May-25							
Review of Strategic Risks	Deputy Chief Executive	Annual	May-25							
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	Nov-24							
Partnership Updates (details TBC)	Deputy Chief Executive	TBC	TBC							
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Executive	TBC	TBC							
Nursing, Midwifery & Allied Health Professionals Strategy 2023/27	Chief Nurse		2027							
People Strategy 2023/27	Chief People Officer		2027							
Research & Innovation Strategy 2023/28	Chief People Officer		2028							
Speaking Up Strategy 2024/28	Chief People Officer		2028							
Tackling Health Inequalities 2023/28	Director of Recovery,		2028							
ASSURANCE & GOVERNANCE										
Board Work Plan (approval)	AD of Strategy, Partnerships &	Annual	May-24							
Board Effectiveness	AD of Strategy, Partnerships &	Annual	Mar-25							
Integrated Quality & Performance Report	COO/CN/EMD/CPO	Every Meeting	Every Meeting							
Financial Position	Chief Financial Officer	Every Meeting	Every Meeting							
Staff Survey Results	Chief People Officer	Annual	Mar-25							
Research & Innovation Bi-annual Report	Chief People Officer	6 monthly	Sep-24							
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	Nov-24							Zoe Lintin & FTSU Guardian agreed new reporting schedule in May 2024 October 2024 (PC) and November 24 (BoD) and then six months later
Chair's Assurance Log - Finance & Performance Committee	F&P Chair	Post Committee	Nov-24		verbal					
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Sep-24							
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Nov-24							
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Nov-24							
Chair's Assurance Log - Charitable Funds Committee	CFC Chair	Post Committee	Sep-24							
Board Assurance Framework & Trust Risk Register	Executive Directors	Qtly	Sep-24							
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships &	Annual	Nov-24							Revert to May 2025/committee review
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships &	Annual	Nov-24							Revert to May 2025/committee review
Terms of Reference - People Committee	AD of Strategy, Partnerships &	Annual	Nov-24							Revert to May 2025/ committee review
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships &	Annual	Nov-24							
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	Jul-25							
Annual Report - Chartable Funds Committee	Chair of CFC	Annual	Nov-24							Revert to June 2025
CORP/FIN 1 - A Standing Orders - Board of Directors	AD of Governance	Annual	Nov-24							Revert to July 2025
CORP/FIN 1 - B Standing Financial Instructions	AD of Governance	Annual	Nov-24							Revert to July 2025
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	Nov-24							Revert to July 2025
CORP/FIN 1 - D Fraud, Bribery and Corruption Policy and Response Plan	Chief Financial Officer	2 Yearly	Mar-26							
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships &	3 yearly	Sep-25							
CORP/COMM 11 - Management of Reviews, Visits, Inspections and Accreditations Policy	AD of Strategy, Partnerships &	2 yearly	Dec-25							
CORP/COMM 25 - Establishment and Administration of Committees Policy	AD of Strategy, Partnerships &	3 yearly	Feb-26							
CORP/FIN 4 - Standards of Business Conduct and Employees Declarations of Interest Policy	AD of Strategy, Partnerships &	3 yearly	Jun-26							
CORP/RISK 30 - Risk Identification, Assessment, and Management Policy	AD of Strategy, Partnerships &	3 yearly	Oct-26							
CORP/COMM 1 - Approved Procedural Documents (APDs) Development and Management Policy	AD of Strategy, Partnerships &	3 yearly	Mar-27							
STATUTORY & REGULATORY										
Maternity & Neonatal Update	Director of Midwifery	Every Meeting	Sep-25							
Maternity Workforce	Director of Midwifery	Bi-annual	Nov-24							
Learning from Deaths	Executive Medical Director	Quarterly	Nov-24		verbal					
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Nov-24							
Workforce Race Equality Standards	Chief People Officer	Annual	May-25							
Workforce Disability Equality Standards	Chief People Officer	Annual	May-25							
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annual	Nov-24							
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Jul-25							
Quality Report	Chief Nurse	Annual	Jul-25							
Going Concern	Chief Financial Officer	Annual	Mar-25							
Trust Seal	AD of Strategy, Partnerships &	As Req'd	Nov-24							
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-25							currently reports directly to BoD
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-24							currently reports directly to BoD
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-24							
INFORMATION										
Work Plan	AD of Strategy, Partnerships &	Every Meeting	Every Meeting							
Appointment of External Auditors	Chief Financial Officer	As Req'd	Sep-24							
Appointment of Internal Auditors	Chief Financial Officer	As Req'd	Sep-24							
CLOSING ITEM										
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting							
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting							
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting							
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting							
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd							

LEGEND KEY - (ensure reason entered in comments column or cell as appropriate)

Presented as planned
Planned for future meeting(s)
Rescheduled for valid reason(s) - as stated
Not considered as planned
Items added to the work plan post agreement - ensure reason entered in comments column

Process for administration of actions logs/work plans:

A review of the work plan administration process has been undertaken. Each Year a Board work plan MUST be assigned a separate worksheet (plan) for each Year. Once agreed, ***no changes to workplan must be added without correct audit trail tracking and comments*** *. If an item has been identified for addition to a workplan then this* ***must*** *be added to the appropriate board/board committee meeting action log so full audit trail is available. Full annotation of whether a report has been to committee or not MUST be logged on to the workplan with appropriate comments as to why and when it will be presented and appropriate colour coding used identified in the legend (see above legend key). An additional column has been added to each work plan at the end headed "comments" to log any required supplementary information for audit/tracking purposes.*

2409 - F2 APPOINTMENT OF INTERNAL & EXTERNAL AUDITORS

Information Item | Jon Sargeant, Chief Financial Officer | 12:55

REFERENCES

Only PDFs are attached

F2 - Appointment of Intenal & External Auditors.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	3 September 2024	**Agenda Reference:**	**F2**
Report Title:	**Appointment of Internal & External Auditors**		
Sponsor:	Jon Sargeant, Chief Financial Officer		
Author:	Rodney Muskett, Interim Deputy Director of Finance		
Appendices:	None		

Report Summary

The Trust Board along with governor colleagues ran a procurement programme to renew its contract for external auditors in 2021. At the time of tender the contract was for a 3-year initial phase with ability to extend the contract for a single year on 2 occasions. The first phase of the contract ends on the 30th September 2024. There is therefore an option to extend the contract for up to two years. The contract allows for a price review if an extension is agreed at the end of each year of the extension. The Audit Committee considered the options over its last two meetings and made a recommendation to the Council of Governors to take up the option to extend the contract under the original tender for those two extra years.

At its Meeting on 11 July 2024 the Council of Governors considered the Chief Financial Officer and Audit Committees recommendation and approved the proposal to take up the 2 year options to extend the contract and to commence the tender process to appoint External Auditors at the end of the two year extension period.

360 Assurance Internal Audit Contract
The Chief Financial Officer has worked with procurement to become a partner organisation in the NHS internal audit provision with a seat on the board for the Trust. This arrangement brings the Trust into line with the rest of our ICS. The Trust will receive a discounted rate as a partner organisation for the service as well as input to the strategy and service provision of the internal audit function going forwards.

The proposal has been considered by the Audit and Risk Committee and supported as a solution to the requirement for the Internal Audit serves for the Trust.

Recommendation:	To note the position relating to the Trust's external and internal audit contracts.			
Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	Information only
Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	*We work together to enhance our services with clear goals for our communities.*	***We are efficient and spend public money wisely.***

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

Implications			
Relationship to Board assurance framework:		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
		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
		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
		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
	X	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
		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
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:	**External Audit is a legal requirement for a Foundation Trust and part of the NHS regulation regime**		
Resources:	**External Audit** this cost is part of the annual budget and fees in line with the tender terms. Internal Audit cost are part of the Annual budget and fees set at the 360 Board with days agreed with the Director of Finance and Audit and Risk Committee.		

Assurance Route	
Previously considered by:	Audit and Risk Committee (for both internal and External Audit) Council of Governors (for External Audit)
Date:	18/4/2024 Audit & Risk Committee 11/7/2024 Council of Governors
Any outcomes/next steps	Contract extension to be issued to the external auditor Tender process to commence for appointment of External Auditors at the end of the two year extension. Consortium agreement with 360 Assurance
Previously circulated reports to supplement this paper:	N/A.

2409 - G CLOSING ITEMS

2409 - G1 MINUTES OF THE MEETING HELD ON 2 JULY 2024

Decision Item | Suzy Brain England OBE, Chair of the Board | 12:55

5 minutes

REFERENCES

Only PDFs are attached

G1 - Public Board of Directors Minutes - 2 July 2024 v2.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 2 July 2024 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 Jo Gander - Non-executive Director Karen Jessop - Chief Nurse Dr Emyr Jones - Non-executive Director Zara Jones - Deputy Chief Executive Dr Nick Mallaband - Acting Executive Medical Director Lucy Nickson - Non-executive Director Richard Parker OBE - Chief Executive Jon Sargeant - Chief Financial Officer Denise Smith - Chief Operating Officer
In attendance:	Rebecca Allen - Associate Director of Strategy, Partnerships & Governance Danielle Bhanvra - Head of Midwifery (agenda item D1) Anthony Jones - Deputy Director of People & Organisational Development Mohammad Khan – Guardian of Safe Working (agenda item D3) Angela O'Mara - Deputy Company Secretary (minutes) Emma Shaheen - Director of Communications & Engagement
Public in attendance:	Gina Holmes - Staff Side Chair Joseph Money - Staff Governor Clive Smith - Public Governor Sheila Walsh - Public Governor
Apologies:	Mark Day - Non-executive Director Zoe Lintin - Chief People Officer Lois Mellor - Director of Midwifery Kath Smart - Non-executive Director

P24/07/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

The Chair welcomed everyone to the virtual Board of Directors meeting, including governors and observers, the above apologies for absence were noted.

Non-executive Director Mark Bailey referenced his recent appointment as a Trustee of Ashgate Hospice, included in the register of director's interests and Non-executive Director Hazel Brand reported a change to committees membership in her role as Councillor at Bassetlaw District Council.

P24/07/A2 **Actions from Previous Meetings**

Action 1 - Health & Wellbeing Offer - verbal updated provided and action to be closed.
Action 2 - Patient Strategic Priority - wording amended and action closed.
Action 3 - Strategic Priorities - paper included at agenda item B1 - action to be closed.
Action 4 - Quality Improvement & Innovation Strategy - updated strategy circulated to Board members on 27 June 2024 - action to be closed.
Action 5 - Focus on Quality Improvement Initiatives on Board ward and departmental visits - the template had been updated - action to be closed.
Action 6 - Integrated Quality & Performance Report - action not yet due.
Action 7 - L2P Medical Appraisal System - action not yet due.
Action 8 - Uptake of Covid and Influenza immunisations - action deferred to the People Committee - Board action to be closed.
Action 9 - Chair's Assurance Log - Finance & Performance Committee – assurance log updated to Team Engine. Action to be closed.
Action 10 - Refresh of Board Assurance Framework - action not yet due
Action 11 - Board Assurance Framework 3 (Operational Performance) - action not yet due.

P24/07/A3 **Chair's Report (Enclosure A3)**

The Chair of the Board provided an overview of her activities, visits, and key events in the Trust calendar since her last report.

The Board:

- ***Noted the Chair's Report***

P24/07/A4 **Chief Executive's Report (Enclosure A4)**

The Chief Executive's report provided an overview of items of interest at a local, system and national level connected to the work of the Trust and aligned to its strategic priorities.

The Board:

- ***Noted the Chief Executive's Report***

P24/07/B1 **Strategic Priorities – Measuring Success (Enclosure B1)**

The Deputy Chief Executive brought the Board's attention to the strategic priorities delivery framework which proposed success measures, aligned to an executive director and Board, or Board Committee. A six monthly progress report would be shared with the Board of Directors, which would replace the previous framework for reporting directors objectives towards delivery of the True North objectives. **ZJ**

The workplans of the Board and its assurance committees would ensure oversight through scheduled agenda items and supported by commentary in the Chair's Assurance Logs.

In response to a question from the Chair of the Board, the Deputy Chief Executive confirmed there was no change in committee oversight responsibilities.

Non-executive Director, Jo Gander sought clarity on the oversight arrangements for the success measure relating to the delivery of clinically effective and efficient services. It was confirmed it would be the Quality & Effectiveness Committee for quality matters and for performance elements, such as Virtual Wards and the Getting it Right First Time programme, the Finance & Performance Committee.

The Board:

- ***Approved the proposed approach for monitoring delivery of the Trust's strategic priorities***

P24/07/B2 **Doncaster & Bassetlaw Healthcare Services Update (Enclosure B2)**

The Chief Financial Officer provided an update on the financial performance and operational activity of Doncaster & Bassetlaw Healthcare Services (DBHS) Limited. A pre-tax profit of £98K was reported for 2023/24 and as at 31 May 2024 performance continued to be favourable to plan.

The 2023/26 strategic plan referenced the five strategic pillars and associated work related to pharmacy, education and resource, homecare services, digital innovation, and social and charitable causes.

The Managing Director of DBHS highlighted the current contract with the Trust ran until October 2026. A dividend payment was made to the Trust in 2023 and a decision would be taken at the next subsidiary Board meeting regarding the potential to pay a dividend in 2024.

In respect of the acquisition of homecare services, the Chief Financial Officer acknowledged the support and learning opportunities available as part of the development of Trust wide tenders.

The Board of Directors would continue to receive a quarterly update relating to the business of its wholly owned subsidiary, Doncaster & Bassetlaw Healthcare Services.

The Board:

- ***Noted and took assurance from the Doncaster & Bassetlaw Healthcare Services Update***

P24/07/C1 **Integrated Quality & Performance Report (Enclosure C1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to access, quality, and workforce standards for May 2024. The refreshed format included an executive summary, key performance indicators, assurance reports and a summary of future developments of the IQPR.

The Chief Operating Officer brought the Board's attention to the impact of sustained high demand on the emergency care pathways, the Trust continued to collaborate with system partners to drive improvements. In respect of cancer, the faster diagnosis and 31 day decision to treatment standards had been met; whilst the 62 day referral to treatment standard had not been achieved, the Trust's performance was above the national position.

The Chief Nurse confirmed that work on the quality dashboard was in progress. The 2024/25 national C.difficile threshold remained unconfirmed but was expected to be challenging. The current level of infection was below the 2023/24 threshold.

Both reported never events had been resolved from a patient perspective and the completed patient safety incident investigations would be presented to the Board's Quality & Effectiveness Committee for assurance. The never event framework was currently under review, with feedback awaited from the consultation.

The Acting Executive Medical Director reported good progress on e-job planning, with further improvements expected following the new system go live date in August 2024. The combined Hospital Services Mortality Rate (HSMR) stood at 109 and disease level structured judgement reviews had been undertaken to identify and understand any themes. The reporting of Venous thromboembolism (VTE) risk assessments was now live following the implementation on WellSky®, with 92% achieved against the 95% target. The need to integrate remaining paper based records, such as the theatre checklist to an electronic version was noted.

The Deputy Director of People & Organisational Development confirmed that since the paper had been written the statutory and essential training compliance had increased to 88.56%. The Trust was now in the final month of the non-clinical appraisal season and the current rate exceeded that seen at this point in 2023 by 16%. 55.37% of appraisals had been completed and recorded and action plans were in place to meet the 90% standard. As in previous years it was expected that completion rates would increase during July as objectives were cascaded through the management structure.

In response to a question from Non-executive Director, Hazel Brand with regards to plans to report time to hire for non-Agenda for Change colleagues. The Deputy Director of People & Organisational Development confirmed this would not be extended to medical recruitment due to the differing pathways which required the support of external bodies and was outside of the organisation's control.

Non-executive Director, Mark Bailey confirmed plans to expand the range of people data reported and the Deputy Director of People & Organisational Development would establish a set of key performance indicators for inclusion within the IQPR.

In response to a question from Non-executive Director, Lucy Nickson in relation to the steps taken to ensure the publicly available content was understandable, the Director of Communications & Engagement recognised the importance of appropriate supporting narrative. In addition, where multiple reports were available at a trust, Place and system level the Chief Executive acknowledged the benefits of bringing together key information in a simplified way, which allowed comparisons to be made. Alongside the information shared at the Board of Directors, there was a quarterly Council of Governors meeting held in public which considered the Trust's achievement of key performance standards.

The Board:

- ***Noted and took assurance from the Integrated Quality & Performance Board***

P24/07/C2 **Financial Position & Financial Plan Update (Enclosure C2)**

The Chief Financial Officer reported a year to date deficit at month two of £8.8m, £1.4m adverse to plan. The position was largely due to an underperformance against elective income of £1.3m and a pay overspend of £800k, partly offset by an underspend on independent sector work of £700k. There would be a refocus on efficiency and effectiveness led by the Chief Executive and the Chief Operating Officer was working closely with the Orthopaedic Team to address the elective underperformance, support was being received from the national Getting It Right First Time team and the use of temporary staffing was being scrutinised.

The cash balance at month two was £16.8m. A change to the cash support regime was expected in July, when money would be received via the Integrated Care Board as part of the contract, the mechanics of which were being worked though.

The total year to date capital spend was £2,864k, £2,418k of which related to the purchase of robotic equipment through charitable funds.

With regards to the refocus on the efficiency and effectiveness of the organisation, Non-executive Director, Lucy Nickson enquired what form this would take and what was expected on a monthly basis. The Chief Financial Officer confirmed the various gateways for delivery were currently being established with the Transformation Board being reformed as the Efficiency & Effectiveness Committee. There was a need to address underperformance, including the impact on urgent and emergency care activity on elective performance, however, the number one priority remained patient safety.

The Board:

- *The Board noted the financial position and financial plan update*

P24/07/C3 **Response to the Outcome of the Infected Blood Inquiry (Enclosure C3)**

The Acting Executive Medical Director shared with the Board the Trust's compliance with the recommendations of the national inquiry and those actions planned to ensure full compliance.

Progress against the actions would be monitored via the Medical Director's Office and reported to the Quality & Effectiveness Committee.

In response to a question from Non-executive Director, Emyr Jones, regarding the support required to roll out the electronic tracking of blood products, the Acting Executive Medical Director confirmed the trust wide roll out was being prioritised by IT, there was excellent colleague engagement and good progress was being made.

The Chair of the Board welcomed the report and acknowledged the importance of objectively assessing the Trust's practice and acting on the identified learning.

The Board:

- ***Noted and took assurance from the Response to the Outcome of the Infected Blood Inquiry***

P24/07/C4 **Chair's Assurance Log – Quality & Effectiveness Committee Enclosure C4)**

Jo Gander, Chair of the Quality & Effectiveness Committee provided an overview of the four quadrants of the assurance log, positive assurance, areas of major works, areas of focus and decisions made.

Following a review of the Trust's paediatric audiology services the Trust had embarked upon a significant programme of work to improve practice and procedures in line with recommendations. Support was being received from the regional team and mitigating actions had been taken to ensure delivery of a safe service. An unexpected delay to progress was noted, arising from the implementation of a new software solution which required a reassessment of records to take place.

In terms of complaint handling, the Committee agreed a revision to its internal response deadline, for which divisions would be held accountable, and aligned its reporting metric to that of the Parliamentary Health Service Ombudsman.

The Board:

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

P24/07/C5 **Chair's Assurance Log – People Committee (Enclosure C5)**

Mark Bailey, Chair of the People Committee provided an overview of the four quadrants of the assurance log, positive assurance, areas of major works, areas of focus and decisions made.

Progress against the People Strategy delivery plan was noted, with strong evidence of colleague engagement evident from the findings of the staff survey.

In terms of areas to improve, further work was required to reduce the time to close casework files and whilst the Committee was assured that an appropriate risk based framework was in place for the violence prevention and reduction standard, more evidence was required to seek assurance on actions to address/reduce incidents.

The Board:

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

P24/07/C6 **Chair's Assurance Log – Finance & Performance Committee (Enclosure C6)**

In the absence of the Chair of the Finance & Performance Committee, Non-executive Director, Mark Bailey provided a verbal update from the meeting of 25 June 2024, supported by the Chief Financial Officer.

The Committee had been appraised on the work of the Getting It Right First Time Programme, a lessons learnt review of 2023/24 winter plans and discussions relating to the utilisation of the Mexborough Elective Orthopaedic Centre. Alongside the regular monthly financial and performance reports the Estates and Facilities annual performance report highlighted key performance indicators relating to its broad portfolio of work and its people.

A written copy of the assurance log would be provided post meeting and uploaded to the portfolio of papers.

The Board:

- ***Noted and took assurance from the verbal update***

P24/07/C7 **Chair's Assurance Log – Audit & Risk Committee (Enclosure C7)**

In the absence of the Chair of the Audit & Risk Committee, Non-executive Director, Jo Gander provided an overview of the four quadrants of the Chair's assurance log, positive assurance, areas of major works, areas of focus and decisions made.

Work arising from the corporate governance audit was ongoing, Committee Chairs would meet with the Associate Director of Strategy, Partnerships & Governance to review workplans and terms of reference.

A comprehensive overview of the Trust's 2023/24 emergency preparedness, resilience and response plans had been received, progress to date was noted and a further review would take place during the Autumn of 2024.

The Board was informed of decisions taken at the year-end meeting relating to the annual governance statement, annual report and accounts and the Committee's annual report. In view of the efforts to complete the year end work in a timely manner, agreement had been reached to defer the review of the Standing Financial Instructions, Standing Orders and Reservation of Powers to the Board and Delegation of Powers to September's meeting.

The Board:

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

P24/07/C8 **Chair's Assurance Log – Charitable Funds Committee Enclosure C8)**

The Charitable Funds Committee scheduled for 1 July had been postponed until 16 July 2024, as such the Chair's Assurance Log would be presented to September's Board meeting.

P24/07/C9 **Audit & Risk Committee Annual Report (Enclosure C9)**

In the absence of the Chair of the Audit & Risk Committee, Non-executive Director, Jo Gander provided an overview of the Audit & Risk Committee Annual Report.

The Board:

- ***Noted and took assurance from the Audit & Risk Committee Annual Report***

P24/07/C10 **Compliance with the Provider Licence Continuity of Service Condition – CoS7 (Enclosure C10)**

The Board reviewed and approved the statement of compliance relating to the Continuity of Service condition (CoS7) of the Provider Licence. The going concern principle had been reported to the Finance & Performance Committee and following the addition of the Chair and Chief Executive's signatures, the declaration would be uploaded to the Trust's website.

The Board:

- ***Approved the compliance declaration related to the Provider Licence Continuity of Service Condition – CoS7***

P24/07/D1 **Maternity & Neonatal Update (Enclosure D1)**

The report provided an overview of the progress made against the national standards within maternity and neonatal services. The format of the report had been revised in accordance with NHSE recommendations and aligned to the requirements of the Clinical Negligence Scheme for Trusts (CNST).

Work in relation to Year 6 CNST standards was ongoing and currently safety actions were on track to declare full compliance in March 2025. A change in guidance relating to the British Association of Perinatal Medicine (BAPM) national standards was currently being worked through.

The transitional care action plan had been revisited and refreshed in line with Year 6 standards and approval was sought and provided by the Board.

In their capacity as Board level maternity safety champions Non-executive Directors Jo Gander and Emyr Jones continued to be actively engaged with the service and recognised the dedication and open, honest, and constructive dialogue with colleagues.

With regards to the impact of negative national press on maternity services, Non-executive Director, Hazel Brand enquired of opportunities to share local good news stories, which the service confirmed they worked closely with the Communications & Engagement Team to facilitate.

Following her attendance at an internationally educated event, Hazel Brand enquired of the support available to international midwives, which encompassed a variety of sources including the Workforce Matron, Practice Development Midwife, Professional Maternity Advocate, and pastoral support.

The Head of Midwifery presented the midwifery workforce report, which provided assurance for the period Quarter 3-4 2023/24 related to an effective system of midwifery workforce planning and monitoring of safe staffing levels. A summary of key workforce measures for obstetricians and anaesthetics was also provided relating to Year 6 of the Maternity Incentive Scheme.

Non-executive Director, Mark Bailey acknowledged the significant interest from newly qualified midwives and recognised colleagues efforts to proactively engage with prospective colleagues to retain their interest. The Chief Nurse welcomed the positive feedback and highlighted the support required from the existing team to integrate the new colleagues into the service.

The Chief Executive reflected on the Board's commitment to work towards achievement of the national Birthrate Plus® standard, despite not being fully funded. The level of interest from newly qualified midwives was uplifting, particularly considering the impact of high profile national maternity safety review. The importance of delivering the required improvement actions was noted.

The Board:

- ***Noted and took assurance from the Maternity & Neonatal Update including the Q47 perinatal mortality report***
- ***Approved the revised transitional care action plan***
- ***Took assurance from the Maternity Workforce report***

P24/07/D2 **<u>Learning from Deaths</u>**

The Acting Executive Medical Director provided a verbal update, which confirmed a total of twenty colleagues had now been trained to undertake Structured Judgement Reviews (SJR). To date, a limited number of reviews had been returned in Quarter 1, aside from the SJRs, learning from sepsis related deaths had been established which identified specific areas of focus including the sampling of blood cultures and delivery of antibiotics. A formal learning from deaths report would be considered by the Quality & Effectiveness Committee before reporting to the Board of Directors.

In response to a question from Non-executive Director, Lucy Nickson, the Acting Executive Medical Director confirmed the Trust was an outlier for Hospital Standardised Mortality Ratio (HSMR) and further work was required to understand the reasons why the Trust's rate remained above 100. The impact of local health inequalities was recognised,

including respiratory disease and disease specific mortality reviews would further develop understanding.

Non-executive Director, Emyr Jones stressed the importance of translating learning into sustained systemic change in practice. The need to increase the number of SJRs to extract the learning was acknowledged.

P24/07/D3 **Guardian of Safe Working Quarterly Report (Enclosure D3)**

The Chair of the Board welcomed the Guardian of Safe Working to his first Board meeting.

During the period February to April 2024 a total of 67 exception reports were received from junior doctors in training across General Medicine, Obstetrics/Gynaecology and Paediatrics. The majority of reports related to additional hours worked, reflecting the high workload of junior doctors. An update would be provided in the next Board report relating to the two exception reports relating to immediate safety concerns. **MK**

The Chief Executive encouraged exception reporting and welcomed the current engagement to raise awareness and remove barriers. Discussions between the Guardian of Safe Working and the Chief People Officer had taken place regarding supervisor support, to ensure a streamlined process with an escalation route, where required. The Acting Executive Medical Director noted there had been no recent evidence of reporting being discouraged.

In response to a question from the Chief Nurse regarding exception reporting from the GP training scheme, the Guardian highlighted the educational focus of such placements and the reduced likelihood of exception reporting, but agreed to establish where such information would be received.

The Board:

- ***Noted and took assurance from the Guardian of Safe Working Quarterly Report***

P24/07/D4 **Workforce Race Equality & Disability Equality Standards (Enclosure D4)**

The 2023/24 annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submission was received for information. A revision to the national deadline had resulted in the submission being shared with the Trust Leadership Team before remote approval by members of the People Committee.

An improving picture was noted, where areas of continued focus were highlighted these were included with the Equality, Diversity and Inclusion action plan which also incorporated NHSE's high impact actions. Delivery against this action plan was monitored by the Equality, Diversity & Inclusion Committee and overseen by the People Committee.

In addition to the data reported for Black and Minority Ethnic (BME) applicants, shortlisted candidates, and appointees it was suggested it would be helpful to receive a career development comparison for BME and white colleagues. The importance of evidencing the positive impact of race discrimination, rather than reporting the position was encouraged.

The Trust's governor election process would commence shortly and nominations were invited from the diverse communities served by the Trust.

The Board:

- ***Noted the Workforce Race Equality & Disability Equality Standards***

P24/07/D5 **2023/24 Annual Report & Accounts, including Annual Governance Statement and Quality Accounts (Enclosure D5)**

The Board received 2023/24's final annual report and accounts, letter of representations and Quality Accounts for noting.

The Audit & Risk Committee had scrutinised the draft report and subject to the incorporation of non-material amendments, recommended by the external auditors, authority for approval had been delegated to the Chief Executive.

The annual report and accounts had been submitted to NHSE on 28 June 2024 and would be received at the Trust's Annual Member Meeting; a pre-recording of which would be made available at 6pm on 26 September 2024. Members of the public would be invited to raise questions to be answered as part of this meeting.

The Chief Financial Officer acknowledged the following achievements: delivery of 2023/24's financial plan, the auditors clean opinion that the financial statements provided a true and fair view of the financial position and the accepted position as a going concern.

The efforts of colleagues were recognised in the preparation of the annual report and accounts.

The Board:

- ***Noted the 2023/24 Annual Report & Accounts, including Annual Governance Statement, Letter of Representations and Quality Accounts***

P24/07/D6 **Use of Trust Seal (Enclosure D6)**

The report confirmed the application of the trust seal in relation to an extension to lease, approved by the Chief Financial Officer and Chief Executive.

The Board:

- ***Noted the Use of the Trust Seal***

P24/07/D7 **Estates Return Information Collection 2023/24 (Enclosure D7)**

The Board received the 2023/24 national return for approval. The return provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and supports work to improve efficiency. The increasing complexity of the return was noted.

Despite expenditure of c.£9m, the backlog maintenance had reduced by only c.£3m.
A slight increase had been seen in capital expenditure in 2023/24, with £21m invested in the capital projects which included the Mexborough Elective Orthopaedic Centre, Community Diagnostic Centre and Bassetlaw Emergency Care Village.

The Board:

- ***Approved the Estates Return Information Collection 2023/24***

P24/07/E1 **Board of Directors Workplan (Enclosure E1)**

The Board:

- ***noted the Board of Directors Workplan***

P24/07/F1 **Minutes of the meeting held on 7 May 2024 (Enclosure F1)**

The Board:

- ***Approved the minutes of the meeting held on 7 May 2024***

P24/07/F2 **Pre-submitted Governor Questions regarding the business of the meeting (verbal)**

No questions had been received prior to the meeting; the Chair of the Board invited any questions post meeting to be submitted to the Trust Board Office for a written response to be provided. Governor question and answers would continue to be available via the governor portal and provided for information at the Council of Governors meeting.

P24/07/F3 **Any other business (to be agreed with the Chair prior to the meeting)**

On 26 June 2024 NHSE wrote to all trusts to highlight the need to maintain focus and oversight of the quality of care and experience in pressurised services.
It was recognised that the sustained national pressure across services had impacted the standard of service provided and all Trust Boards were asked to assure themselves that all efforts were being made to work with system partners to provide alternative solutions to emergency department attendance and admission and to maximise in-hospital flow with senior decision making and board and ward rounds.

Assurance on six action points was required, which would be considered at this month's Urgent & Emergency Care Board, to be reported to the Board's Finance & Performance Committee.

P24/07/F4 **Date and time of next meeting (Verbal)**

Date: Tuesday 3 September 2024
Time:
Venue: MS Teams

P24/07/F5 **Withdrawal of Press and Public (Verbal)**

The Board:

- ***Resolved 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.***

P24/07/E **Close of meeting (Verbal)**

The meeting closed at 11:54

2409 - G2 PRE-SUBMITTED GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 13:00

10 minutes

2409 - G3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 13:10

10 minutes

2409 - G4 DATE AND TIME OF THE NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 13:20

Date: Tuesday 5 November 2024
Time: 09:30
Venue: MS Teams

2409 - G5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Suzy Brain England OBE, Chair of the Board | 13:20

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.