Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING

BOARD MEETING

5 November 2024

09:30 GMT Europe/London

Virtual - MS Teams

AGENDA

2411 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 5 November 2024 v3.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 5 November 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	Frailty Services at DBTH *Dr Victoria Barradell, Consultant Geriatrician*	*Assurance*		15
C	**STRATEGY, PLANNING & PARTNERSHIPS**			**10:15**
C1	Winter Planning 2024/25 *Denise Smith, Chief Operating Officer*	*Approve*		5
C2	Doncaster & Bassetlaw Healthcare Services Update *Jon Sargeant, Chief Financial Officer*	*Assurance*		5
C3	NHS Nottingham & Nottinghamshire Integrated Care Board Forward Plan Update *Zara Jones, Deputy Chief Executive*	*Note*		5

D	**ASSURANCE & GOVERNANCE**			**10:30**
D1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
D2	Financial Position Update *Jon Sargeant, Chief Financial Officer*	*Note*		10
BREAK 11:00 – 11:10				
D3	Audiology Service Update *Zara Jones, Deputy Chief Executive*	*Note*		20
D4	Freedom to Speak Up Bi-annual Report *Zoe Lintin, Chief People Officer* *Paula Hill, Freedom to Speak Up Guardian*	*Assurance*		10
D5	Board Assurance Framework *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Assurance*		20
D6	Committee Terms of Reference & Dates Proposal *Rebecca Allen, Associate Director Strategy, Partnerships & Governance*	*Approve*		10
D7	Chair's Assurance Log – Finance & Performance Committee *Mark Day, Non-executive Director*	*Assurance*		5
D8	Chair's Assurance Log – Quality & Effectiveness Committee *Jo Gander, Non-executive Director*	*Assurance*		5
D9	Chair's Assurance Log – People Committee *Mark Bailey, Non-executive Director*	*Assurance*		5
D10	Chair's Assurance Log - Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*		5
D11	Chair's Assurance Log – Charitable Funds Committee *Hazel Brand, Non-executive Director*	*Assurance*		5
D12	Charitable Funds Committee Annual Report 2023/2024 *Hazel Brand, Non-executive Director*	*Assurance*		5
E	**STATUTORY & REGULATORY**			**12:40**
E1	Guardian of Safe Working Report *Zoe Lintin, Chief People Officer* *Mohammad Khan, Guardian of Safe Working*	*Assurance*		10
E2	Maternity & Neonatal Update *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery*	*Assurance*		10
E3	Learning from Deaths *Dr Nick Mallaband, Acting Executive Medical Director*	Assurance		10

BREAK 13:10 – 13:20				
E4	Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards *Denise Smith, Chief Operating Officer*	*Assurance*		5
E5	Board of Directors Register of Interest & Fit & Proper Person Test *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Note*		5
E6	Use of Trust Seal *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Note*		5
F	**INFORMATION**			**13:35**
F1	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-
G	**CLOSING ITEMS**			**13:35**
G1	Minutes of the meeting held on 3 September 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 7 January 2025 **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**			**14:00**

*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

2411 - 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 (4.11.2024).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 Director 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
Supports the Board and Officers of NHS Retirement Fellowship as a consultant

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

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)
Visiting Fellow – Cranfield University
Chair of the Board & Charity Trustee – NHS Retirement Fellowship

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

(as at 4 November 2024)

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

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

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)

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance
Scorer - Advisory Committee on Clinical Impact Awards
Committee Member of East Midlands Branch of Chartered Governance Institute
Vice Chair, Stow Parish Council
Vice Chair of the Governing Body & Chair of Finance & Personnel Committee at Saxilby Church of England Primary School

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 4 November 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 4 November 2024)

2411 - 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 - 3 September 2024.pdf

A2 - Action - Medical Appraisals L2P Implementation.pdf

Action notes prepared by: Angela O'Mara
Updated: 30 October 2024

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	3 September 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/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 to be closed**.
2.	**P24/05/D1**	**L2P Medical Appraisal system** – to provide post implementation feedback to the Board of Directors	**NM**	**November 2024**	**Update 30/10/2024 –** paper appended to the action log
3.	**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 – **action to be closed.**

Action notes prepared by: Angela O'Mara
Updated: 30 October 2024

No.	Minute No.	Action	Responsibility	Target Date	Update
4.	**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 – **action to be closed.**
5.	**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 – **action to be closed.**
6.	**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**	**Update 30/10/2024** - included within the Guardian of Safe Working Report @ agenda item E1

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**A2**
Report Title:	**Medical Appraisals – post implementation of L2P**		
Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Julie Butler, Senior Manager to Exec Medical Director		
Appendices:			

Report Summary

1. Purpose of Report and Executive Summary

The purpose of this report is to provide the Trust's Board of Directors with an update on medical appraisals following implementation of a new medical appraisal system from L2P Enterprise Ltd (L2P).

2. Background

The Trust's management of appraisals had been underpinned by the Medical Advice Guidance (MAG) 4.2 form and Excel spreadsheets until the announcement from NHS England that the Medical Advice Guidance (MAG) 4.2 form, was no longer fit for purpose. [1] In conjunction with this, the server which held the internally developed system was at the end of its life and at high risk of system failure resulting in loss of medical appraisal and revalidation information.

Following a procurement exercise to seek a new electronic medical appraisal system, the contract was awarded to L2P in the summer of 2023, followed by a soft launch of the system in November 2023, and full implementation in April 2024.

3. Current Position

Since 1 April 2024, all medical appraisals have been undertaken using the L2P system. The medical staff whose appraisals have been due within the first quarter of the financial year have given excellent feedback not only on the system which is a great improvement on the old MAG form, but also on the administration support provided by our Revalidation Coordinators.

Table 1 shows appraisal performance for quarter 1 of the 2024/25 financial year.

The 'Reviewed and Satisfied' row is the number of medical appraisals successfully completed.

[1] [1]https://www.england.nhs.uk/professional-standards/medical-revalidation/appraisers/mag-mod/

Table 1: Appraisal Performance Quarter 1 2024/25

	Apr 2024	May 2024	Jun 2024	Performance year to date	
				No.	%age
Appraisals due	**24**	**40**	**27**	**91**	
Meeting booked	22	36	26	84	92%
Meeting held on time	10	18	9	37	41%
Meeting held late	10	18	9	37	41%
Meeting not yet held	3	3	0	6	7%
Documentation submitted on time	13	23	18	54	59%
Documentation submitted late	8	11	8	27	30%
Documentation not yet submitted	3	6	1	10	11%
Submission awaiting review	0	0	0	0	0%
Referred back (even if satisfied later)	0	0	0	0	0%
Reviewed and satisfied	21	32	26	79	87%
Reviewed and not satisfied	0	0	0	0	0%
Cancelled	0	0	0	0	0%

To add further context, medic appraisals are not held in an appraisal season as with other staff. They are scheduled throughout the year (in accordance with the commencement date of employment and appraisal held the previous year). The compliance rate of 87% is for the medics scheduled to hold their appraisals in Quarter 1. This is not 87% of our medic population.

Although compliance is 87% for quarter 1, the remaining clinicians do have an appraisal date booked and will still be undertaking their appraisal, it will be just outside their designated quarter and therefore at year end.

In line with NHS England guidance, compliance is based on an appraisal being completed by the end of the financial year, regardless of start date/due date.

4. Summary

NHS England require a Designated Body to submit its annual report to Board in respect of medical appraisal compliance in the autumn of each year. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is the Designated Body for in excess of 400 doctors. For 2023/24 data, the annual report was presented to the People Committee, on behalf of the Board, on the 22 October 2023. Both the annual report and Statement of Compliance signed by the Chief Executive were submitted to NHS England on the 23 October 2024. Compliance for this period was 94.10%.

In summary, the transition to L2P has been successful, has received positive feedback, and medical staff are engaging with the medical appraisal and revalidation process.

Recommendation:	The Board of Directors are asked to note the content of the report and be assured the new medial appraisal system is robust and effective.			
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
		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:	

2411 - 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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**A3**
Report Title:	**Chair's Report**		
Sponsor:	Suzy Brain England OBE, Chair of the Board		
Author:	Angela O'Mara, Deputy Company Secretary		
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 September 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

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:			
		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 **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 Report

November 2024

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Help shape the future of the NHS – NHS Change

The NHS has been a vital part of our lives for over 76 years, and now the Government has launched NHS Change; asking for your input to ensure it continues to support the health of future generations.

This is an opportunity to be part of the biggest conversation about the future of the NHS. Whether you have a lot or just a little to share, your experiences and ideas will contribute to shaping a new 10 Year Health Plan for England.

Open to everyone, including members of the public and health and care colleagues, this is your chance to tell us what changes the NHS needs to make.

Have your say at: https://change.nhs.uk

Governor Engagement

In late September, the Trust welcomed a total of seven governors, six new and one re-elected to its Council. I extend a warm welcome and look forward to working with; Debbie Benson, Patrick Bond, Andrew Flynn and Colin Wallace from the Doncaster constituency, and Eric Boocock, Phil Mettam and retuning governor, Sheila Walsh from the Bassetlaw constituency. I would also like to take the opportunity to thank those governors who did not to stand for re-election at the end of their terms of office for their support and contribution during their time on the Council of Governors.

Almost immediately, and along with existing governors, the newly elected governors had the opportunity to be engaged in trust and system events, which included the bi-annual NHS Nottingham & Nottinghamshire governor event, where governors across the system were welcomed by Dr Kathy McLean, Chair of the Nottingham & Nottinghamshire Integrated Care Board. DBTH were well represented at the event where governors received an update on key local and national topics, reflecting on Lord Darzi's independent investigation of the NHS and the government's anticipated NHS Ten-year Plan. In breakout groups governors explored three proposed areas of focus in the Ten Year Plan for Health "to build an NHS fit for the future" - hospital to community, analogue to digital and sickness to prevention.

Governors were also invited to an internal briefing session led by Professor Sam Debbage, Director of Education & Research and Kelly Turkhud, Head of Education for Widening Participation. The value of participating and promoting career and education opportunities was highlighted through proactive engagement with schools, We Care into the Future events and apprenticeship opportunities.

Colleague Engagement

The third cohort of the Board Development Programme celebrated their involvement in the Programme in September. The scheme provides an opportunity for aspirant individuals from a diverse range of backgrounds, both inside and outside of the Trust, to understand what it takes to become an Executive or Non-Executive Director within a large and complex organisation in both the public and private sector. Special thanks to Jodie Deadman, Chinwe Russell and Khai Shahdan for your participation and contribution and to Gavin Portier, Head of Leadership & Organisational Development for your support and facilitation.

At the beginning of October and as part of "Our People's Path" series, colleagues from across the organisation joined me on a virtual session to hear about my career path, achievements, and ambitions with time for colleagues to ask questions about my experiences.

As a Board we continue to maintain and develop our skills, knowledge and experience and have recently undertaken a workshop with NHSE's Making Data Count Team to support the trust in making the best use of available data. Exploring how the presentation of data, including the use of statistical process control charts can influence analysis and decision making. Members have also undertaken Level 3 fraud awareness training, facilitated by the Trust's Local Counter Fraud Specialist, Mark Bishop.

It was my pleasure to attend the annual Star Awards again this year. I continue to be inspired by the care, compassion and contribution of Team DBTH. It was a wonderful night of celebrations, expertly organised by our Communications Team and supported by our generous sponsors and I share my thanks with you all!

As usual, it was my privilege to present my Chair's award and this year the worthy winners were colleagues from Kingfisher Ward. The Team have supported each other through difficult times, with grace and professionalism; they offer outstanding care for some of our most vulnerable patients, exhibiting dedication, courage, and unwavering compassion.

On 18 October I had the pleasure of opening the 16th National ENT Nursing Masterclass hosted by Professor Quraishi in the Education Centre at Doncaster Royal Infirmary. The event is the largest free of charge training platform in the UK for surgeons, nurses and medical students and it was great to see so many delegates in attendance.

Members Engagement

The Trust's Annual Members Meeting was broadcast on 26 September 2024, as in recent years the decision was taken to pre-record the event to be shared on the Trust's website and through social media channels to maximise engagement. Members, colleagues, and the general public were 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 also took the opportunity to join NHS South Yorkshire's Annual Members Meeting as a system partner.

Partner Engagement

Operating across South Yorkshire and Nottingham and Nottinghamshire integrated care systems, I continue to work proactively with our partners, through attendance at a range of meetings, engagement and consultation sessions for the benefit of our organisations, its people, patients and the communities we serve. Since my last report I have contributed to a meeting of Nottingham & Nottinghamshire Chairs and Elected Members, Notts Healthier Together Board, South Yorkshire and Yorkshire & Humber Chairs events.

At the time of writing, I am preparing for November's South Yorkshire & Bassetlaw Acute Federation Board meeting and along with Cathy Hassell, Managing Director of the Acute Federation, I have been meeting with my fellow Chairs to develop the future work of the Acute Federation.

For the second consecutive year, the gardens at Doncaster and Bassetlaw Teaching Hospitals have been awarded the prestigious Green Flag Award.

The accreditation programme recognises expertly tended parks and green spaces across the world and both the Rainbow and Butterfly Gardens at Doncaster Royal Infirmary and the Rainbow Garden at Bassetlaw Hospital have been acknowledged as beautiful, accessible green spaces, offering valuable respite and comfort to those that visit them.

Deputy Chair, Kath Smart and I, had the pleasure of joining our estates colleagues at each site to raise the 2024 Green Flag. The estates team maintain the gardens with such care and I would encourage everyone to visit and enjoy these havens when they can.

Following the change in government, Richard Parker and I took the opportunity to welcome the local Doncaster MPs to Doncaster Royal Infirmary. We shared with them the opportunities and challenges faced by the Trust and sought their support in championing the need for funding to enable the hospital to provide services to our communities.

Patients

Last month construction of the multi-million pound facility at Bassetlaw Hospital was completed. The facility will provide urgent and emergency care, paediatric and selected inpatient services.

Jo White, Labour MP for Bassetlaw, officially declared the building complete with a formal ribbon cutting ceremony. Richard Parker and I toured the Emergency Department and Children's Assessment Unit, highlighting the benefits the new development will offer local communities.

Other colleagues, including representatives from the Capital Planning Team, clinicians, and those involved in the construction and design, also toured the building. They had the opportunity to see the state-of-the-art facilities first-hand, including the new Emergency Department, Assessment and Treatment Centre, and Children's Assessment Unit.

Emergency and paediatric services will gradually transition into their new facilities in a phased approach, with the opening of services expected to be complete in the coming months.

The Bassetlaw Emergency Village represents years of planning, public consultation, and collaboration between DBTH, construction partners, and the local community. The completion of this modern facility highlights the hospital's commitment to delivering high-quality, accessible care that will benefit patients and staff alike for generations to come.

Non-executive Director (NED) Champion Roles & Activities

Non-executive Director, Hazel Brand attended the in-house Leadership Listening & Learning Seminar in her role as NED Champion for Speaking Up. October was Speak Up month. Katherine Bradshaw, Lead for Communications & Engagement at the Freedom to Speak Up (FTSU) National Guardian's Office, talked about the power of listening: the importance of listening and creating and embedding a positive Speak Up, listening, and learning culture.

Led by Airish Saluta, some of our internationally trained colleagues spoke about settling into their new roles in this country and the language and cultural difficulties they had encountered. Having the courage to speak up had resolved many initial concerns.

Julie Huggan, FTSU Guardian, and Lisa Johnson, Head of People Services, both from North Tees & Hartlepool NHS Foundation Trust, gave an insight into understanding neurodiversity in the workplace and how we support our colleagues and each other. Neurodiversity covers the range of differences in individual brain function and behaviour traits, regarded as part of normal variation in the human population (but used especially in the context of autistic spectrum disorders). While just 15-20% of the population have been diagnosed, many wait years for a diagnosis and 45% of those with neurodiverse features leave their jobs.

Led by Paula Hill, DBTH's Speak Up Guardian, the seminar ended with a challenge: If you could change one thing, what would it be?

Since the last Board report, Non-executive Director, Emyr Jones has attended a Doncaster Chamber event exploring innovation, including the use of Artificial Intelligence. He was welcomed as a speaker at the Clinical Directors timeout at Castle Park, where he shared with colleagues the role of the Clinical Director and attended the Trust's 2024 Research and Innovation Conference 'Starting Well: Improving Maternal, Child, and Young People's Health through Research and Innovation' held at Doncaster Royal Infirmary and hosted in partnership with Born and Bred in Doncaster.

2411 - 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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 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
	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:	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

November 2024

This report presents 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*

DBTH has been chosen as a pilot site for genetic testing in patient who have had a stroke
Genetic testing in patients who have had a stroke can be an effective tool in assessing whether clopidogrel (which prevents platelets from sticking together) is an appropriate treatment to prevent further strokes. This testing is not currently available routinely in the NHS.

Doncaster and Bassetlaw Teaching Hospitals (DBTH) will be one of only four sites across the country to pilot genetic testing within stroke patients.

The pilot will be led by the NHS Pharmacogenomics and Medicines Optimisation Network of Excellence, working in collaboration with the chosen sites, including DBTH, and supported by NHS England's Stroke Programme and Genomics Unit. The pilot will run from October 2024 to April 2025 and will produce an implementation guide for providers and information to support future commissioning decisions.

This will help to assess how routine testing could be rolled out at scale to all patients who experience a stroke where Clopidogrel use is being considered. The pilot will enable NHS England's genomic unit to design and refine this new genetic testing service, before it is rolled out across the NHS.

Midwifery services strengthened with record recruitment and retention
As highlighted in the paper updating on maternity services; over the past three years, significant strides have been made in midwifery recruitment and retention.

Thanks to the introduction of a structured midwifery preceptorship programme, support from the pastoral team and practice development midwives, maternity services have seen the biggest intake of newly qualified midwives to date, with 68 new midwives recruited since 2022.

In addition, the retention rate has significantly improved, with more colleagues choosing to stay in the profession at DBTH. Furthermore, since 2022 have also welcomed 11 internationally educated midwives. Since 2021, the number of whole-time equivalent midwives at DBTH has grown from 169 to 221, helping to meet Birthrate Plus standards.

I would like to thank midwifery leadership colleagues and the diverse and talented teams, working to support women, children and families in Doncaster, Bassetlaw and beyond.

New support clinic opens at DRI
Last month, a new maternity-based clinic at Doncaster Royal Infirmary opened its doors, dedicated to helping expectant mothers who have previously been subjected to female genital mutilation (FGM).

This new clinic is a vital service aimed at supporting women through their pregnancies and birth, offering specialist knowledge of the issues that can arise following FGM. It reflects the hospital's commitment to providing compassionate, specialised care and support for women and girls affected by this practice.

This new service is just one of the ways in which Doncaster and Bassetlaw Teaching Hospitals is tackling health inequalities, by providing specialist services that cater to the needs of communities disproportionately affected by specific health issues.

An update on Audiology services
A National Paediatric Hearing Improvement Programme has been established by NHS England to support providers and Integrated Care Boards (ICBs) with improving the quality of Paediatric Audiology services following safety concerns raised in relation to the newborn hearing screening programme.

As part of this process, and following an independent review, DBTH was found to have quality related issues within its paediatric service which need to be subject to an improvement programme. More recently further concerns have been raised across the breadth of the service, including adult provision, requiring the Trust to limit the service offer until improvements can be made.
We have communicated with our patients, partners and stakeholders and will continue to update them on progress and we are working with the other providers in South Yorkshire and a private provider of audiology services to support the patients who are being affected.

A paper on today's agenda will provide the full background and context to this challenged position including the initial service review findings and subsequent actions.

Whilst at the time of writing no patient harm has been confirmed, the Trust is sincerely sorry for the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically. The service is undergoing a necessary and complex recovery and improvement process. We will deliver this as soon as we can, but we must ensure the actions are undertaken carefully and robustly to ensure we can safely provide an effective audiology service in the future.

People - *We are supportive, positive and welcoming*

Update on work on Anti-Racism
As I shared in my July Board paper, alongside the other NHS organisations in South Yorkshire, DBTH has made a commitment to adopting an Anti-Racism Framework developed by NHS organisations in the North-West to support our anti-racism journey.

A steering group has been developed at Doncaster Place to progress this work and three key areas have been identified as priorities. They are:

1. A statement of commitment (aligned to 'Choose Kindness')
2. Recruitment practices
3. Training

I will continue to update as this work progresses.

Employment Rights Bill
In early October the Government introduced the Employment Rights Bill, which contains some important employment law reforms including new day-one rights to flexible working.

At DBTH we have already done a lot of work on flexible working with a toolkit available on the Hive https://extranet.dbth.nhs.uk/people-organisational-development-pod/human-resources-hr/flexible-working-toolkit/

The Bill also enhances the duty to prevent sexual harassment, by requiring employers to take 'all' reasonable action. This is aligned to our sexual safety charter, launched in the last year, which describes our zero-tolerance approach. https://extranet.dbth.nhs.uk/safeguarding/sexual-safety/

We will also be working through all elements of the Bill to consider any further work.

Flu and Covid vaccinations
As we approach the winter months, I want to encourage all members of Team DBTH, and our communities, to make getting the flu and Covid vaccinations a priority.

For colleagues protecting yourself from flu and covid is more important than ever, ensuring we can continue to care for our patients, support our teams, and safeguard those around us. Within the Trust it has never been easier to get your jab – Regular drop-in clinics are available within Occupational Health at both Doncaster Royal Infirmary and Bassetlaw Hospital. We also have around 50 peer vaccinators across the Trust, based on wards and within services, providing convenient access to the jab during your working day.

Taking this step will help reduce the risk of flu outbreaks, minimise absences, and ensure we continue to deliver high-quality care throughout the busy winter period.

All details, including clinic times, locations, and availability of peer vaccinators, can be found here: https://extranet.dbth.nhs.uk/dbth-vaccination-centre/

Primary care services will also be delivering some Covid vaccination services and providing vaccination services in the communities.

Star awards
Congratulation to our outstanding colleagues who were shortlisted and winners at the annual Star Awards. It is great to be part of an event celebrating so many well deserving colleagues, taking the time to acknowledge their contributions to health and care for our communities.

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

Cheswold Park Hospital
On 1 October adult secure mental health services provided at Cheswold Park Hospital in Doncaster transferred to South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), a new NHS partner operating at Doncaster Place.

The previous provider, Riverside Healthcare Ltd shared its intention to leave the adult secure mental health sector earlier in the year. NHS England subsequently asked SWYPFT to take over the services provided from the hospital to ensure the continuity of adult secure mental health services in South Yorkshire, and that service user care in the local area will be maintained.

Aspire to Be - health and care simulation room launch

Working with the Strategic Workforce Forum at Doncaster Place, DBTH Estates and Facilities Team have helped to create a new health and care simulation room for the Aspire to Be employability programme.

Aspire to Be provide employability programmes for people with communication or learning difficulties. At the Health and Care simulation room, hosted at the Doncaster school for the Deaf, people on the programme can practice skills in preparation for interviews and employment. The Estates and facilities team at DBTH have donated equipment and shared cleaning protocols to ensure that the programme is a life like as possible.

The room was officially opened 29 October 2024.

Acute Federation update

A mid-year review of progress against the seven Acute Federation priorities for 2024/25 has taken place.

The priorities are: Elective & Diagnostics Recovery, Clinical Services Sustainability Review, Corporate Services Review, Plan for People, Acute Paediatrics Innovator Programme, Contribution to System Efficiency and Digital Convergence.

Highlights include the elimination of 104 week waits for patients, implementation of corneal transplant mutual aid, reduced length of stay and high patient satisfaction at the new Mexborough Elective Orthopaedic Centre which was launched in January 2024. A pilot is underway to deliver the Benign Prostatic Hyperplasia pathway through the Urology Area Network. Patients are already benefitting from wider treatment choice under this scheme and evaluation will take place once it concludes.

For diagnostics, the new Yorkshire Endoscopy Training Academy, located at Sheffield, immersive training has resulted in accelerated return to practice.

A clinical services sustainability review has completed and identified six services across the Acute Federation which would benefit from collaboration. The work will move from the review stage into implementation.

The Acute Paediatric Innovator Programme is making progress: Funding has been secured from the ICB to pursue a paediatric dental hub in South Yorkshire and Bassetlaw and to carry out work standardising the way we deliver oral surgery and exodontia for children.

A strategy has been developed for Developmentally Appropriate Healthcare for young people with chronic conditions who are transitioning from paediatric services into adult services.

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

Medical Imaging services to expand at Bassetlaw

We will soon expand Medical Imaging services at Bassetlaw Hospital with the installation of an additional CT scanner having successfully secured £1.8 million in funding from NHS England. This state-of-the-art equipment will significantly boost diagnostic capacity, enabling faster and more accurate scans for patients.

The development is part of the Trust's wider imaging strategy, complementing the in-development Imaging Suite at Montagu Hospital. Together, these improvements are designed to streamline diagnostics, improve access to services, and ultimately enhance patient outcomes across South Yorkshire and Nottinghamshire.

To accommodate the scanner, plans have been finalised within the service to repurpose spaces within the CT suite at Bassetlaw. These plans include creating a new scanning room, an adjacent control room, and

associated utility spaces. Following works, it is anticipated that the expanded service will be available to patients early in the new year.

Change in appointment reminders
The way patients receive appointment reminders has changed. From Tuesday 15 October, patients receive appointment reminders via the NHS app.

This change means that patients will primarily receive updates about appointments on the app. If a notification is unopened after eight hours, they will receive a follow-up SMS text from a system called 'DrDoctor'.

By including the NHS app in the notification process, patients are less likely to miss reminders and important updates to their care. This new process will also help to reduce costs, and, we hope, improve waiting times.

Patients who wish to receive notifications and messages via the NHS App will need to ensure they have enabled notifications for the NHS App on their mobile device, and on the NHS App as well.

Our financial position
In my last report to Board, I highlighted the potential that without interventions our financial position to be significantly off plan.

Our colleagues, and especially divisions, responded positively to additional grip and control measures, which has seen some encouraging impacts on the overall financial position.

The Director of Finance's report to Board contains a re-forecasted end of year position, based on improvements against our plan, and highlights where there are improvements still to be made.

2411 - B BOARD LEARNING & REFLECTION

2411 - B1 FRAILTY SERVICES AT DBTH

Discussion Item | Dr Victoria Barradell, Consultant Geriatrician | 10:00

15 minutes

REFERENCES

Only PDFs are attached

B1 - Frailty Services at DBTH.pdf

Current & future frailty services at DBTH (& beyond)

VICKY BARRADELL

CONSULTANT GERIATRICIAN

1	2	3	4	5	6	7	8	9
Very fit	Well	Managing well	Vulnerable	Mildly frail	Moderately Frail	Severely Frail	Very Severely Frail	Terminally ill

Frailty

Syndrome of increased vulnerability to stressor events associated with adverse outcomes

Minor event/illness, usually manageable in community in healthy adult, leads to decompensation

- Fall
- Reduction in mobility/function
- Delirium

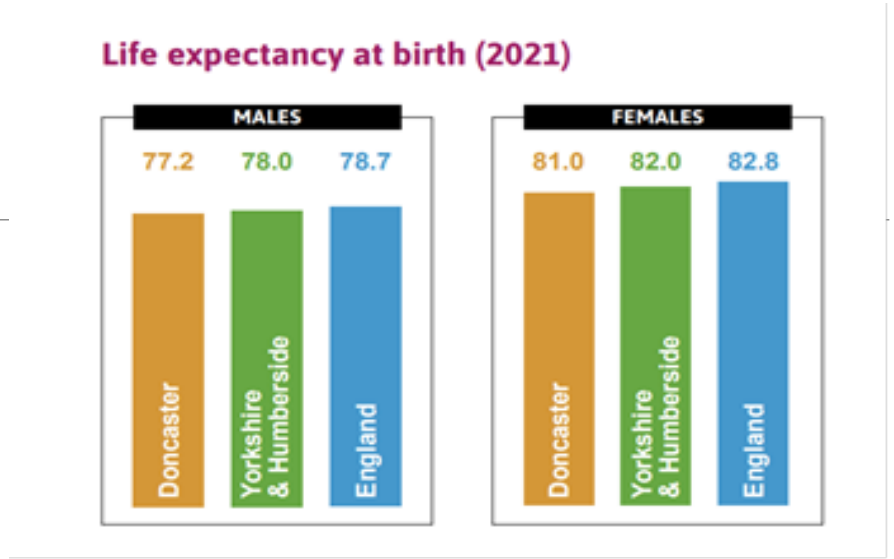
Admission, deterioration in hospital, hospital associated harm, long LOS, institutionalisation

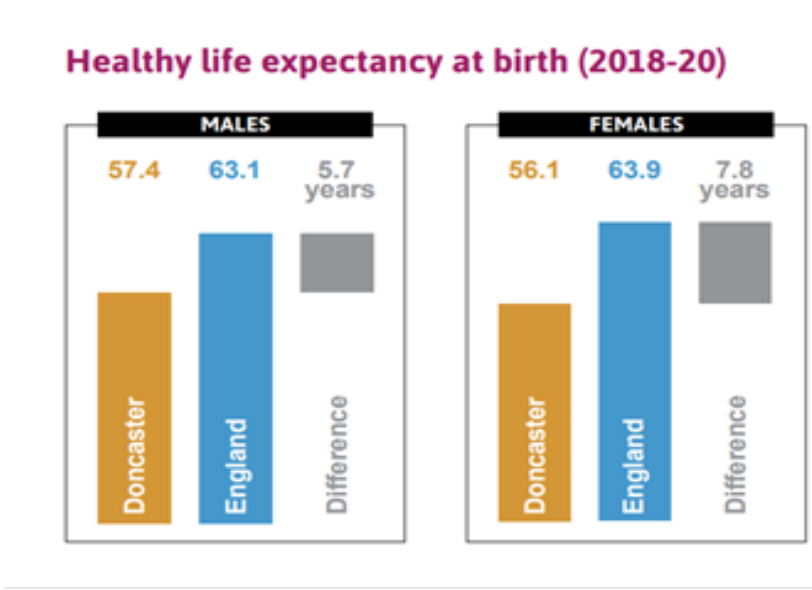
Frailty in Hospital

Nationally 60% hospital beds occupied by > 65's

47% of hospital inpatient over 65 are frail, 30% in AMU, 5 -10 % in ED

Doncaster is much frailer at a much younger age





Current frailty services

Bassetlaw

1 x LTFT consultant, ½ ward

1 x Movement disorders clinic

DBTH serves 440,000

6 substantive consultants

STH serves 580,000

27 consultants

Frailty in Hospital

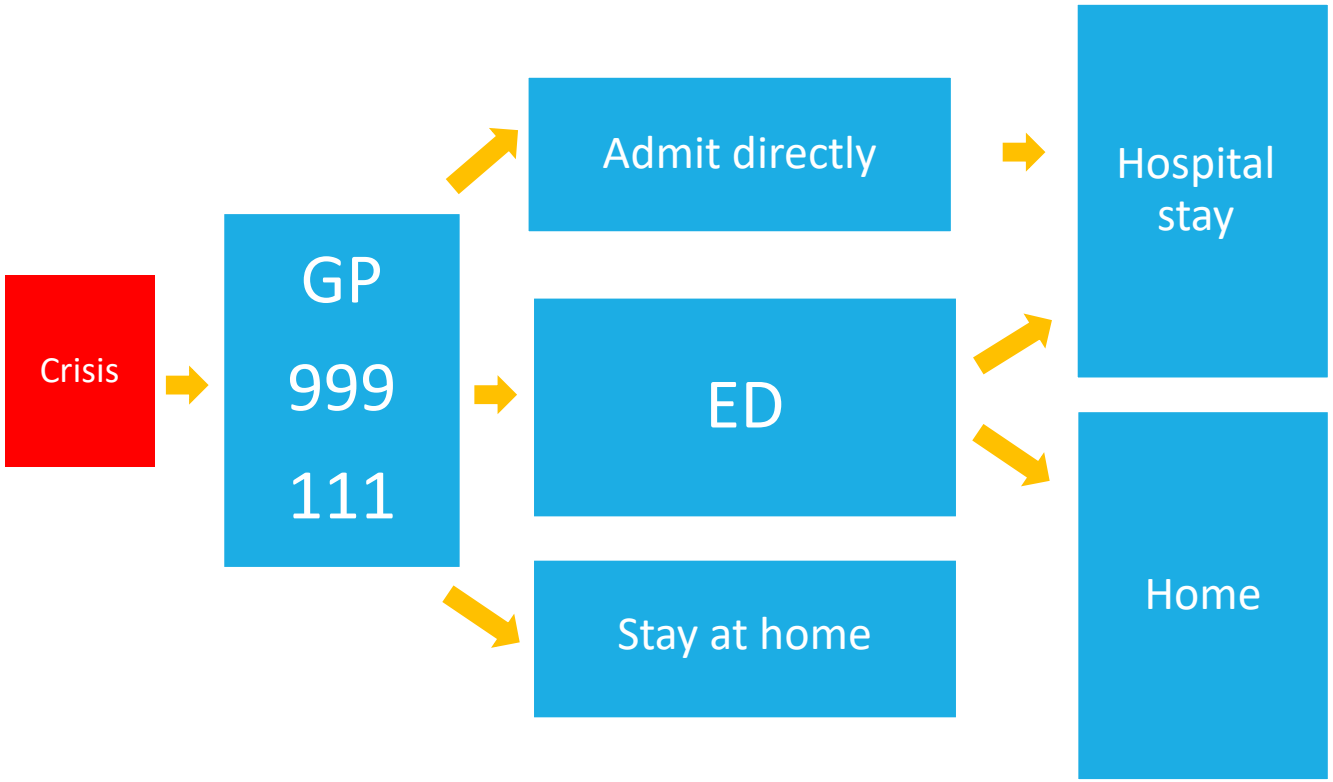
Frailty and hospital admission associated
- Loss of autonomy
- Deconditioning
- Discharge to long term care or with functional dependence

Prevalence of delirium in hospital 20-30%

Patients admitted with a CFS 7-9
- inpatient mortality 11-31%
- readmission 10-14%
- 1 year mortality 50%

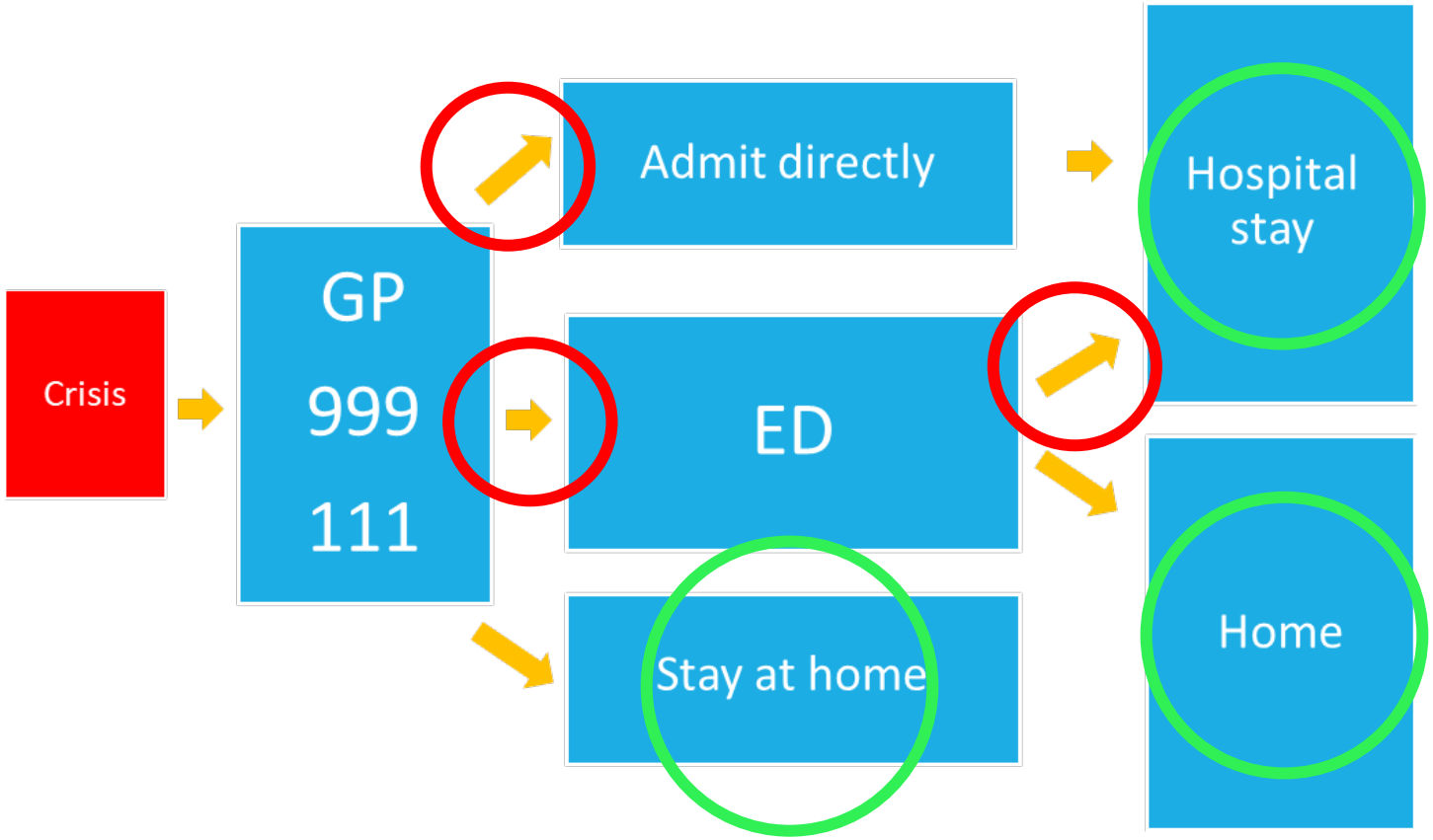
2/3 people have at least 1 emergency admission in their last 3 months of life
7.1% have 3 or more

Why do people with frailty get admitted?



- Clinical need for admission
- Lack of community service
- Lack of access to community service
- Lack of experience/knowledge/links in community provider
- Overwhelmed, under resourced, inexperienced ED & acute teams
- Time consuming
- Culture of ‘safety’

Proactive Care



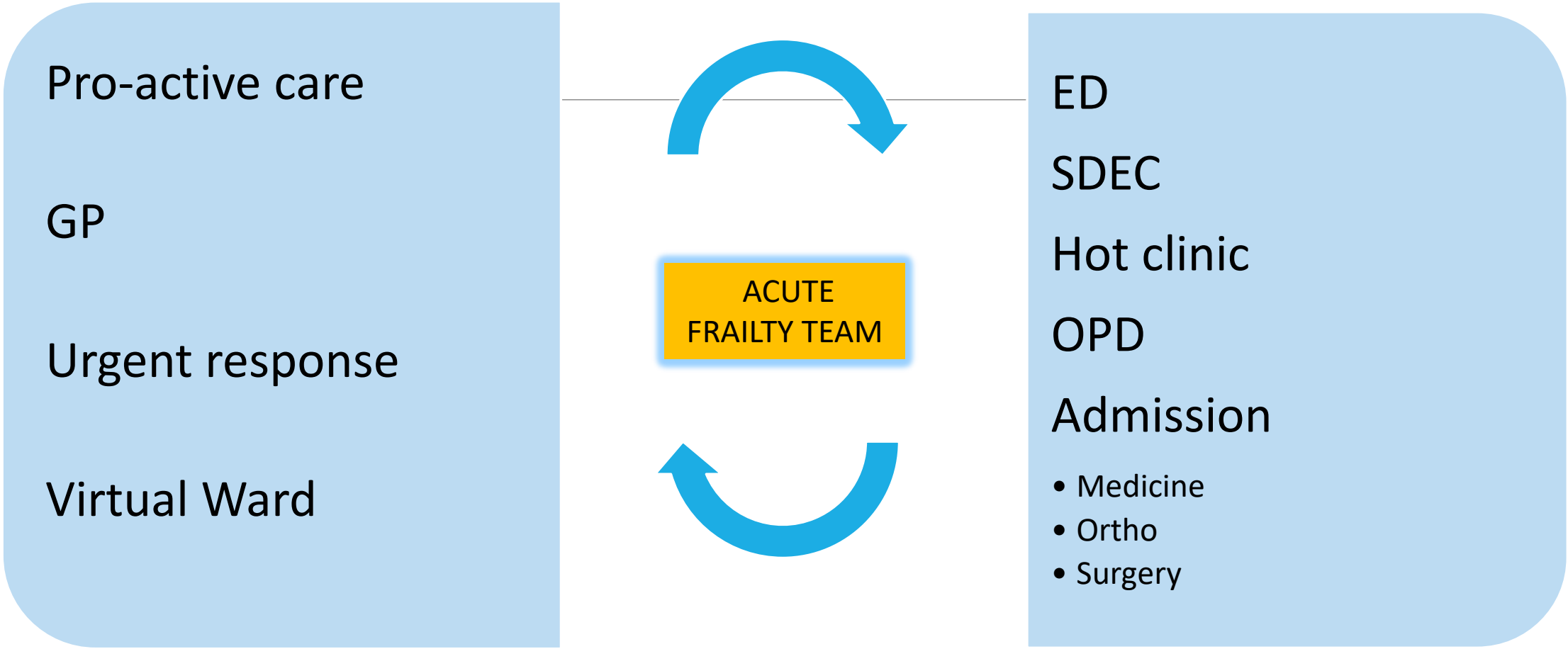
At critical decision point need SENIOR decision maker with knowledge of local services and ability to manage risk

If admitted they need a Comprehensive Geriatric Assessment & discharge ASAP

If not admitted/discharged need CGA

Rapid response AHP and social services, Virtual Wards, Hot clinics, Access to diagnostics, POCT

Community & acute services in frailty



Timely social care provision

National context

NICE National Institute for Health and Care Excellence

Mail Online

NHS England

NELA National Emergency Laparotomy Audit

- 10 hours acute frailty service to ED/SDEC
- Acute frailty units
- Orthogeriatric care
- Surgical liaison
- Virtual wards
- Community proactive care

NHS ENGLAND , NCEPOD AN AGE OLD PROBLEM , CERNTRE FOR PERIOPERATIVE CARE, NICE HIP FRACTURE GUIDELINES

Our challenges

Consultants (6 v's 27 in Sheffield)

Recruitment and retention

Challenges in social care

Culture

Partnership working with community services & primary care

- Promoting activity and independence
- Voluntary sector
- Social prescribing
- Community teams
- Information technology!

Our aspirations

Daily consultant presence in ED

All referrals via consultant

SDEC services for people with frailty

Rapid access clinics

Expand FAU

Further develop virtual ward

Acute Frailty Service

Orthogeriatric – geriatrician led model

Inreach in to other inpatient areas
- AMU
- Surgery

Pre-operative frailty assessments
- Cancer services
- Elective surgery/pre-op

Develop falls pathways and fracture prevention services

Community geriatricians

Integrated community teams

Timely access to rehabilitation at home

Same provision for level 1 medical care, therapy and social care at home as in hospital

Same at Bassetlaw!

2411 - B STRATEGY, PLANNING & PARTNERSHIPS

2411 - C1 WINTER PLANNING 2024/25

Decision Item | Denise Smith, Chief Operating Officer | 10:15

5 minutes

REFERENCES

Only PDFs are attached

C1 - Winter Planning 2024-25.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**C1**
Report Title:	**Winter Planning 2024/25**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:	Appendix A Winter Plan Schemes		

Report Summary

Purpose of the report & Executive Summary

This paper sets out the outline for winter planning for 2024/25; this has been developed in conjunction with senior leadership teams from both clinical and corporate areas.

NHS England winter planning guidance was released on 16 September 2024. The guidance confirms delivery priorities for this winter remain unchanged from those agreed in system plans. The guidance sets out the actions for NHS England, ICBs and NHS Trusts to deliver the following:

- Providing safe care over winter
- Supporting people to stay well
- Maintaining patient safety and experience

Recommendation:	The Trust Board of Directors is asked to receive the paper for APPROVAL			
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

		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

Relationship to Board assurance framework:		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
		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:	N/A		
Resources:	As detailed in the paper		
Assurance Route			
Previously considered by:	Finance & Performance Committee		
Date:	29 October 2024		
Any outcomes / next steps	To be considered by the Trust Board of Directors in November 2024		
Previously circulated reports to supplement this paper:			

1. Introduction

This paper sets out the outline winter plan for 2024/25; this has been developed in conjunction with senior leadership teams from both clinical and corporate areas.

2. Background

NHS England winter planning guidance was released on 16 September 2024. The guidance confirms delivery priorities for this winter remain unchanged from those agreed in system plans, as set out above. The guidance sets out the following:

2.1 Providing safe care over winter

It is recognised that, despite improvements, far too many patients will face longer waits at certain points in the pathway than is acceptable. Given that demand is above expected levels across the UEC pathway, there is a need to ensure all systems are re-confirming that demand and capacity plans are appropriate and are taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

2.2 Supporting people to stay well

It is important to maximise the winter vaccination campaign, for eligible population groups and patient facing staff.

This year for the first time, the NHS is offering the respiratory syncytial virus (RSV) vaccine to those aged 75 to 79 and pregnant women.

NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders
- record vaccination events in a timely and accurate way, as in previous campaigns
- monitor staff uptake rates and take action accordingly to improve access and confidence
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely

2.3 Maintaining patient safety and experience

It is recognised that this winter is likely to see UEC services come under significant strain and a whole system approach is required to managing winter demand.

NHS England will continue to support patient safety and quality of care by:

- standing-up the winter operating function from 1 November:
- completing a Getting It Right First Time (GIRFT) data-led review of support needs of all acute sites:
- convening risk-focused meetings with systems:
- expanding the Operational Pressures Escalation Levels (OPEL) framework

NHS England will continue to support operational excellence by:

- co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored
- running an exercise in September to test the preparedness of system co-ordination centres (SCCs) and clinical oversight for winter, including issuing a new specification to support systems to assess and develop the maturity of SCCs

NHS England will continue to support transformation and improvement by:

- continuing the UEC tiering programme to support those systems struggling most to help them to enact their plans
- reviewing updated maturity scores for UEC high-impact interventions with regions and ICBs, to identify further areas for improvement
- as part of NHS IMPACT, launching a clinical and operational productivity improvement programme in September:

ICBs are asked to

- ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter
- provide alternatives to hospital attendance and admission
- work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
- assure at board level that a robust winter plan is in place
- make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
- review the 10 high-impact interventions for UEC published last year to ensure progress has been made

NHS trusts are asked to:

- review general and acute core and escalation bed capacity plans
- review and test full capacity plans
- ensure the fundamental standards of care are in place in all settings at all times:
- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:

3. Winter plan schemes 2024/25

Winter planning workshops were held in the summer with Divisional and Corporate teams to develop the long list of proposed winter plan schemes for 2024/25. Further prioritisation of these schemes has been undertaken; and a confirm and challenge session has taken place.

The final winter plan schemes for 2024/25 are as summarised below:

- Additional Acute Medicine Consultant support to in reach to DRI Emergency Department 7 days per week

- Extended opening of the Trauma Ambulatory Care Unit
- Escalation bed capacity at Bassetlaw
- Escalation bed capacity at Doncaster
- Additional Pharmacy resource to support timely discharge across both sites
- Additional Portering resource to support patient flow
- Additional Domestic teams to support timely turnaround of bed spaces.

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

It is proposed that all schemes commence in December 2024 and remain in place until the end of March 2025.

The total cost of the 2024/25 schemes assessed as high priority is £674,709

4. Summary

The Trust winter plan schemes for 2024/25 are aligned to the NHS England winter planning guidance priorities to:

- Providing safe care over winter
- Supporting people to stay well
- Maintaining patient safety and experience

5. Recommendations

The Trust Board of Directors is asked to approve the winter plan schemes for 2024/25.

Appendix A Winter Plan Schemes 2024 / 25

Division	Scheme	Description	Benefits	Operational Dates	Pay cost (per month)	Non-pay costs (per month)	Spent 2023/24	Total cost
Surgery	Trauma	Trauma Ambulatory Care Unit to remain open 7 days a week (7am-8pm)	Increase trauma assessment capacity during the forecasted peaks in trauma demand, enabling more timely flow out of ED	Dec 24 - Mar 25	6,679		Y	26,716
Medicine	Bassetlaw bed ba	Open A5 to 18 patients	Expansion of the bed base provides a phased increase in medical bds to support the forecast peaks in demand for emergency admissions. Reconfiguration of the floor supports the maintenance of the elective activity programme during the winter period.	Jan 24 - Mar 25	92,393		Y	309,594
UEC	Acute Medicine	Additional Consultant (9am-1pm) to provide in reach to ED.	Support in reach into ED to reduce time to acute medicine review and support admission avoidance	Dec 24 - Mar 25	6,346		Y	25,384
CSS	Pharmacy	Weekend and week day support for TTO's and patient discharge dispensing	Support timely discharges and flow through the organisation	Dec 24 - March 25	11,325		N	45,300
Medicine	DRI Bed base	Open Modular ward to 11pts	Increase bed base to support increased forecast demand	Jan 24 - March 25	63,905		N	£191,715
E&F	Facilities	Dedicated Porter MRI / CT / Diagnostics at DRI & BDGH only.	Additional Portering Resource to facilitate patient flow through ED / MRI / CT / Diagnostics, and AMU/SAU	Jan 24 - Mar 25	13,500		N	40,500
E&F	Facilities	Additional cleaning resource ED	Additional cleaning in ED functional areas due to increased footfall / activity. 3pm until 10pm at DRI & BDGH sites only.	Jan 24 - Mar 25	5,800		N	17,500
E&F	Facilities	Deep Clean / HPV	Additional resource input for deep clean service over the weekends to provide a 7 day service across the Trust.	Jan 24 - Mar 25	6,000		N	18,000
							Total	674,709

2411 - C2 DONCASTER & BASSETLAW HEALTHCARE SERVICES UPDATE

Discussion Item | Jon Sargeant, Chief Financial Officer | 10:20

5 minutes

REFERENCES

Only PDFs are attached

C2 - Doncaster & Bassetlaw Healthcare Services Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**C2**
Report Title:	**Doncaster and Bassetlaw Healthcare Services Update**		
Sponsor:	Jon Sargeant, Director - Doncaster and Bassetlaw Healthcare Services Mark Bailey, Chair - Doncaster and Bassetlaw Healthcare Services		
Author:	Mark Olliver, Managing Director - Doncaster and Bassetlaw Healthcare Services		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

This report aims to provide the board with the following information

1. An update on the current financial position of the business
2. A financial forecast for the year end position 2024/25
3. An awareness of current operational activity and proposed annual dividend payment

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:		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:			

Executive Summary

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

The current financial position continues to track favourably to budget. The board are asked to note the information pertaining to the next dividend payment, to be processed as a matter of urgency.

The Subsidiary Board would expect the current performance to continue within the medium and long term. However, the business is currently in dispute with the Trust (in relation to the QIMET contract). Failure of delivery of all contractual obligation(s) would have an adverse effect on financial performance, covering the periods 2024/25 and 2025/26. This in turn could have a marked impact on future Trust dividend payments.

Financial Update

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

Year to September 2024 (£k)	**Actual**	**Budget**	**Variance**	**Budget for the year**
Turnover	**5,795**	**5,262**	**533**	10,524
Cost of Sales	(5,261)	(4,762)	(499)	(9,524)
Gross Profit	**534**	**500**	**34**	**1,000**
Admin Expenses	(439)	(438)	(1)	876
Profit before tax	**95**	**62**	**33**	**124**
Tax	(23)	(14)	(9)	(28)
Profit after tax	**72**	**48**	**24**	**96**

Table 2: Financial forecast summary 2024/25

	Actual to September 2024	**Forecast to March 2025**
Turnover	5,795	11,590
Cost of Sales	(5,261)	(10,522)
Gross Profit	**534**	**1,068**
Admin Expenses	(439)	(878)
Profit before tax	**95**	**190**
Tax	(23)	(46)
Profit after tax	**72**	**144**

Table 3: Corporate assets and liabilities register

As at 30th September 2024	
Current Assets	
Inventory	550
Accounts Receivable	948
Prepayments	72
VAT Receivable	546
Cash	359
Total	**2,475**
Current Liabilities	
Accounts Payable	1,075
Accruals	311
Corporation Tax Payable	14
Intercompany	293
Total	**1,693**
Net Assets	**782**
Share Capital	550
I&E Reserve	232
Total Capital Employed	**782**

The year-to-date gross profit margin is 10%, which is in line with expectations. Dispensing fees were £391k year to date, again, in line with expectations. The business is performing strongly and profit forecasts for 2024/25 represent the highest annual profit return to date. A pre-tax profit projection of circa £200k has been calculated, based on the assumption that all business activities are delivered. This includes all expected commercial components of the QIMET programme.

Table 3: Financial forecast risk – QIMET

	Actual to September 2024	**Forecast to March 2025**
Turnover	5,739	11,478
Cost of Sales	(5,261)	(10,522)
Gross Profit	**478**	**956**
Admin Expenses	(431)	(862)
Profit before tax	**47**	**94**
Tax	(14)	(28)
Profit after tax	**33**	**66**

The table above presents the forecast position because of QIMET contractual obligations not being delivered. For reference, the annual pre-tax profit position would reduce to circa £94k, representing a reduction of £100k.

Strategic Plan 2023-26

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

Strategic Operations

QIMET

The QIMET programme, at the request of Doncaster and Bassetlaw Teaching Hospitals NHS Trust, was incorporated into a tripartite partnership under the guidance of Doncaster and Bassetlaw Healthcare Services. The work stream now represents a valued part of the business and expansion plans are being developed accordingly.

To date, no contractual clauses have been activated and the business has continued to support the pipeline of international doctors from Nepal and other international countries. Furthermore, an investigation conducted by the Trust, which has taken circa 7 months to reach end point, has just been completed and the outcome has not identified any issue that would cause the business concern. The timeline adopted has caused significant impact on the programme, leading to unbudgeted and unexpected operating costs.

There are currently 11 doctors sitting within the training programme and these are due to commence years 2 and 3 training in DRI. Unfortunately, the programme has been subject to significant delays throughout 2024. This has caused much angst for the individuals involved. At present, we still do not have an operational

timeline to advise the said candidates accordingly. Failure to support the process could lead to significant operational and reputational damage. Further delays will also impact financially, and more costs will be incurred from November onwards, due to delays in candidate placements. These costs fall outside of the tripartite contractual obligation and will be requested in due course.

Conversations have taken place with the Education Team and an action plan has been developed to allow for more programme transparency. This has been signed off by all parties. However, it is now imperative that the candidates are placed appropriately and timely and the business awaits this notification from the Trust.

Homecare Services

The homecare service continues to expand, and the incorporation of a further Haematology service is now in progress. The business has highlighted the desire for expansion (with the inpatient pharmacy team) and requested the development of an action plan in due course, to identify future collaborative opportunities and to prioritise commercial growth.

From an operations perspective, the current homecare strategy has focussed on the incorporation of simple services. Further expansion may consider more complex models and, as a result, will need to include due diligence and consideration for current resourcing levels and capability.

From an operations perspective, the current increased workload attributed to the newly incorporated services has been assimilated into the existing operational structure. Future services will be balanced accordingly, and service charges will reflect all potential impacts on logistics and resourcing levels.

Charity

Duncan Batty, the new Head of Charity, has now integrated into the business and completed his induction. As a result, Duncan has already begun building strong relationships with the wider charity team.

An income generation plan was submitted to the Charitable Funds Committee in September, and this will be supported by a formalised budget that will be presented to Trustees in December. To generate a robust pipeline for unrestricted income, agreement was reached to explore potential lottery opportunities, and this work is currently being completed at pace.

Smart ER

The business continues to work with Healthcare Engineering Limited in developing the SMART ER concept. The application being developed utilises technology to provide supportive triage services for Accident and Emergency patients. Furthermore, the application focusses on providing valuable information for patients post visit and could provide the platform for a wider and more robust interface between primary and secondary care.

Working with a company called Physiotec, a demonstration application is being created and this is currently undergoing preliminary testing. Discussions have taken place with a number of IT healthcare providers and buy and hold investors and the application will be showcased in due course.

Dividend Payment 2024

It was resolved in a meeting of the Board of Directors of Doncaster and Bassetlaw Healthcare Services Limited that the company should pay an interim dividend of £0.36 on its ordinary shares to its registered stakeholders.

As per the current financial position, a total dividend payment of 200k will be made accordingly, payable to Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust.

Conclusion

Doncaster and Bassetlaw Healthcare Services continues to evidence strong financial management and the financial forecast for 2024-25 is extremely encouraging.

Several work-streams are being explored, to diversify the offer and aid commercial expansion. However, the current contractual delays re the QIMET programme must be resolved quickly and the business expects the Trust to honour its contractual obligations and support the candidates within the current training programme.

The proposed dividend payment highlights the businesses' ability to function as a commercial entity. Furthermore, continued growth will provide long term financial benefit to both the business and Trust.

Mark Olliver

MD Doncaster and Bassetlaw Healthcare Services

October 2024

2411 - C3 NHS NOTTINGHAM & NOTTINGHAMSHIRE INTEGRATED CARE BOARD FORWARD PLAN UPDATE

Information Item | Zara Jones, Deputy Chief Executive | 10:25

5 minutes

REFERENCES

Only PDFs are attached

- C3 - NHS Nottingham & Nottinghamshire ICB Joint Forward Plan Update.pdf
- C3 - Appendix 1 - JFP Delivery Plan Progress Update September 2024.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**C3**
Report Title:	**NHS Nottingham and Nottinghamshire Integrated Care Board Joint Forward Plan Update**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen Associate Director Strategy, Partnerships and Governance		
Appendices:	**Appendix 1** Joint forward Plan Progress Update Power Point presentation, September 2024		

Report Summary

Purpose of the report
This report provides the Board of Directors with an overview of the strategic priorities and progress made against these.

Summary
NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) aims to be a national centre of excellence with high performance against the four core aims of Integrated Care Systems (ICS) which they aim to do through four related focus areas:

- **Prevention**: we will reduce physical and mental illness and disease prevalence.
- **Proactive management** of long-term conditions and frailty to support early identification and avoid unnecessary escalation.
- **Improve navigation and flow** to reduce emergency pressures in physical and mental health settings.
- **Timely access** and early diagnosis for cancer and elective care.

The report provides greater details on the workplans and where these are on track for delivery. To note, there are areas that relate specifically to activities within the Bassetlaw site. These include work programmes that aim to reduce a patients need for secondary acute care admission and attendance, plus improve hospital discharge so that patients get home as quickly as possible following their treatment.

Working with our partners within the Nottingham and Nottinghamshire ICB, DBTH are able to align their own strategic priorities and delivery plans to maximise partnership value.

Recommendation:	The Board of Directors is asked to **note** the strategic focus of the Nottingham and Nottinghamshire ICB strategic focus, plus the progress made to date in its delivery.			
Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	**Information**

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.***

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
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	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**		
Legal/ Regulation:	The DBTH strategic priorities and operational plans also relate to the Integrated Care Systems (ICS) in which it delivers its services. For DBTH this is across two neighbouring ICB's.		
Resources:	Our Strategies and Plans - NHS Nottingham and Nottinghamshire ICB		

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

NHS
Nottingham and Nottinghamshire

Joint Forward Plan Progress Update

September 2024

Delivering the right care at the right time

JFP focus areas

NHS
Nottingham and Nottinghamshire

Prevention: we will reduce physical and mental illness and disease prevalence

Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation

Improve **navigation and flow** to reduce emergency pressures in physical and mental health settings

Timely access and early diagnosis for cancer and elective care

Progress summary

NHS
Nottingham and Nottinghamshire

- Overall, delivery of the focus areas within the Joint Forward Plan remains on track.
- Key deliverables that have been identified as off track with recovery plans in place are:
    - Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.
    - Based on identified local and system priorities, Place Based Partnerships will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.
    - System-wide approach to personalised care planning across all sectors (acute, community and primary) and roll-out personalised care, optimise integrated care pathway and referrals.
    - Increase immunisation and screening uptake for 'at risk' groups.
    - Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count.
    - Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, Cardiovascular disease (CVD).
    - Frailty same-day emergency care (SDEC) and expanding our SDEC offer across hospitals ensuring direct access for all professionals and implementing new data requirements.
    - Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts.
    - Develop a co-located urgent treatment centre at QMC to reduce demand on Accident & Emergency.
    - Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.
    - Transform our Pathway 2 and 3 offer to improve patient flow for patients who are medically safe for transfer and reduce length of stay in Pathway 2 beds.
    - Develop an urgent care coordination hub (UCCH) which will act as a single point of access for health professionals.
    - Continued support to eliminate waits of over 65 weeks for elective care.
- There are some areas where resource / capacity has been identified as a risk e.g. transformation of integrated neighbourhood working and embedding of Making Every Contact Count.
- There is a need for further financial analysis to maximise opportunities in planned care.
- Deep dives of two priorities are included in this report:
    - Priority 1: Prevention: reduce physical and mental illness and disease prevalence
    - Priority 4: Timely access and early diagnosis for cancer and elective care.

Priority 01 Prevention: reduce physical and mental illness and disease prevalence.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Improve early cancer diagnosis	Reduction in avoidable premature mortality Stabilise obesity in Year 6 children Increase in the proportion of people reporting high satisfaction with the services they receive Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing

Key Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.	**Amber**	• Cardiovascular disease (CVD) hypertension case finding and management progressing with Core20+5 Accelerator programme and quality improvement approach to hypertension case finding aligned. • Using System Analytics Intelligence Unit (SAIU) analysis and recommendations, Integrated Neighbourhood Teams (INTs) are prioritising hypertension case finding and management for neighbourhoods most at risk. • Successful bid awarded through NHS England (NHSE) to expand the optometry hypertension case finding pilot in Mid Nottinghamshire. • Development of a Children and Young People's (CYP) data dashboard underway with initial area of focus being on Special Educational Needs and Disabilities (SEND) to be published in August 2024.	• Optometry pilot system planning terminated due to uncertainty around General Practice (GP) collective action.
Based on identified local and system priorities, Place Based Partnerships will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.	**Amber**	• Community transformation programmes are being embedded following learning and a Place Based Partnership (PBP) approach to integrated neighbourhood working (INW) is being rolled out. • PBPs received funding for INW developments which supports a targeted approach to improve the co-ordination of services, provide person-centred care and to address the wider determinants of health and wellbeing. Currently in 11 priority neighbourhoods/Primary Care Networks (PCNs) in the County. City PBP progressing INW in 2 PCNs with ambition to embed across all PCNs by March 2026. • Improving CYP vaccination and immunisation rates. CYP remains a priority with targeted work.	• City progressing INW without dedicated resource. • 2024/25 Delivery Plans are in place across all neighbourhoods/PCNs and PBPs have established appropriate governance structure to ensure work remains on track.
System-wide approach to personalised care planning across all sectors (acute, community and primary).	**Amber**	• Engagement will be undertaken through INW where frailty is a key programme of work. • Healthy Weight Management programme for CYP is funded to support personalised care and bespoke packages of care where core intervention does not meet the child's need. • The "You know Your mind" service is embedded in the County for children in care and care leavers. • Embedding of the localised Social Prescribing offer continues including continuation funding for Green Social Prescribing.	• Effective Care and Support planning requires increased level of training. Opportunities are being discussed. • SAIU considering future data capture/reporting requirements. • Work to ensure ownership within the System Transformation programmes is required to further personalisation being everyone's business.
Implement structured education programmes	**Green**	• CYP services commissioned holistically alongside public health, social care and education to provide training to all professionals working with children. • Continued promotion of face to face and virtual diabetes structured education programmes to healthcare professionals and patients (Diabetes Education & Self-Management Service, DESMOND and Dose Adjustment for Normal Eating, DAFNE). • Health care professional sessions delivered – footcare, 4 diabetes in young people sessions planned for September/October. 4 Chronic Kidney Disease (CKD) sessions planned for October.	• Working with providers of patient education programmes to understand uptake and impact. • Collaborative working continues across providers to ensure good update to training and education programmes.

Priority 01 Prevention: reduce physical and mental illness and disease prevalence. Annual Deep Dive

Tobacco dependency

- NHS services in place for inpatient, maternity and mental health as part of the Nottingham and Nottinghamshire Alliance and Vision for Tobacco Control.
- Between June 23 and July 24, 1,471 people were referred for support to stop smoking via maternity pathways at NUH, SFH and Doncaster and Bassetlaw Teaching Hospitals (DBTH).
- ICB Smoking At Time Of Delivery (SATOD) rate decreased by 1.3% from 22/23 to 23/24, the sharpest decrease in 10 years of reporting.
- In July 24, SFHT recorded their lowest SATOD rate of 6.8% from highs of 15% reported previously.
- NHS services integrating with local authority commissioned services and working with Public Health to take a targeted approach.

Severe Mental Illness Health Checks (SMI)

- Annual health checks are increasing. In 2023/24 6,137 people received a complete core physical health check equating to 72% of the GP SMI register and 21% more patients than in 2022/23. This resulted in 5-8% more patients being identified for weight management, lifestyle interventions for high blood pressure, and for high cholesterol.
- 98% of General Practices have signed up to the Local Enhanced Service for 2024-26 to deliver health checks and follow up interventions.
- A pilot is taking place in Nottingham City for a peer support offer to increase access to physical health interventions identified e.g. lifestyle interventions and cancer screenings.

Cancer

- Continuing to expand access to community lung health checks.
- Early stages of developing East Midlands Cancer Alliance Advancing Cancer Equity (ACE) Programme. The programme aims to explore, define, address and narrow inequalities in access, outcomes and experience. The programme will comprise of 5 key improvement delivery components.
- Women's health hub focused on screening with a focus on addressing the barriers experienced by women and girls.

Maternity

- Work and development of programmes continues to be supported by the maternity equity strategy.
- CardMedic implemented in Nottingham University Hospitals and Sherwood Forest Hospital. CardMedic is a healthcare translation app that provides on-demand access to clinically interpreted interactions in almost 50 languages, as well as formats such as EasyRead and sign language. Nottingham University Hospital has appointed a community engagement matron. Key priorities include interpreting services; cultural competency training; engagement with local BAME community groups; workforce diversity; antenatal forums in different languages.
- Preterm Birth Clinics: Midwifery Leads in post at Sherwood Forest Hospital and Nottingham University Hospitals and progressing optimisation work.
- Refreshed Maternity and Neonatal Voices Partnership Model recruited to e.g. Engagement Leads in post at both Sherwood Forest Hospital and Nottingham University Hospitals – increased capacity to reaching out service users and staff. Evaluation being scoped.

Long Term Conditions

Respiratory

- Targeted work to increase uptake of vaccines.
- Lung health check programme screening for respiratory disease in areas of highest prevalence and deprivation.
- In-patient smoking cessation services targeting respiratory wards.
- Increasing access to spirometry and targeting specific groups to be supported by Integrated Neighbourhood Teams. Successful bid to increase spirometry testing in targeted groups. Increasing access to Pulmonary Rehab.

Cardiovascular disease: hypertension case finding and management

- Progressing with Core20PLUS5 Accelerator programme and quality improvement approach to hypertension case finding.
- Since September 2022, hypertension diagnosis across the ICS has increased by 10.4% (August 2024) with over 17,800 new cases diagnosed. System Analytics Intelligence Unit (SAIU) analysis and recommendations, Integrated Neighbourhood Teams prioritising hypertension case finding and management for neighbourhoods most at risk
- Successful bid to expand the optometry hypertension case finding pilot. Focus will be on Mid-Nottinghamshire and Nottingham City.

Tackling Health Inequalities: our Core20PLUS5 approach Children and Young People including Special educational needs and disabilities. Continuation of priorities in Children and Young People Core20Plus5, with a focus on the nationally identified 5 areas of priority and on locally identified ”Plus” populations.

National priorities

Asthma: Increase system understanding of good asthma care and management through targeted education sessions for healthcare professionals, education and social care professionals and families, children and young people. Projects initiated to bring diagnosis rates in line with expected prevalence and provide clinical oversight to Children and Young People with this condition where risk factors are identified, through a community diagnostic centre model.

Epilepsy: understanding in disparities of epilepsy data, working with colleagues from the Children’s Integrated Commissioning Hub (CICH) to understand how mental health support can be provided to Children and Young People with epilepsy. Focus on epilepsy nurse specialist workforce and aligning this with areas of national priority.

Diabetes: close loop continuous glucose monitoring (CGM) roll out.

Oral Health: oral health promotion ongoing through local authority.

Infant Mental Health: 0-5 – Infant mental health system mapping work underway. This includes maternal and paternal mental health, parent-infant relationships, and the mental health of infants and young children. A review of key evidence, parent and carer feedback and gaps or inequalities in access will follow (Q4 24/25).

Local priorities

Special educational needs and disabilities (SEND)

- Joint oversight and accountability by the NHS and local authorities for children and young people with SEND and their families with reporting into the ICS Children and Young Peoples Board. Contractual arrangements have been implemented for providers to report on SEND activity. A data dashboard is under development and due to be published in August 2024. Partner organisations within the ICS are working collaboratively to meet the needs of this population through population needs-led and efficient commissioning.

Children in Care and Care Leavers

- Nottingham City continuing to pilot mental health provision in Leaving Care Team. Equivalent provision is being mobilised in county in Q2 23/24. The equivalent provision is being mobilised in the Leaving Care Team in the county.
- Sustaining personal budgets (You Know your Mind) for looked after children within the county and city.
- Nottinghamshire County Council Joint Strategic Needs Assessment for Children in Care and Care Leavers is due to be presented to the Health and Wellbeing Board in September 2024 for ratification. Actions for improvement will be overseen by Partnership Board.
- Children in Care Nursing Team have implemented a transformation plan to ensure equity of practice for children and young people originating from Nottingham and Nottinghamshire and those placed in-area. A levels of needs framework is also in development to ensure right care at the right time.
- The system average waiting time for Children in Care’s Initial Health Assessments are reducing.

Youth Justice

- Joint Commissioning opportunity for Youth Justice Health between the councils, ICB and Office of the Police and Crime Commissioner is progressing (Q3 24/25).
- Youth Justice Nursing Team service delivery changes to ensure equitable practice across the city and county are progressing (Q3 24/25).

Health Inequalities Investment Fund

The ICB remains committed to the implementation and evaluation of schemes identified in 23/24 along with a new process being identified for 24/25 and in preparation for 25/26 onwards.

Nine schemes across three areas of health inequalities are being supported:

- **Community:** Integrated Neighbourhood Teams is developing in all four Places (Nottingham City are progressing without additional funding), this includes targeted work to support frailty and long-term conditions e.g. community hypertension case finding and management/cardiovascular disease (CVD) case finding.
- **Best Start in Life**: Children and Young People immunisations and vaccinations in Nottingham City, Family Mentor Programme and Children and Young People Healthy Weight Management Programme.
- **Inclusion Health**: Severe Multiple Disadvantage programmes in Nottingham City and Nottinghamshire County.

Through the Integrated Care Strategy and Joint Forward Plan, the focus will remain on how best to target resources in line with the commitment to equity.

Case study for Best Start in Life

Children and Young People Healthy Weight Management

- A Child who has completed the Tier 2 + programme lost 8.4% of his body weight.
- He was able to reduce portion sizes despite significant barriers to food preparation.
- His activity level has significantly increased, and he now swims regularly.
- Consultations with the dietician and making recommended changes to his diet have improved his digestion and bowel habits.

Best Years Hub

The Best Years Hubs launched in June 2024 in both Newark and Sherwood. The hubs provide residents over the age of 65 living with a long-term health condition in Newark and Sherwood, with educational groups, weekly activities, one-to-one befriending to help improve wellbeing and reduce social isolation and Advanced Care Planning. The hubs are delivered and supported by an integrated team of professionals and volunteers working across health, social care, local authority, community, and voluntary sectors.

The first month of the Newark Hub at Cleveland Square proved to be so successful that we are already looking to open other hubs!

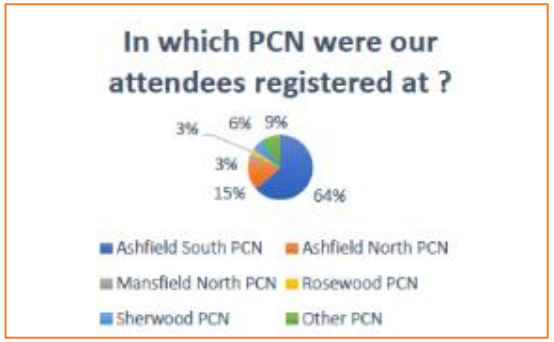
"I am really glad that I was told about the Best Years centre, the staff and volunteers are so kind to me and it's nice to have something to look forward to every week. My volunteer driver Jackie is absolutely lovely she takes me every week and I am so grateful that I am getting out a bit more now. I think it's marvellous they are taking us on a trip something a lot of us at this group would not be able to do on our own- I thank everyone of them."

With the support of Diabetes UK and Abbott, Ashfield South PCN were able to offer a free and comprehensive Diabetes Health check to the residents of Kirkby in Ashfield and the surrounding areas.

Residents were able have their BMI confirmed according to their height and weight, have their blood pressure checked, and undergo a finger-prick blood test to confirm their blood glucose and cholesterol levels. The specialist Abbott machines were able to produce results from the blood tests in just 7 minutes and therefore residents were able to receive their results instantly and left with their results recorded on a record card.

Diabetes UK, NDPP (Diabetes Prevention) and DESMOND (Diabetes Education & Self-management Service) were also on site to help inform residents about Diabetes, answer any questions, and to help signpost to services which may benefit them.

In addition, local leisure centre provider, Everyone Active, was on site offering free trial sessions as well as information on how to access their exercise referral schemes, to help residents become more active.



Targeting and Promotion

To promote the event, local practices sent text message invites to patients who would most benefit from the service. These included those:

- Aged 30-60, with a BMI > 30.
- Who did not already have a Diabetes diagnosis.
- Who had not had a Hba1c test within the last 6 months.
- Who lived within our District's "priority place", Coxmore Estates (Abbey Ward).

In addition, we sought the support of colleagues from within our INT (Integrated Neighbourhood Team) including:

- Ashfield District Council
- Ashfield Voluntary Action
- Everyone Active

We even had a shout out from our Local MP on social media!

On the day

We were blessed with good weather and had a great turn out to the event. Thanks to NHS Property Services we were able to provide seating to residents waiting and had fans in the consultation rooms to keep the blood test machines (and our staff) nice and cool. We had a steady flow of visitors throughout the day thanks to the promotional work undertaken before the event as well as some leaflet promotions within the town centre and at local businesses on the day.

Our PCN team of Nurses, General Practice Assistants and a Pharmacist worked tirelessly throughout the day, and we had some great feedback from residents who were extremely grateful of the services. Whilst most attendees were local, we did have some visitors from further afield across Mid-Notts and beyond!

In total we were able to test 77 people as well as bring awareness of the risks of Diabetes, how to prevent or manage the condition, and to promote a healthy diet and active lifestyle.

It was a fantastic event, and we thank everyone involved in making the day a success.

Priority 02	Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy	Reduction in average number of years spent in poor health Reduction in avoidable premature mortality

Key Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Develop Place-Based Partnership (PBP) focus on tackling the quality of care in frailty that would be supported by the whole system and its partners. Identify the frailty cohort of focus based on data which indicates where resources are being over utilised and where care could be provided more appropriately.	**Green**	• PBP plans aligned to system-wide approach to Frailty. • Workflows used by Care Navigators in eHealthScope have been updated to reflect requirements for multi-disciplinary teams (MDTs). New workflows developed for frailty and long-term conditions (LTCs). • Engagement will be undertaken through INW/ local design teams where frailty is a key programme of work. • Local design teams across all 4 PBPs are focussing on the greatest areas of need including CVD and long-term conditions.	• New model for care navigation requires sign off and approval of investment. This is on track. • Workflows require agreement for technical development. This is on track.
Reinvigorate the Practice Pack model at a Practice, Primary Care Network (PCN) and Place.	**Green**	• Practice / PCN and PBP high level dashboard available on SAIU Portal. • Primary Care Performance and Delivery Group reviewing outliers and determining next steps.	• The refreshed Practice Pack approach will rely on General Practices to access information via the SAIU portal and undertaking their own analysis.
Frailty same-day emergency care embedded.	**Amber**	• External audit assessment has been completed on the system discharge arrangements. The final report presented to the Discharge Governance Steering Group and Urgent and Emergency Care Programme Board. • Implementation of Discharge Recovery Action Plan focusing on immediate actions to reduce the no criteria to reside (NCTR) / medically safe for transfer (MSFT) numbers.	
Asthma diagnosis tools embedded within primary care for children and young people.	**Completed**	• System-wide education programme for upskilling professionals in asthma identification and care embedded in primary care, Emergency Department, community services and schools. • System deep dive to understand local population and prioritise areas of focus for improvement of asthma undertaken in 2022 and currently being updated.	
Increase immunisation and screening uptake for ‘at risk’ groups.	**Amber**	• Efforts continue to increase vaccination rates. • Actions are being taken to support PCNs to reach out. Increased clinics in NG7, targeting in schools and of older people. • Local Authorities are working with PBPs on increasing health checks. • PBPs have implemented INTs which will include a focus on immunisation and screening.	• Transient population in Nottingham City. • Capacity and funding required to carry out extensive outreach. • Sherwood Forest Hospitals capacity to do maternal vaccinations escalated as a risk.

Priority 02	Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy	Reduction in average number of years spent in poor health Reduction in avoidable premature mortality

Key Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Deliver Primary Care Strategy and integrated approach to Long Term Conditions Management with a focus on the top five health conditions for the population.	**Green**	• Primary Care Strategy Delivery Group established. Community Pharmacy chapter drafted and under consultation. Plans for developing a Dental and Ophthalmology Strategy working group to support the creations of the relevant chapters. Outcomes and metrics for the strategy are being developed as the chapters are established to ensure monitoring of delivery can be reported. • Actions aligned to Prevention, Identification and management of Long-Term Conditions (LTC)/Frailty are being implemented and are aligned to the system wide transformation priority.	• There may be delivery risks associated with uncertainty around General Practice (GP) collective action. Work ongoing to understand impact of any collective action.
Continued identification of physical health issues in people with a serious mental illness thorough physical health checks to ensure proactive management in this group who do not routinely access physical health services.	**Green**	• Local data for the rolling 12 months to July 2024 shows 5,795 patients have had a complete core check, which is 64.3% of the Severe Mental Illness (SMI) register. National Q1 data will be reported in August 2024. • Communications for primary care, health improvement workers and other stakeholders continue to raise awareness of checks, signpost to training opportunities, guidance on engaging patients and making reasonable adjustments. • Peer Support Workers and existing Health Improvement Workers continue to support with delivery of the checks, alongside primary care delivery. • SMI Local Enhanced Service extension approved 2024-26, 98% of practices signed up. This supports delivery of an enhanced health check and referral into follow up interventions.	• PCN Test and Learn pilots during Q1-Q3 to include approaches to targeting patients who have not had any checks, under-represented populations and those with partial checks • Recruit the final x2 Health Improvement Workers for City by Q3.

Priority 03	Improve navigation and flow to reduce emergency pressures in physical and mental health settings.

Outcomes		
	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Reduction in avoidable premature mortality	Increase in the proportion of people reporting high satisfaction with the services they receive Reduction in Hospital Emergency admissions to hospital (Length of Stay 1+ bed-days) Reduction in Hospital Emergency admissions for COPD, Cancer, CVD, Falls, Alcohol (including same-day discharges)

Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, Cardiovascular disease (CVD).	**Amber**	• Key areas of focus for initiatives to be undertaken across our community landscape (2024-2026) will be frailty prevention, early identification and ongoing management.	Robust programme management arrangements are in place to oversee this approach.
Further develop social prescribing model across all Places/care navigation across primary care, aligned with Make Every Contact Count approach.	**Green**	• A multi-level, consistent 'Make Every Contact Count' (MECC) training offer will be co-designed with the Health and Social Care workforce. • An extended MECC and wider prevention training offer will support the workforce to facilitate better conversations about health behaviours and the building blocks of health. • A new social prescribing mental health model is being developed which will focus therapeutic interventions building on existing mental health community provision. • A new care navigation model is in development whereby workflows developed are aligned to addressing Frailty and Long-Term Conditions.	
Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts	**Amber**	• Providers are developing a new system wide model that will deliver improved performance and efficiencies in 24/25. Implementation expected to commence in Q3. • 276 beds against an NHSE submitted plan of 204 beds. 69% occupancy (snapshot @ 20th June) against an NHSE target of 80%. • Focus for 24/25 will be on community led respiratory and frailty.	There is a risk that any reduction in financial investment may impact on the capacity that can be delivered in 24/25. Providers are working together to mitigate the risk and a proposal is expected in Q2.
Develop a co-located urgent treatment centre at QMC to reduce demand on Accident & Emergency.	**Amber**	• Co-located designated Urgent Treatment Centre is being developed at Queens Medical Centre with a phased implementation plan and go live date of April 2025. • Phase 1 went live in July 2024 – launching a new expanded inclusion criteria with an aim of increasing the number of patients streamed to the 'UTC'	There is a risk that the financial investment required means that a fully compliant designated UTC may not be delivered by April 2025. Providers are working to mitigate the risk and a proposal is expected in Q2.
Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.	**Amber**	• Significant improvements seen in medically safe for transfer (MSFT), no criteria to reside (NCTR), and long length of stay (LLOS) at both trusts. In May, NCTR was the lowest since September 2023 and MSFT lowest since November 2021. LLOS was lowest since October 2021. • Improvements in discharge levels seen at Nottingham University Hospitals over previous months, significant reduction in patients waiting for Pathway 2. Averaging over 300 discharges per day.	There is a risk that if investment in P1 and P2 is reduced there will be an impact on the progress made with MSFT delays. Providers are working together on mitigations and proposals are expected in Q2/3.

Priority 03	Improve navigation and flow to reduce emergency pressures in physical and mental health settings.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Reduction in avoidable premature mortality	Increase in the proportion of people reporting high satisfaction with the services they receive Reduction in Hospital Emergency admissions to hospital (Length of Stay 1+ bed-days) Reduction in Hospital Emergency admissions for COPD, Cancer, CVD, Falls, Alcohol (including same-day discharges)

Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Expand our same-day emergency care (SDEC) offer across hospitals ensuring direct access for all professionals and implementing new data requirements.	**Amber**	• During 2024 SDEC pathways and services will continue to expand at both NUH and SFHFT. Surgical SDEC is now live at SFHFT, with medical SDEC expanding at NUH through the multi-specialty SDEC development on A Floor. Phase 5 of the multi-specialty SDEC A floor project is expected to go live in October. • Specialty referral Policy was signed off by acutes trusts and UEC board which will open up access to specialties for all competent trained clinicians in the Nottinghamshire system rather than designated clinical groups.	
Transform our Pathway 2 and 3 offer to improve patient flow for patients who are medically safe for transfer and reduce length of stay in Pathway 2 beds.	**Amber**	• A meeting has been held with SFHFT and NHT re community bed provision in Mid Nottinghamshire as part the new P2 model and offer. • Aiming for new model ahead of winter 24/25.	Risk that a P2 model is not agreed before winter due to complexities around contracting of beds. Proposal going to Chief Operating Officers (COOs) in Q2 for support to mitigate.
Develop an urgent care coordination hub (UCCH) which will act as a single point of access for health professionals.	**Amber**	• Average of 290 calls transferred to the UCCH per week, of which, 61% of calls are managed without an emergency response. • Percentage of urgent community response (UCR) increased to 84% of calls resulting in a response (was 50% visit rate prior to UCCH) – more efficient use of resources. Funding has been sourced to continue this initiative. Expansion of this service is being explored to further reduce activity sent to ED e.g. from care homes etc. • Further development of the service during the 'perfect fortnight' including referrals from ambulance crews and improving onwards referral to UCR.	Risk that the service cannot be expanded any further due to the lack of additional investment available. NEMS are investigating any efficiencies that can be made.

Priority 04	Timely access and early diagnosis for cancer and elective care.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Improve Early Cancer diagnosis	Reduction in avoidable premature mortality Increase in the proportion of people reporting high satisfaction with the services they receive Reduction in Hospital Emergency admissions to hospital Reduction in Hospital Emergency admissions for Cancer

Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Continued support to eliminate waits of over 65 weeks for elective care.	**Amber**	• At week ending 23 June 2024 there were 647 patients against a plan of 338. Forecast remains to achieve zero by September, particular focus on Ears, Nose and Throat (ENT).	• Plans in place and assurance sought for at risk specialties.
Elective hubs and clinical diagnostic centres established (Newark, City, Mansfield).	**Green**	• Elective Hub (City Campus); Main construction works for phase 2 begun in June 2024. However further delays are expected to affect the planned completion of March 2025. • Elective hub (Newark). The operating theatre opened as planned and has operational since 6th November. The “Getting it Right First Time” (GIRFT) regional team visited the hub on 23rd May 24. Working towards a hub accreditation review in Spring 2025.	• Ongoing as plan.
Expansion of targeted lung health check, (TLHC) breast cancer screening, community prostate clinics and community liver surveillance programmes.	**Green**	• Targeted Lung Health Check (TLHC) expansion plans continue to be implemented with next phase in Sherwood from July 24. Phase 2 starts in Hucknall, Calverton and Arnold in April. • TLHC recently located in Nottingham City Centre to provide open access service to severe multiple disadvantage (SMD) population. 16 people were identified as at risk and supported to attend. • Overall, 200 cancers now diagnosed across the programme with 65% early diagnosis rate (compared to 30% for symptomatic patients). Significant levels of non-cancer diagnosis - Respiratory, heart and liver disease.	• Ongoing as plan.
Identify the top 5 specialities with the longest waits for CYP elective care. Differentiating waits and preoperative care for children and young people where development is disproportionately affected compared to adults.	**Green**	• Diagnostic productivity programme focussing on MRI and Audiology utilisation improvement, impact from July. • System partners working together around Echocardiography, MRI and Audiology. • In Audiology, clinic changes will be introduced for school ages children from end of July, which will double capacity. Patient Initiated Follow Up (PIFU) has been introduced for Paediatric Audiology. Additional Audiology clinics run by insourcing provider at weekends. Review underway to maximise efficiency of scheduling and booking rules. • CYP elective wait data is regularly reported against and reviewed.	
Roll-out personalised care, optimise integrated care pathway and referrals. Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count.	**Amber**	• Work continues with Digital Notts to develop the enhanced eMeet and Greet programme to support early health screening and elective recovery. • Opportunities identified through the newly published NHSE Missed Appointments Toolkit with speciality teams who experience high Did Not Attend (DNA) rates to refine action plans. • A review of the referral optimisation outcomes is underway, and work will continue to focus on reducing unwarranted variation across the patient pathway and link to the GIRFT productivity programmes. Revised Gynaecology guidelines are being reviewed by primary care and self-care guidelines for patients to compliment the referral guidelines are being drafted.	• Focus continues via the Getting it Right First Time (GIRFT) Programme Board and reported to the Planned Care Transformation Board. Plans aligned with digital team. There is a need for further financial analysis to maximise opportunities.

Priority 04 | Timely access and early diagnosis for cancer and elective care. Annual Deep Dive.

Cancer
Position Overview:

- **62-day backlog** – NUH is delivering against the revised improvement trajectory: 272 v 284 @2/7/2024. There has been recent progress in reducing the 62-day backlog, with reductions over the past few weeks. Urology remains the largest backlog at 122 patients. The trust is working to achieve the fair shares target of 233 patients by September. The SFH Cancer backlog remains under the fair shares.
- **Faster Diagnosis Standard** – Consistently achieving target. May performance was 79.9% for SFH and 79.6% for NUH. June forecasts are to similar levels.
- **31-day** – May performance was 85.7% for SFH against a plan of 87% and 93.1% for NUH against a plan of 90.6%. Both providers forecast to achieve operational plans in June
- **62-day** – NUH and SFH exceeded operational plans in April. Provisional May data is below operational plans but is subject to validation. NUH forecast to achieve plan in June of 60.8% and SFH forecasting 66.3% in June which is below their plan of 70%. SFH forecasting plan achievement in August.

Areas of focus to improve performance in the short and medium term

- Jubilee theatres at NUH opened in March 24 – additional capacity for Lower Gastrointestinal (LGI), Lung, Urology and Gynaecology.
- Mutual aid opportunities in Gynaecology being explored by NUH (proposed – 7 patients, 1 colposcopy per list) ongoing actions to identify how SFH staff member can provide additional support due to Human Resources (HR) and accreditation requirement issues. The service are reaching out to Leicester and Ilkeston too to explore further mutual aid opportunities.
- Industrial Action Update - all specialties have very limited impact on cancer pathways as capacity maintained or shifted to accommodate where changes have had to be made.
- A range of specialty actions are taking place around Pathology, Radiology Skin, Urology and others funded via East Midlands Cancer Alliance (EMCA) Quick Win Funding.
- Enhanced Faecal Immunochemical Testing (FIT) protocol to be implemented in LGI at NUH to triage patients from Cancer Patient Tracking List (PTL) to Routine waiting list.
- Cancer Tele-dermatology service implemented at SFH and to be extended to Newark. NUH piloting service in Q2.

Transformation

- Targeted Lung Health Check (TLHC) expansion plans continue to be implemented with next phase in Sherwood Mid Nottinghamshire from July 24. Phase 2 starts in Hucknall, Calverton and Arnold in April 25. TLHC recently located in Nottingham City Centre to provide open access service to severe multiple disadvantage (SMD) population, through joint working with Framework and local Charities. Of the first 13 scanned, 2 cancers diagnosed.
- Overall, 200 cancers now diagnosed across the programme with 65% early diagnosis rate (compared to 30% for symptomatic patients). Significant levels of non-cancer diagnosis - Respiratory, heart and liver disease.

Priority 04 | Timely access and early diagnosis for cancer and elective care. Annual Deep Dive.

Elective Care
Position Overview:

- **104 week wait (ww)** – delivered zero for end of June 2024 at NUH and SFH.
- **78 ww** – delivered zero for end of June 2024 at NUH and SFH.
- **65 ww** – At week ending 23.6.24 there were 647 patients against a plan of 338 (NUH 529 against plan of 220, SFH 118 against plan of 118). Forecast remains to achieve zero by September, particular focus is at NUH for Ears, Nose and Throat (ENT).
- **52 ww** – Behind the provider system plan with 4,942 patients against a plan of 4,620 patients (NUH 3,759 against 3,390 plan, SFH 1,183 against 1,230 plan).
- **Incomplete Referral to Treatment (RTT)** – Latest position at 26.6.24 is 127,412 patients against a provider plan of 120,743.

Areas of focus to improve performance in the short and medium term

- System work is progressing to reduce waits across a number of pathways by Trusts working together and reviewing capacity from a combined perspective.
- SFH are adopting the digital solution used at NUH (DrDr) to increase pace on validation from mid-July. This is positive progress and an example of 'adapt and adopt'.
- Milestone plans are being finalised to improve outpatient and theatre productivity.
- NUH has revamped and relaunched the outpatient improvement programme under the Productivity Workstream of the financial sustainability programme.
- Productivity opportunities will continue to be scoped in detail and shared across providers; where there is a similar opportunity, joint working may be appropriate, and learning will be shared.
- The existing groups for Musculoskeletal (MSK) and Eye Health are clinically led and will encompass wider transformation and milestone plans will be agreed.
- The System Analytical & Information Unit (SAIU) are working with trust Business Information (BI) teams to confirm datasets, benchmarking information, and key metrics to inform and identify financial opportunities.

Outpatient transformation

- Work continues with Digital Notts to develop the enhanced eMeet and Greet programme to support early health screening and elective recovery.
- Opportunities identified through the newly published NHS England Missed Appointments Toolkit with speciality teams who experience high Did Not Attend (DNA) rates to refine action plans.
- A review of the referral optimisation outcomes is underway, and work will continue to focus on reducing unwarranted variation across the patient pathway and link to the Getting it Right First Time (GIRFT) productivity programmes. Revised Gynaecology guidelines are being reviewed by primary care and self-care guidelines for patients to compliment the referral guidelines are being drafted.
- Elective Hub (City Campus); Main construction works for phase 2 begun in June 2024. However further delays are expected to affect the planned completion of March 2025. Further details on mitigation plans and revised timelines are expected week commencing 17th June 24.
- Elective hub (Newark). The operating theatre opened as planned and has operational since 6th November, with full sign off in place from the beginning of January allowing full range of procedures suitable for Newark. The GIRFT regional team visited the hub on 23rd May 24 and shared a report which summarises the discussions and outline of the opportunities and recommendations for SFH to take forward. These include working towards a hub accreditation review in Spring 2025.

Priority 04 | Timely access and early diagnosis for cancer and elective care. Annual Deep Dive.

Diagnostics
Position Overview:

- SFH were above their local trajectory in May with 72.6% against a 72.0% plan. NUH were below plan with 66.8% against 69.3%.
- At SFH, seven modalities were achieving 85% ambition in May, with two achieving 85% at NUH.
- **Reduction in both waiting list volume and backlogs from April to May 2024.** The May 2024 waiting list volume was 29,363 patients across NUH and SFH, this is a slight decrease on the 29,483 waiting at the end of April 2024. The backlog volume is 8,843 patients which a reduction of 520 compared to the 9,363 at the end of April 2024.
- **Diagnostic tests delivered in May were above planned levels by 1579 (4.7%),** with 35,475 Diagnostic tests delivered (for tests included in the operational plan). This level was above the April volume by 1,608 tests.
- Echocardiography activity at SFH has increased substantially since implementing the recovery plan. An additional 375 tests were delivered in May 2024 compared to the same period of 2023 (36% growth).
- In May, Computed Tomography (CT) and Echocardiography (Echo) achieved the planned 6-week performance at NUH, with Audiology and Gastroscopy achieving at SFH.
- Challenged specialities include Echo at SFH, MRI and Audiology at NUH. Audiology has increased demand and clinical staff vacancies. Demand control measures in place to limit referrals to Nottingham City and South Nottinghamshire Place until performance is improved and stable.

Areas of focus to improve performance in the short and medium term

- CT performance in May much improved at NUH linked to CT 7 opening- 6 weeks earlier than expected. Backlog reduction already evident, opportunity now to accelerate performance improvement for CT.
- PA supported diagnostic productivity programme at NUH focussing on Magnetic Resonance Imaging (MRI) and Audiology utilisation improvement, impact from July.
- System partners working together around Echocardiography, MRI and Audiology.
- A range of actions have been implemented for Echo at SFH to increase activity and reduce the backlog volume, which include additional weekend working, insourcing at Mansfield and Newark Hospitals and deep dive into booking processes. The trust have secured additional graduate trainee posts including running an internal graduate trainee programme. Four graduates completed internal programme and have been retained at SFH. 5th trainee recruited and commenced training in September.
- Good progress with iRefer roll out at both trusts, ensuring appropriateness of GP referral.
- In Audiology, clinic changes will be introduced for school ages children from end of July, which will double capacity. Changes will also be made around the adult clinic rota from August to reduce clinic time from 60 to 45 minutes. Patient Initiated Follow Up (PIFU) has been introduced for Paediatric Audiology. Additional Audiology clinics run by insourcing provider at weekends. PA consultancy reviewing scheduling and booking rules to maximise efficiency.

CDC planning for 2025/26

- Mansfield Community Hospital Community Diagnostic Centre (CDC) approved by the National Team. CDC accelerator activity underway at Mansfield and Newark sites – MRI, Echo, ultrasound, Phlebotomy.
- Nottingham City CDC is due to open in Autumn 2025 and will deliver an additional 50,000 diagnostic tests during 25/26 across 10 modalities. This will increase to around 108,000 tests in 2026/27.

Key

NHS
Nottingham and Nottinghamshire

	Delivery Confidence
Blue	Delivery complete / delivery complete for 2024/25
Red	Off track to deliver in 2024/25 (major) e.g. • High impact on direct patient care • High negative impact on addressing health inequalities • High impact on provider / partner resilience in one or more sectors • High impact with likely adverse publicity / reputational damage / loss of regulator confidence • High effort. Significant capacity/contractual issues. • High-cost impact, adverse financial impact on the system control total
Amber	Off track to deliver in 2024/25 (minor) e.g. • Medium impact on patient care limited to scope of contract • Medium negative impact on addressing health inequalities • Medium impact on specific provider / partner • Medium impact with likely adverse publicity / reputational damage / reduction in regulator confidence • Medium effort. Some capacity/contractual issues. • Medium cost impact, adverse financial impact on the system control total
Green	On track to deliver in 2024/25 e.g. • Minimal or no impact on direct patient care • Minimal or no negative impact on health inequalities • Minimal or no impact on provider / partners • Minimal or no impact on reputation • Minimal or no issues with delivery • No or low-cost impact, impact over limited geographical area

2411 - D ASSURANCE & GOVERNANCE

2411 - D1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Executive Directors | 10:30

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:	5 November 2024	**Agenda Reference:**	**D1**
Report Title:	**Integrated Quality & Performance Report**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr N Mallaband, Acting Executive Medical Director Jon Sargeant, Chief Financial Officer Denise Smith, Chief Operating Officer		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

This report outlines the key performance and safety measures for September 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.

74 metrics have been identified based on their significance to be presented within the IQPR report to the Trust board. Of these 8 are being further developed, are pending national or local thresholds or have no applicable target and will be included in future reports. Of the 66 included in this document 26 are currently being met and 40 are not meeting the expected standard in month, this is broken down as follows:

Access – 27 metrics. 7 being met, 18 not meeting target (1 in development, 1 no applicable target)

Quality – 31 metrics, 12 being met, 13 not meeting target, (4 in development, 2 awaiting target confirmation)

People – 6 metrics monitored monthly, 1 being met, 5 not meeting target. One annual target not met

Finance – 10 metrics, 6 being met, 4 not meeting target

The Trust has continued to have challenges in meeting expected standards for urgent and emergency care in September. Improvement work undertaken to date has however had a positive impact with a statistically significant increase in 4 hours performance so far this year. This change, although positive, is not sufficient to meet expected targets level so further interventions will be required. Ambulance handovers completed within 15 minutes has seen a statistically significant deterioration since April so will also require further support. Overall UEC demand is driving significant financial pressures and over-spends on pay in the organisation due to the opening of escalation beds. There have however been some reductions in run rate in September suggesting the focussed financial recovery work under-way is having a positive impact.

The Trust continues to deliver significantly less activity than planned for in 2025/26. This is creating a significant income risk on Elective recovery funding and is also a contributory factor in the number of long waiters not reducing in line with expectations.

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
		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:	
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

September 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 8 are being further developed, are pending national or local thresholds or have no applicable target and will be included in future reports. Of the 66 included in this document 26 are currently being met and 40 are not meeting the expected standard in month, this is broken down as follows: Access – 27 metrics. 7 being met, 18 not meeting target (1 in development, 1 no applicable target) Quality – 31 metrics, 12 being met, 13 not meeting target, (4 in development, 2 awaiting target confirmation) People – 6 metrics monitored monthly, 1 being met, 5 not meeting target. One annual target not met Finance – 10 metrics, 6 being met, 4 not meeting target The Trust has continued to have challenges in meeting expected standards for urgent and emergency care in September. Improvement work undertaken to date has however had a positive impact with a statistically significant increase in 4 hours performance so far this year. This change, although positive, is not sufficient to meet expected targets level so further interventions will be required. Ambulance handovers completed within 15 minutes has seen a statistically significant deterioration since April so will also require further support. Overall UEC demand is driving significant financial pressures and over-spends on pay in the organisation due to the opening of escalation beds. There have however been some reductions in run rate in September suggesting the focussed financial recovery work under-way is having a positive impact. The Trust continues to deliver significantly less activity than planned for in 2025/26. This is creating a significant income risk on Elective recovery funding and is also a contributory factor in the number of long waiters not reducing in line with expectations. Both urgent and emergency care and elective recovery are also impacted by sickness and vacancy rates being higher than planned for. There has however been statistically significant improvements in SET training rates, eJP completion rate and time to recruit but these remain below target levels. The Trust has positive trends in performance for reducing MRSA infections, increasing the proportion of % of >18 deaths scrutinised by the medical examiner and the proportion of patients having a VTE assessment. There are however a number of metrics which without further intervention will not consistently achieve target levels. Work is ongoing with executive directors to re-baseline a number of metrics to support more meaningful analysis of trends.

At a Glance

Assurance

Variation

	Will consistently achieve the target if nothing changes	Will not consistently pass or fail the target if nothing changes.	Will consistently fall below the target if nothing changes	No Target
Improving variation (High or Low).		MRSA (Bacteraemia)	A&E Attendances: Proportion < 4 Hours Diagnostics Waits < 6 Weeks VTE % Over 18 in Hospital Deaths Scrutinised Consultants with Signed off Job Plans RTT 78 Week Waiters RTT 65 Week Waiters Number of Vacancies Sickness Absence Average Time to Fill Vacancies Completed SET	
No significant change.	Stroke Early Supported Discharge CHPPD (Total) Nice Guidance Response Rate	A&E Attendances: Proportion > 12 Hours Ambulance Handover More than 60 Mins Average Time for Ambulance Handover Cancer FDS Cancer 31 Day Wait Cancer 62 Day Wait Stroke Thrombolysis Stroke 1 Hour Scanned NICE Guidance None and Partial Compliance FFT Inpatients/Outpatient/Maternity MRSA (Colonisation) HOHA and COHA C.Diff CHPPD (Registered Nurse) CHPPD (Registered Midwife) Sepsis Completed within 1 Hour (Inpatient) Never Events Reported Patient Safety Incidents Completed Appraisals Cancelled Ops Not Rebooked 28 Days Employee Turnover Reported Incidents in DATIX with status of hold for over 48 hours	Ambulance Handovers Within 30 Minutes Stroke 4 Hours Stroke named contacted after Discharge HSMR (Combined) HSMR (Non-Elective) Trust FFT Positive Response Rate Emergency Dept FFT Positive Response Rate Sepsis Completed within 1 Hour (A&E)	A&E Attendances Diagnostic Tests Elective Activity Outpatient First Activity HAPU Cat 4 Falls resulting in Low, Moderate or Severe Harm New Complaints Complaints not signed off in agreed timeframe Patient CNST Claims Staff LTPS Claims
Concerning variation (High or Low).	HSMR (Elective)		Ambulance Handovers within 15 Minutes RTT Waits < 18 Weeks	
Variance where up or down is may not be improving or concerning.				Outpatient Follow Up Activity Daycase Activity

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	Variation Status	Assurance Status
UEC	4 hour ED	78% by March 2025		Sep-24	76.3%	69.78%	-6.48%	75.70%	72.18%	-3.52%		
UEC	12 hours in department	No more than 2%		Sep-24	2.0%	4.3%	-2.28%	2.0%	2.6%	-0.59%		
UEC	Number of arrivals			Sep-24	17089	16946	143	103723	103318	405		N/A
UEC	Ambulance handovers - 15 minutes	65%		Sep-24	65%	35.2%	-29.84%	65%	37.0%	-28.02%		
UEC	Ambulance handovers - 30 minutes	95%		Sep-24	95%	66.3%	-28.68%	95%	70.5%	-24.53%		
UEC	Ambulance handovers - 60 minutes	0%		Sep-24	0%	13.4%	-13.43%	0%	10.5%	-10.50%		
UEC	Average ambulance handover times - YAS			Sep-24	16	0:32:31	-00:16:31	16	0:29:50	-00:14:26		
Diagnostics	Diagnostic waiting times	DM01 99% / Operational guidance 95%		Sep-24	89.0%	73.9%	-15.1%	89.0%	73.9%	-15.1%		
Diagnostics	Diagnostic activity against plan (including NOUS & CT IR)			Sep-24	18649	18456	-193	112539	112605	66		N/A
Elective Care	% patients waiting less than 18 weeks from referral to treatment	92%		Sep-24	92.0%	59.1%	-32.9%	92.0%	59.1%	-32.9%		
Elective Care	65 weeks	0 by September 2024		Sep-24	0	161	-161	0	161	-161		
Elective Care	78 weeks	0		Sep-24	0	23	-23	0	23	-23		
Cancer	Faster Diagnosis Standard	77% by March 2025		Aug-24	77.0%	78.0%	1.0%	77.0%	81.7%	4.7%		
Cancer	31 day combined	96%		Aug-24	96.0%	90.2%	-5.8%	96.0%	94.3%	-1.7%		
Cancer	62 day combined	70% by March 2025		Aug-24	70.0%	74.7%	4.7%	70.0%	71.0%	1.0%		

					Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Variation Status	Assurance Status
Activity against plan	Day Case Activity against Plan			Sep-24	4453	3938	-515	25967	23455	-2512		N/A
Activity against plan	Inpatient Elective Activity against Plan			Sep-24	654	609	-45	3946	3725	-221		N/A
Activity against plan	Outpatient New Activity against plan			Sep-24	14517	14266	-251	87822	86834	-988		N/A
Activity against plan	Outpatient Follow Up Activity against plan			Sep-24	30658	29083	-1575	185115	172932	-12183		N/A
Stroke	Proportion directly admitted to a stroke unit within 4 hours of clock start	75%		Jul-24	75.0%	52.0%	-23.0%	75.0%	52.0%	-23.0%		
Stroke	Proportion of patients scanned within 1 hour of clock start	48%		Jul-24	48.0%	50.0%	2.0%	48.0%	50.0%	2.0%		
Stroke	Percentage of eligible patients given thrombolysis	90%		Jul-24	90.0%	100.0%	10.0%	90.0%	100.0%	10.0%		
Stroke	Percentage treated by a stroke skilled Early Supported Discharge Team	>24%		Jul-24	24.0%	60.0%	36.0%	24.0%	60.0%	36.0%		
Stroke	Percentage discharged given a named person to contact after discharge	80%		Jul-24	80.0%	42.0%	-38.0%	80.0%	42.0%	-38.0%		
Elective Care	No urgent operation to be cancelled for a second time	0	In development (data)								N/A	N/A
Elective Care	Cancelled Operations Not Rebooked within 28 Days	0		Sep-24	0	1	-1	0	24	-24		
Elective Care	Proportion of all outpatient attendances that are for first appointments or Fus attracting a procedure tariff	46%	In development (data)	Sep-24	49%	50.80%	1.80%	49%	51.00%	2.00%	N/A	N/A

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	Sep-24	2,692	1,849	-843	F	19,300	19,841	541	A
ERF position		Sep-24	9,491	8,143	-1,349	A	56,899	51,996	-4,902	A
CIP delivery -vs Plan	£21.2m year-end CIP target	Sep-24	1,779	1,474	-305	A	6,236	5,976	-260	A
Substantive pay spend against plan		Sep-24	27,944	26,275	-1,669	F	166,006	157,983	-8,023	F
Additional sessions pay spend against plan		Sep-24	814	1,242	428	A	4,937	7,055	2,119	A
Bank pay spend against plan		Sep-24	30	1,361	1,331	A	183	8,498	8,314	A
Agency pay spend against plan		Sep-24	950	777	-173	F	4,618	6,444	1,825	A
Capital position YTD versus plan	£48.8m year-end plan	Sep-24	925	1,738	813	A	7,191	8,598	1,407	A
Cash balance		Sep-24	11,952	17,649	5,697	F	11,952	17,649	5,697	F
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	Sep-24	95.0%	91.0%	-4.1%	A	95.0%	88.2%	-6.8%	A

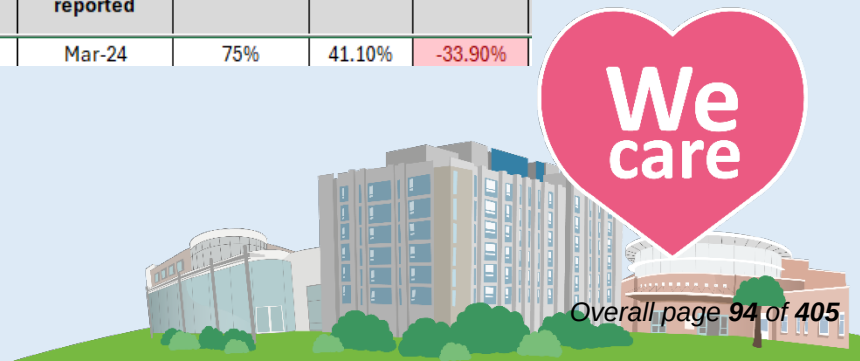
Key Performance Indicators - People

				Current month			Year to date				
Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Variation Status	Assurance Status
Consultants with Signed Off Job Plans in EJP	90%		Sep-24	90.0%	65.0%	-25.0%	90.0%	68.3%	-21.7%		
Overall Sickness Absence	5%		Sep-24	5.0%	5.8%	-0.8%	5.0%	5.9%	-0.9%		
Overall Vacancies			Sep-24	5.0%	5.9%	-0.9%	5.0%	4.7%	0.3%		
Time to hire (from TRAC authorisation - unconditional offer) A4C posts only	47 days		Sep-24	47	68	-21	47	68	-21		
Completed SET Training	90%		Sep-24	90.0%	89.0%	-1.0%	90.0%	88.7%	-1.3%		
Completed Appraisals	90% end July		Sep-24	90.0%	93.3%	3.3%	90.0%	66.0%	-24.0%		

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				
Section	Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Variation Status	Assurance Status
Mortality	Hospital Services Mortality Rate (HSMR): (rolling 12 Months - Combined)	<100		Jul-24	100	108.7	-8.72	100	108.7	-8.72		
Mortality	Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months)	<100		Jul-24	100	118.7	-18.65	100	118.7	-18.65		
Mortality	Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months)	<100		Jul-24	100	108.6	-8.62	100	108.6	-8.62		
IPC	Hospital Acquired MRSA (Colonisation) Cases Reported in Month			Sep-24	1.16	0	1.16	7	7	-0.04		
IPC	Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0		Sep-24	0	0	0	0	0	0		
IPC	Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month			Sep-24	5.75	7	-1.25	34.5	32	2.5		
IPC	Number of Community Onset Healthcare associated (COHA) C.Diff cases in month			Sep-24								
IPC	Overall Number of HAPUs / 1000 bed days		In development (data)	Sep-24								
IPC	Hospital Acquired Pressure Ulcers (HAPU) Cat 4			Sep-24	0	0	0	0	2	-2		
Falls	Inpatient Falls Resulting in Low, Moderate or Severe Harm		In development (data)	Sep-24	0	28	-28	0	188	-188		N/A
Falls	Severe harm falls per 1000 bed days	0	In development (data)	Sep-24	0	0	0	0	5	-5		N/A
Complaints	Number of Complaints Received in Month			Sep-24	0	45	-45	0	291	-291		N/A
Complaints	Number of Complaints Not Signed Off in Agreed Timeframe			Sep-24	0	0	0	0	68	-68		N/A
Claims	Claims CNST (patients) - new in month			Sep-24	0	8	-8	0	55	-55		
Claims	Claims LTPS - (staff) new in month			Sep-24	0	0	0	0	9	-9		

					Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Variation Status	Assurance Status
FFT	Friends & Family Response Rates - Trust			Sep-24	95%	85.2%	-9.8%	95%	87.3%	-7.7%		
FFT	Friends & Family Response Rates - ED			Sep-24	95%	68.5%	-26.5%	95%	71.2%	-23.8%		
FFT	Friends & Family Response Rates - Inpatient			Sep-24	95%	94.2%	-0.8%	95%	93.8%	-1.2%		
FFT	Friends & Family Response Rates - Outpatient			Sep-24	95%	88.2%	-6.8%	95%	92.2%	-2.8%		
FFT	Friends & Family Response Rates - Maternity			Sep-24	95%	100.0%	5.0%	95%	96.7%	1.7%		
Audit & Effectiveness	Mixed Sex Accommodation - nationally reported breaches in month	0		Sep-24	0	4	-4	0	26	-26		
Audit & Effectiveness	% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%		Sep-24	100.00%	100.00%	0.0%	100%	100.0%	0.0%		
Audit & Effectiveness	VTE - % of patients having a VTE Risk Assessment	95%		Sep-24	95.00%	96.31%	1.31%	95%	95.6%	0.6%		
Nice Guidance	NICE Guidance Response Rate Compliance	90%		Sep-24	90.00%	96.60%	6.60%	90%	95.5%	5.5%		
Nice Guidance	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%		Sep-24	10.00%	10.90%	0.90%	10.00%	11.9%	1.9%		
CHPPD	Planned Vs Actual CHPPD RM	90%	No Data Received		90.00%	0.0%	-90.00%	90.00%	98.5%	8.46%		
CHPPD	Planned Vs Actual CHPPD RN	90%	No Data Received		90.00%	0.0%	-90.00%	90.00%	96.3%	6.25%		
CHPPD	Planned Vs Actual CHPPD Total	90%	No Data Received		90.00%	0.0%	-90.00%	90.00%	99.4%	9.35%		
Sepsis	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	90%		Sep-24	90.00%	55.8%	-34%	90.00%	47.3%	-43%		
Sepsis	Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic reatment within 1 hour of diagnosis	90%		Sep-24	90.00%	60.0%	-30%	90.00%	47.6%	-42%		
Patient Safety	Never Events - Reported in month	0		Sep-24	0	0	0	0	4	-4		
Patient Safety	PSIIs reported in month			Sep-24	0	1	-1	0	7	-7		
Patient Safety	Number of incidents over 48 hours in the holding area			Sep-24	0	7	-7	0	7	-7		

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

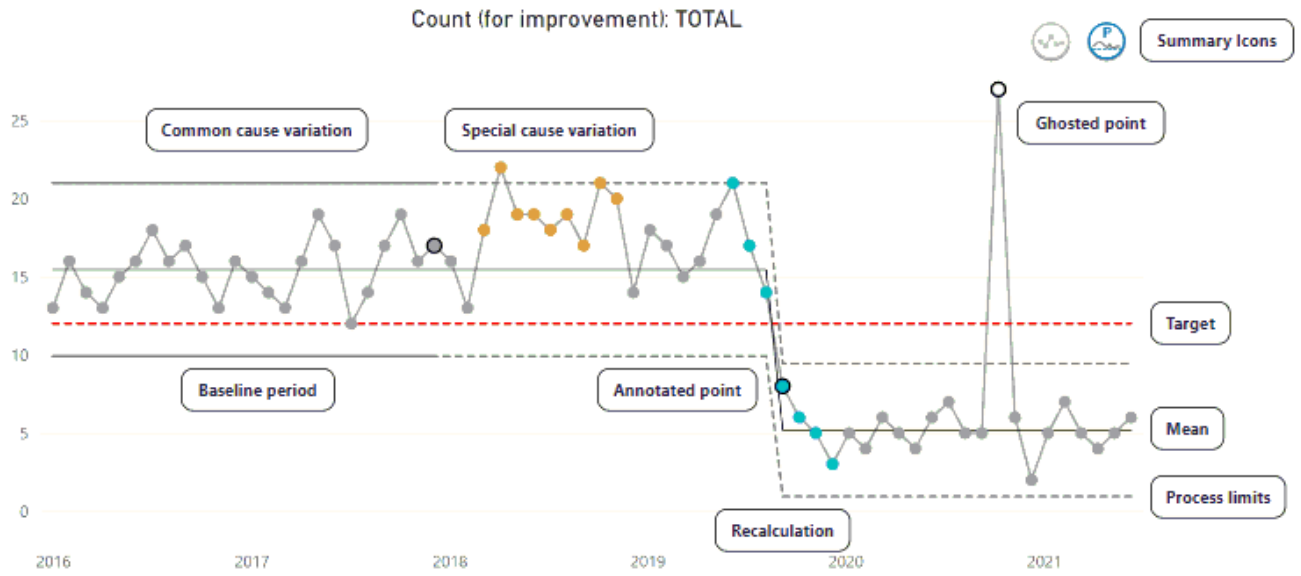
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

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.

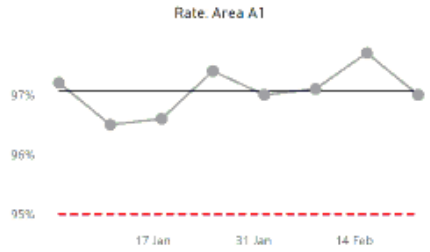
Annotations

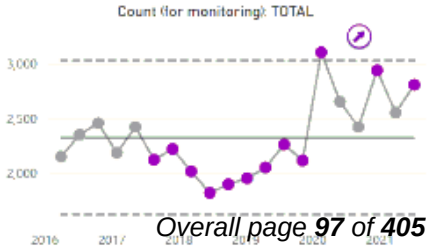
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



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.





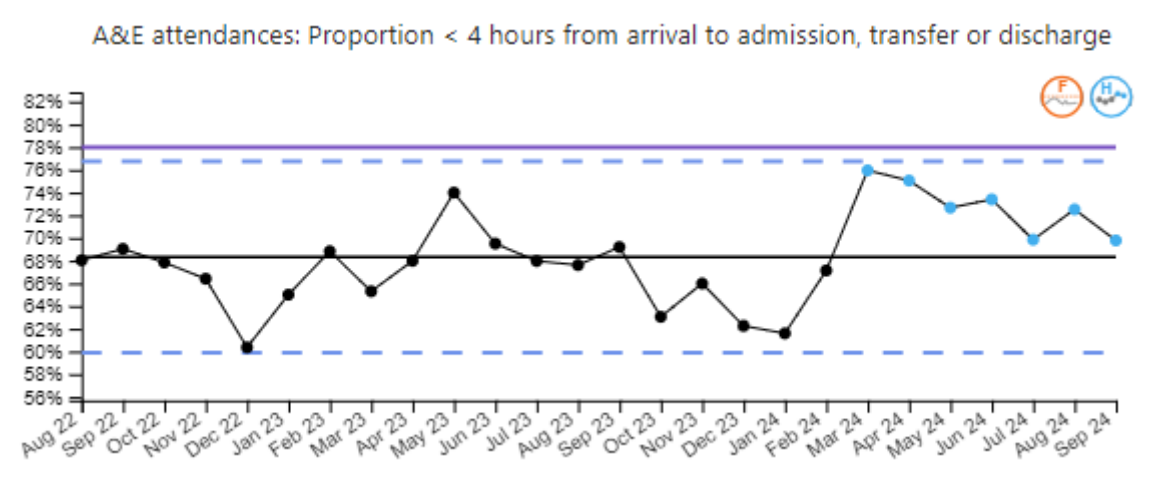
Icon descriptions

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

A&E attendances: Proportion < 4 hours from arrival to admission, transfer or discharge

Summary of challenges & risks	Performance in September 2024 was 69.8%, against the trajectory of 76.3%. ED attendances for the month were 16946 which was below the plan of 17089. The Trust ranked 90 out of 142 acute providers which puts the Trust into the 3rd quartile nationally. The Trust continues to be the second highest performing Trust for 4-hour standard in South Yorkshire. 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	Three times a day touch point meetings with the urgent treatment centre and ambulance service to maximise streaming opportunities and oversight of ambulance conveyance demand. Hourly capacity and demand analysis being undertaken by Divisional Leadership Team to identify further actions required to address the waiting times for initial assessment. Review of the urgent and emergency care improvement plan to ensure appropriate actions in place, across the Trust, to improve access to emergency care prior to winter
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

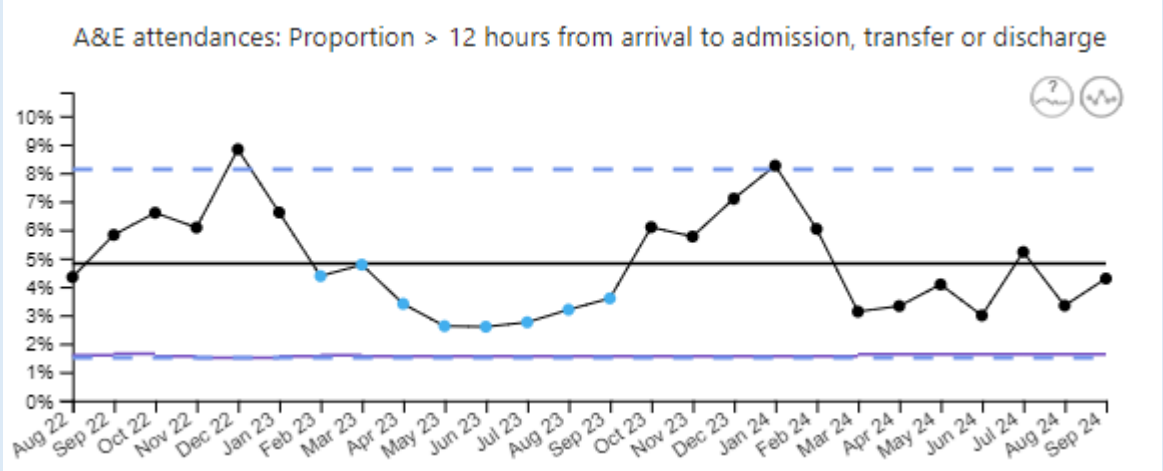


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

A&E attendances: Proportion > 12 hours from arrival to admission, transfer or discharge

Summary of challenges & risks	In September 2024, 4.3% of patients were in the Emergency Department > 12 hours from arrival, against the national standard of no more than 2% The Trust ranked 39 out of 142 acute providers and is in the second quartile. 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	Medical and Surgical bed modelling undertaken to assess the bed capacity required at each site. Hourly capacity and demand analysis being undertaken by Divisional Leadership Team to identify further actions required to address the waiting times for initial assessment. Review of the urgent and emergency care improvement plan to ensure appropriate actions in place, across the Trust, to improve access to emergency care prior to winter.
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

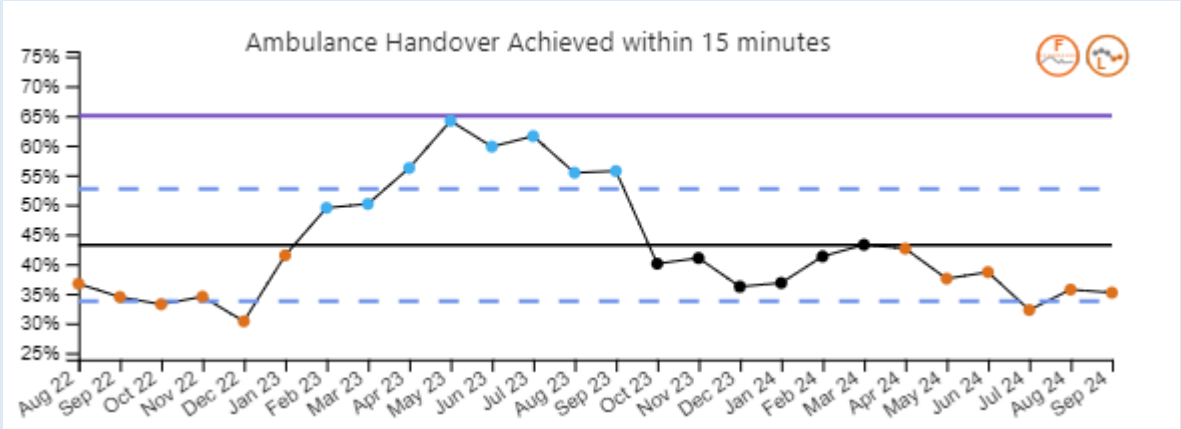


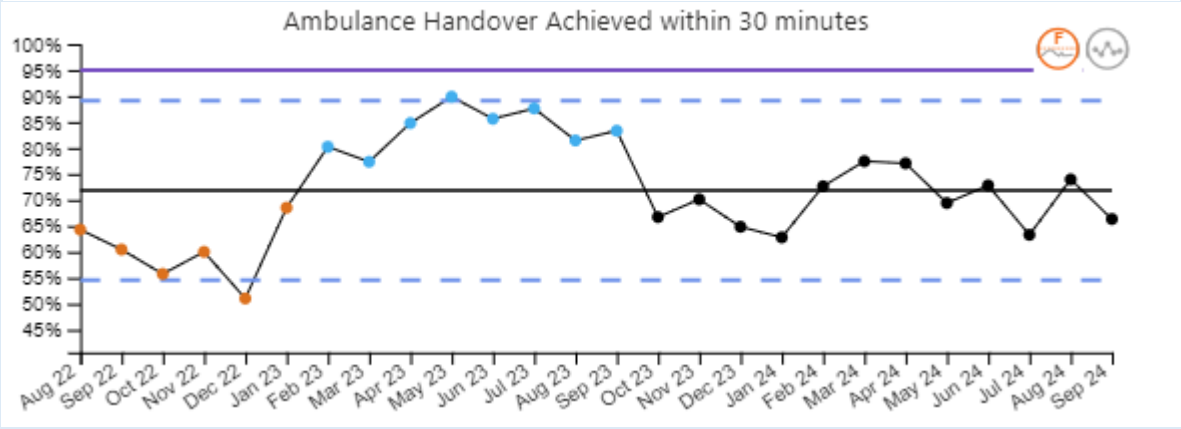
Source DBTH_IQPR_Dashboard_September_2024

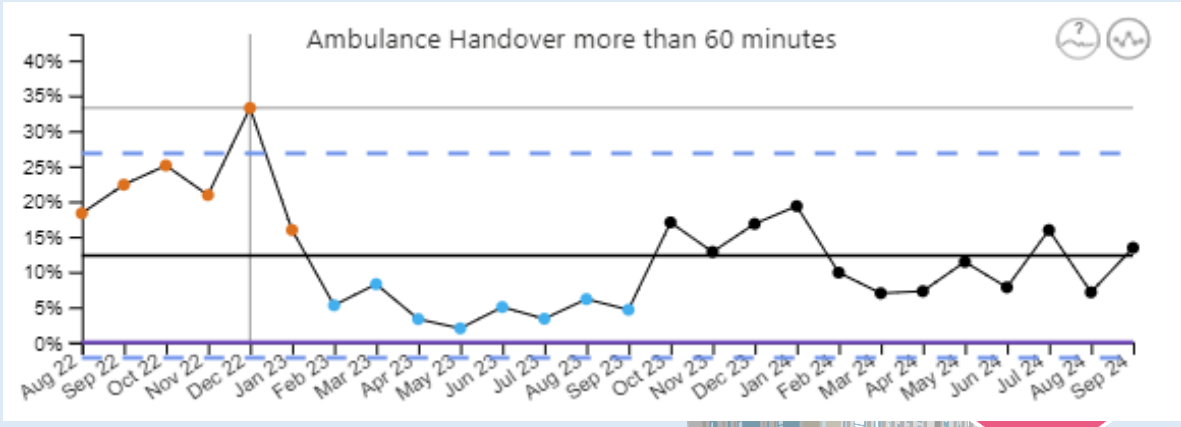
Assurance report

Ambulance Handover within 15/30/60 mins

Summary of challenges & risks	In September 2024, 35.2% of ambulance handovers took place within 15 minutes against the standard of 65%, 66.3% took place within 30 minutes against the standard of 95%, and 86.6% took place within 60 minutes against the standard of 100%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. Utilisation of the escalation area at times of peak demand . Proactive capacity preparation to create capacity for forecast peaks in demand . 3 x daily touchpoint meetings with YAS to review community activity and forecast conveyance demand. Undertake capacity and demand analysis to assess ambulance handover capacity requirements
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care





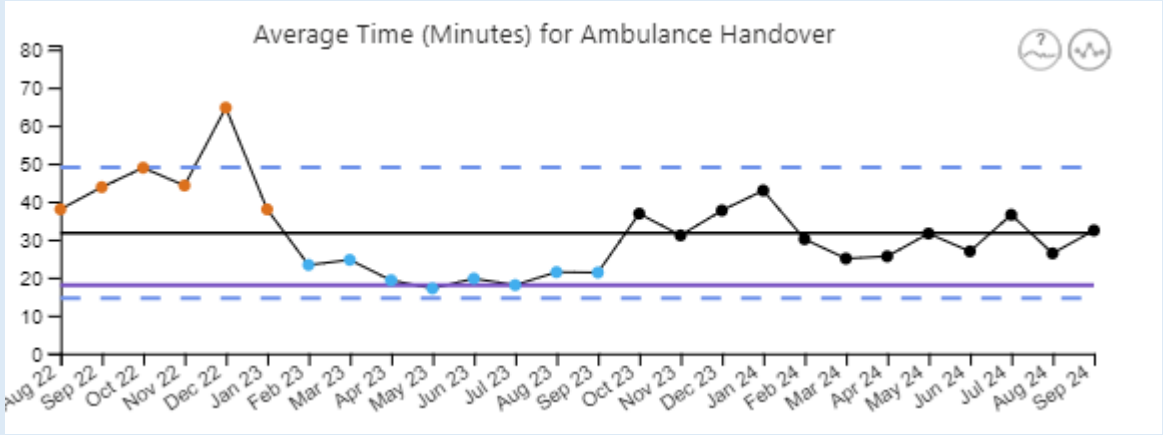


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Average Ambulance Handover Times

Summary of challenges & risks	Average handover time for YAS in September 2024 was 32:31 compared to the trajectory of 16:00
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. Utilisation of the escalation area at times of peak demand . Proactive capacity preparation to create capacity for forecast peaks in demand . 3 x daily touchpoint meetings with YAS to review community activity and forecast conveyance demand. Undertake capacity and demand analysis to assess ambulance handover capacity requirements
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

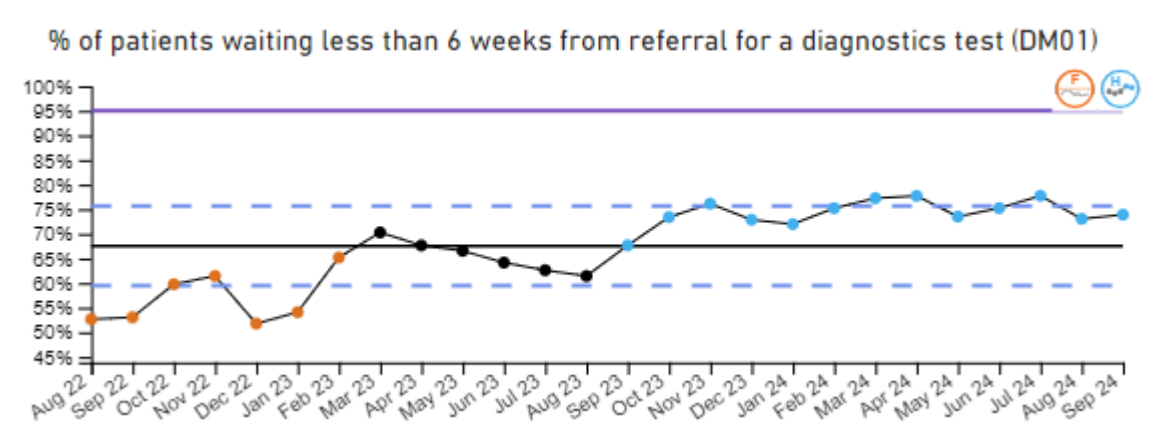


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

DM01 - % of patients waiting less than 6 weeks from referral for a diagnostics test

Summary of challenges & risks	In September 2024, 73.9% of patients received their diagnostic test within 6 weeks of referral, against the national planning requirement of 95% by March 2025. A recently signed off change to the audiology calculation has been applied from September reporting.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• The Trust has outsourced 200 adult patients in Audiology. Further discussions ongoing to agree mutual aid. • Recruited to vacancy and planned return from maternity leave for echocardiography by October 2024. • Additional capacity remains in place for neurophysiology in October 2024. • Review of workforce gaps and alternative cover arrangements within the NOUS service. • Audiology recovery plan in place Key risk: Recovery of audiology position
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee. Actions to be completed in October, with Audiology plans being completed over the remainder of the financial year.
Risk register	Risk 3434 Timely access to diagnostic services

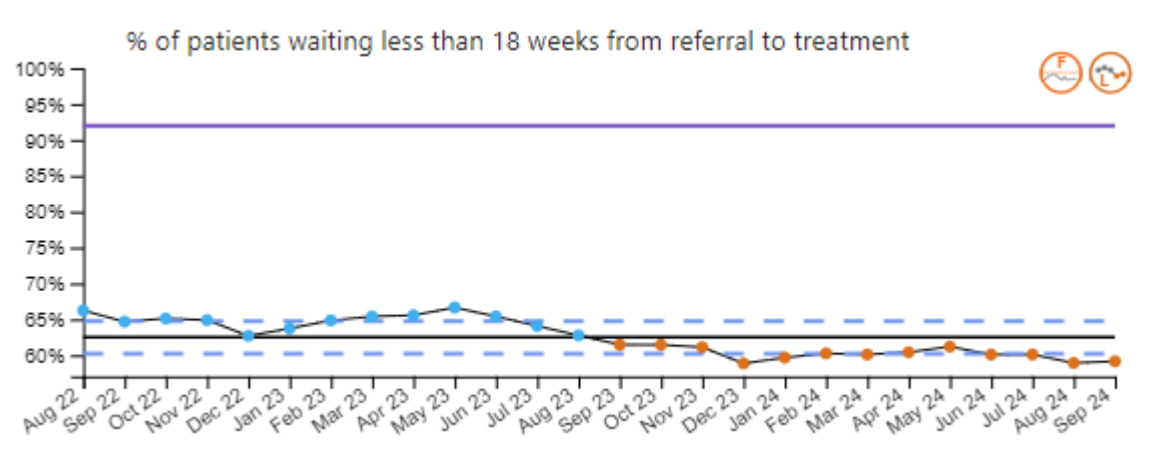


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

RTT % of patients waiting less than 18 weeks from referral to treatment

Summary of challenges & risks	The number of patients on an active waiting list in the Trust at the end of September 2024 was 56,477. 59.1% of the patients on the waiting list have been waiting for less than 18 weeks.
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.

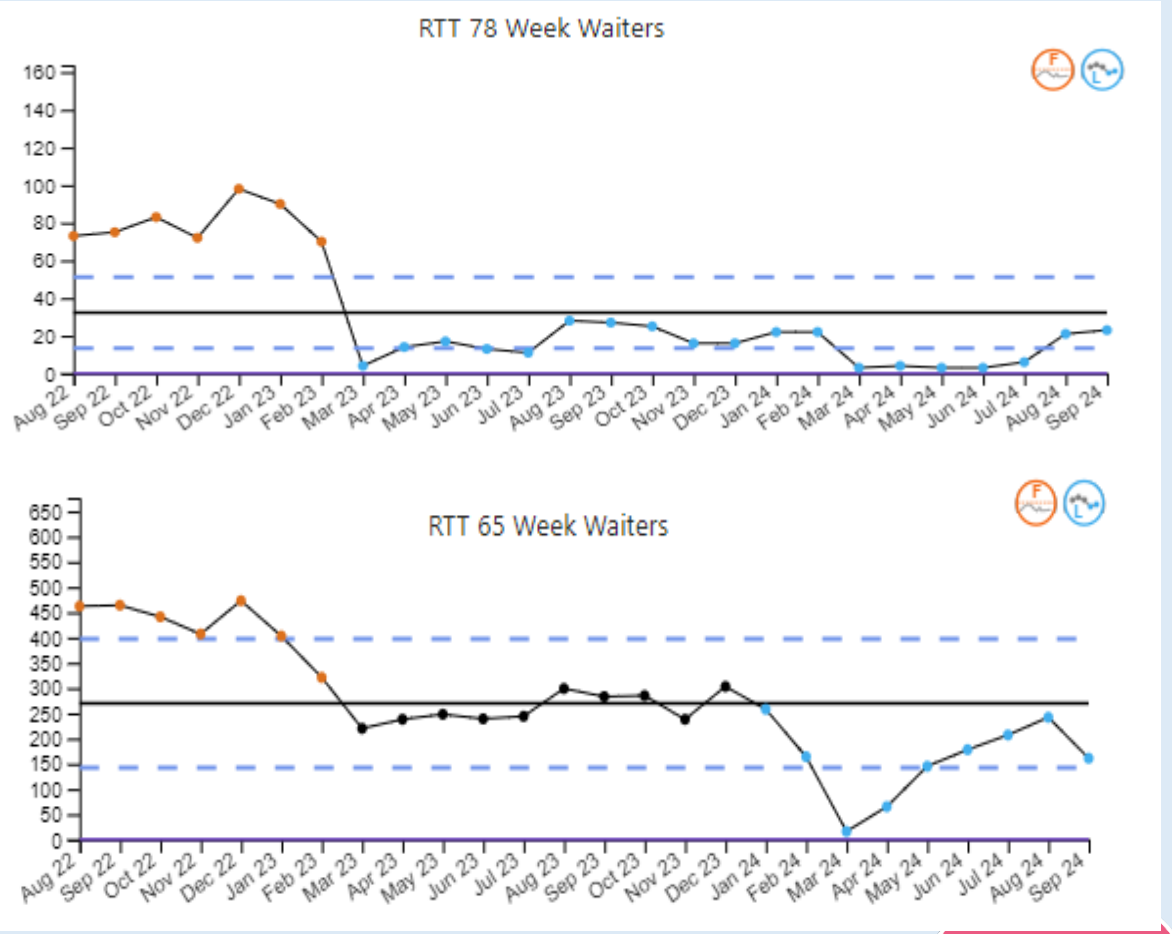


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

RTT – 78+ / 65+ Week Waiters

Summary of challenges & risks	In September 2024, 23 patients were waiting > 78 weeks, against the trajectory of 0. In September 2024, there were 161 patients waiting > 65 weeks, against the trajectory of 0.
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 • **ENT** – maximising existing outpatient capacity, additional outpatient capacity, mutual aid request, Audiology recovery plan in place, Additional theatre time allocated to consultant with Septorhinoplasty waits • **T&O** – maximising existing theatre capacity and additional theatre sessions **Emerging issue:** Increased skin cancer demand, requiring surgery, manifesting in ENT services.
Action timescales and assurance group or committee	The current trajectory for October is 30 patients >78 weeks and 225 >65 weeks, predominantly due to the ongoing challenges in ENT. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

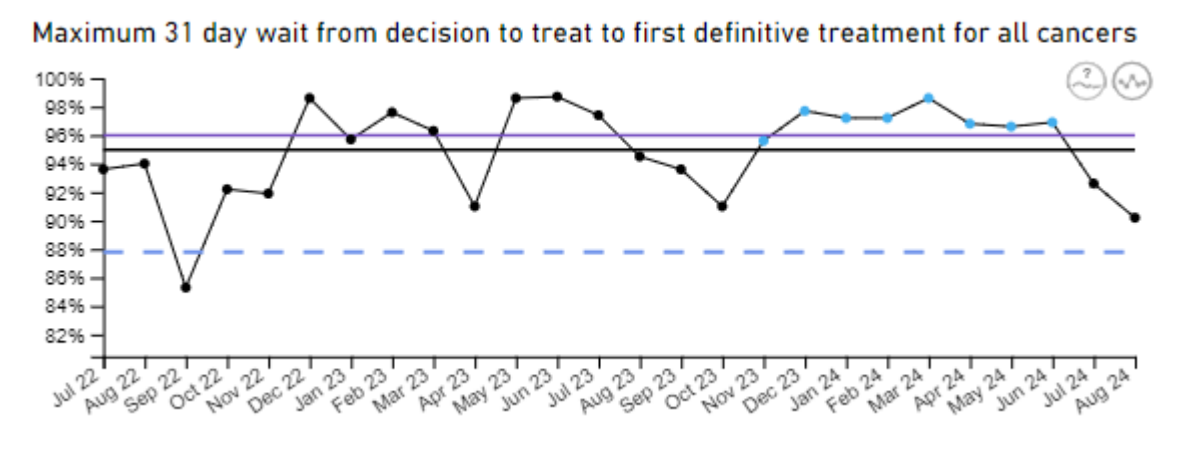


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Cancer – Maximum 31 day wait from decision to treat to first definitive treatment for all cancers

Summary of challenges & risks	Performance in August 2024 was 90.2% against the national standard of 96%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Development of a Trust Cancer Access Policy, due for approval in November 2024 • Early Divisional escalation for patients who cannot be dated within 31 days • External funding for additional minor operations capacity in skin from October 2024. **Emerging Issue:** Increasing demand on skin cancer services.
Action timescales and assurance group or committee	Forecast to be achieving the standard by end of Q3 Monthly reporting to the Finance and Performance Committee.
Risk register	N/A

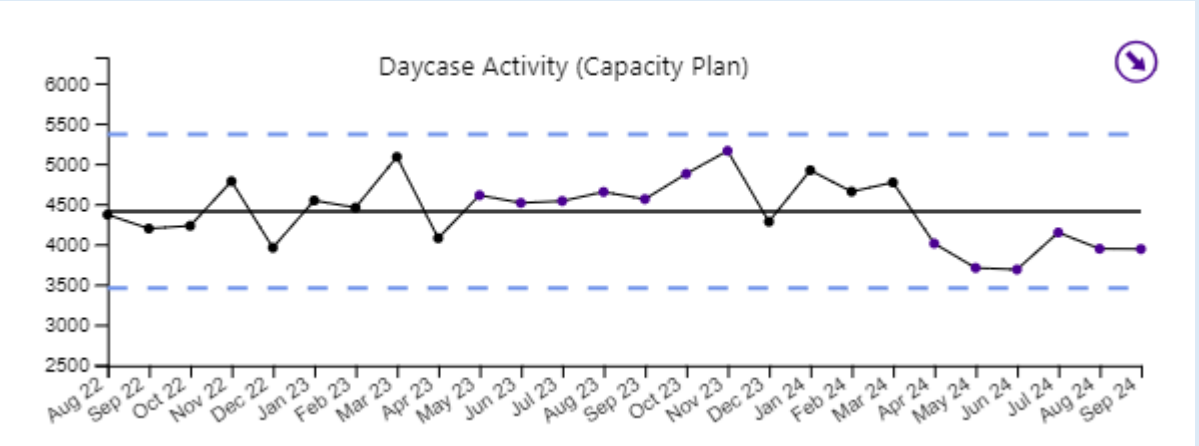


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Daycase Activity against Capacity Plan

Summary of challenges & risks	In September 2024, excluding MEOC, the Trust delivered 88.4% of the day case plan. YTD the Trust has delivered 90.3% of the day case plan.
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 has been 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 has been developed for the remainder of 24/25. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

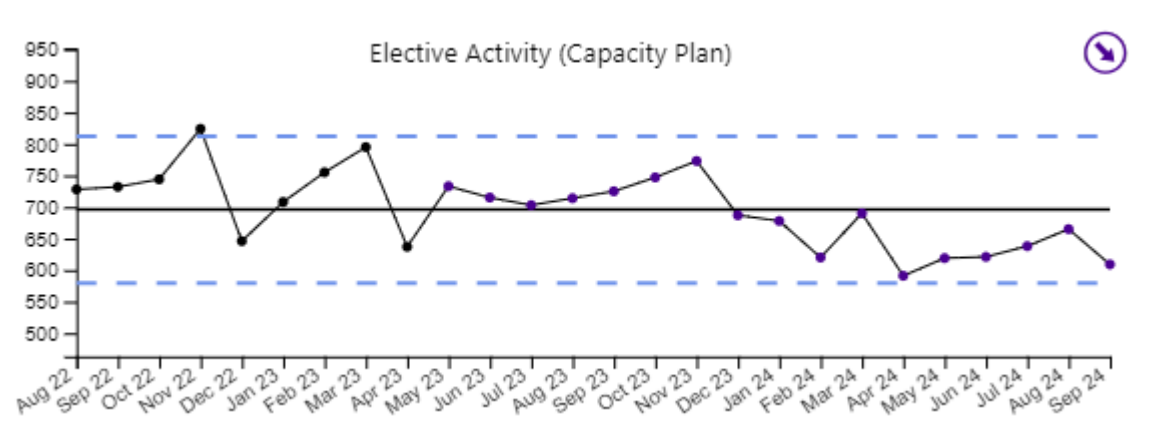


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Elective Activity against Capacity Plan

Summary of challenges & risks	In September 2024, excluding MEOC, the Trust delivered 93.0% of the elective plan. YTD the Trust has delivered 94.4% of the elective plan.
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

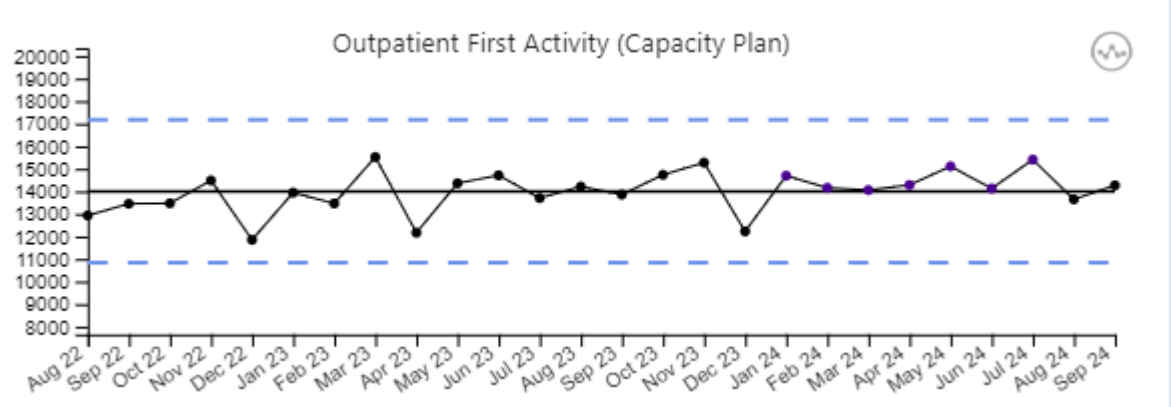


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Outpatient New Activity against Capacity Plan

Summary of challenges & risks	In September 2024, the Trust delivered 98.3% of plan for new outpatient appointments. Year to date the Trust has delivered 98.9% of the new outpatient plan.
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 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. A short term solution is being developed as part of the elective recovery plan 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

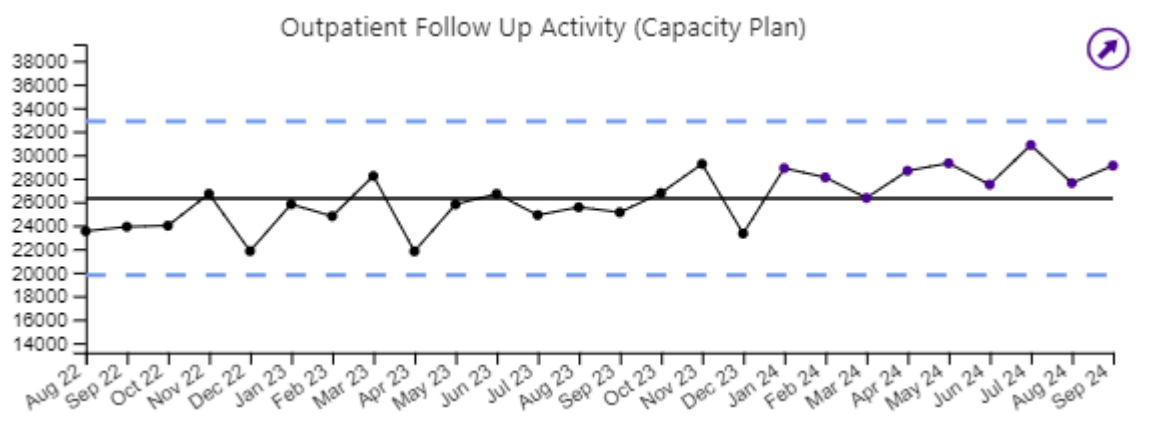


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Outpatient Follow Up Activity against Capacity Plan

Summary of challenges & risks	In September 2024, the Trust delivered 94.6% of plan for outpatient follow up appointments. Year to date the Trust has delivered 93.4% of the follow up outpatient plan
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

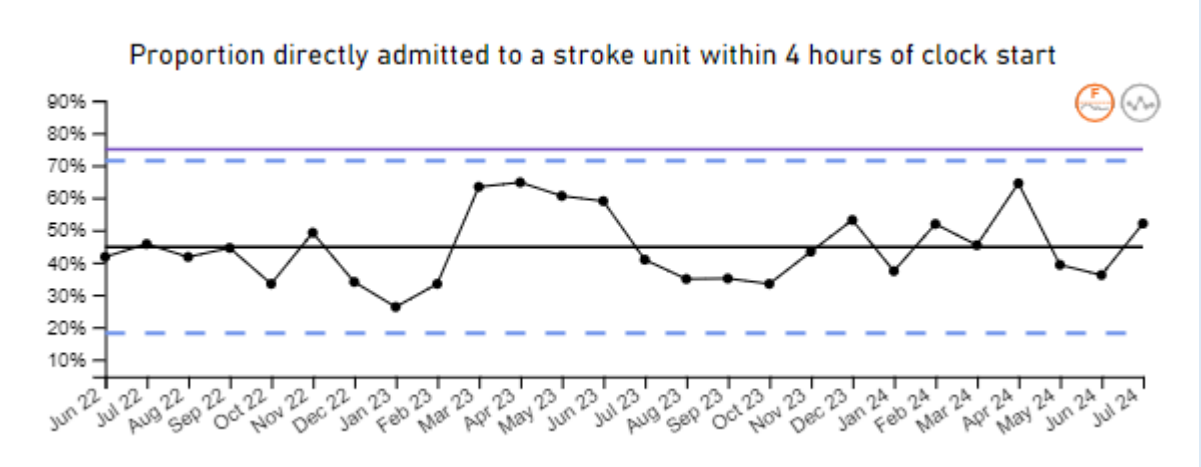


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

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

Summary of challenges & risks	In July 2024, performance was 52.0% against the standard of 75%.
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 minimise 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. Capacity and demand analysis of Stroke pathway. Stroke consultant recruitment process underway.
Action timescales and assurance group or committee	Monthly reporting to the Divisional Performance Review meeting
Risk register	Risk 3495

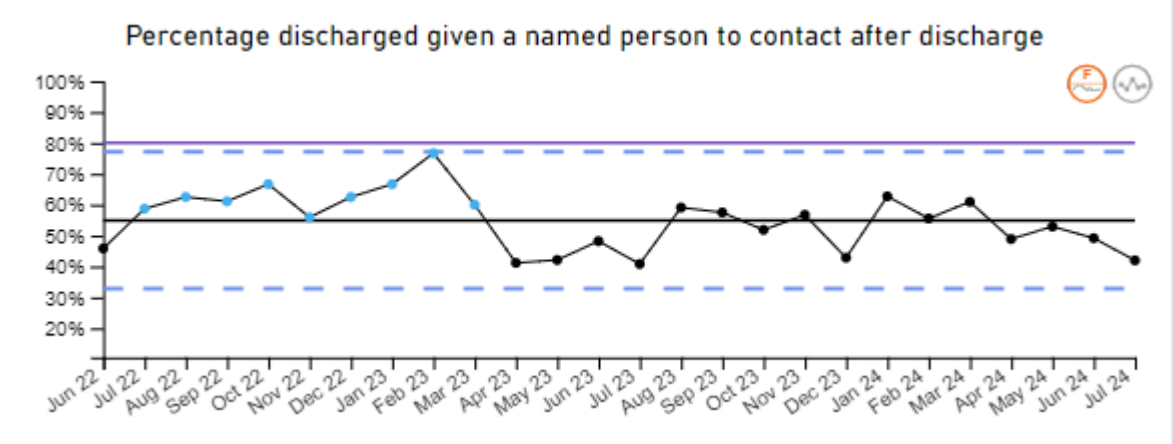


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Stroke – Percentage discharged given a named person to contact after discharge

Summary of challenges & risks	In July 2024, performance was 42.0% against the standard of 80%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	IT solution being developed to amend the clinical system to facilitate complete data entry, which will enable the information to be included on the discharge summary.
Action timescales and assurance group or committee	Monthly reporting to the Divisional Performance Review meeting
Risk register	Risk 3495

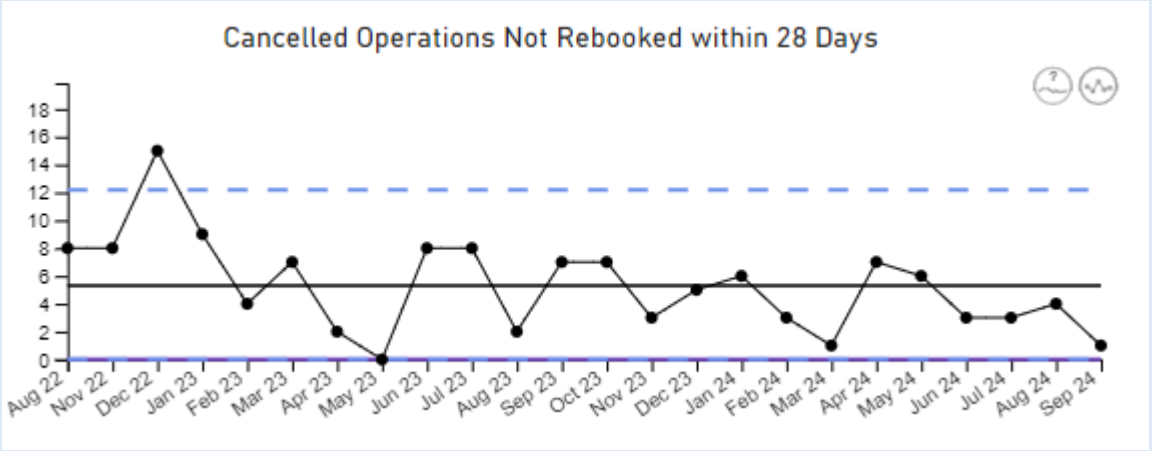


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Cancelled Operations Not Rebooked within 28 Days

Summary of challenges & risks	There were 1 breach of the 28-day guarantee in September 2024 in Trauma and Orthopaedics.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Continuation of 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_September_2024

Assurance report

YTD distance from financial plan I&E

Summary of challenges & risks	The Trust's reported deficit in month 6 was £1.8m, which was £0.8m favourable to budget, £0.1m favourable to forecast and £0.2m favourable to month 5. The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.5m adverse to budget and £0.6m adverse to forecast. YTD variance to budget - £0.5m adverse The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.5m adverse to budget. The key drivers of this are below: • ERF is £4.9m adverse to plan, mainly relating to T&O performance (£4.7m), which is offset with a favourable variance of £2.0m on independent sector expenditure • Pay (excluding one-off benefits) is £1.7m adverse to plan • £1.3m of one-off benefits have been identified from accruals across pay and non-pay • £0.9m favourable variance on Utilities • CDC is £1.2m favourable due to delays in recruitment in relation to new pathways YTD variance to forecast - £0.6m adverse The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.6m adverse to forecast. The key driver of this is financing costs (£0.5m) relating to a timing difference which will correct itself by year-end. Month 6 vs month 5 - £0.2m favourable The Trust's reported deficit in month 6 was £1.8m, which was £0.2m favourable to month 5. The key drivers of this are below: • ERF is £1.3m adverse to month 5 • Pay (excluding reserves, recharges and one-off benefits) is £0.3m adverse to month 5 with increases in substantive costs not being fully offset with reductions in temporary staffing costs • Non-pay (clinical supplies and services and other costs, excluding those offset with income) is £0.6m favourable to month 5, mainly driven by a reduction in activity related consumables and a one-off benefit on the bad debt provision relating to Fresenius invoices (£0.3m) • In month 6, £0.3m of one-off benefits across pay and non-pay have been identified. • In month 6 we received £0.5m of Industrial Action funding
Actions to address risks, issues & emerging concerns relating to performance & 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 & assurance group/ committee	Ongoing
Risk register	

Assurance report

YTD distance from financial plan I&E

1. Income and Expenditure vs. Budget														
Performance Indicator	Annual budget	Monthly Performance						YTD Performance						
		Budget	Actual	Variance to budget		Forecast	Variance to forecast		Budget	Actual	Variance to budget		Forecast	Variance to forecast	
	£'000	£'000	£'000	£'000		£'000	£'000		£'000	£'000	£'000		£'000	£'000	
Income	(562,089)	(47,637)	(45,883)	1,753	A	(45,360)	(523)	F	(281,677)	(279,480)	2,197	A	(279,696)	216	A
Pay	367,665	31,333	30,723	(610)	F	31,719	(996)	F	185,803	186,940	1,137	A	187,956	(1,017)	F
Non Pay	213,000	18,336	16,511	(1,825)	F	14,945	1,566	A	111,139	109,494	(1,645)	F	107,379	2,114	A
Financing Costs	8,590	716	679	(37)	F	737	(58)	F	4,295	3,888	(407)	F	4,170	(282)	F
(Profit)/Loss on Asset Disposals	0	0	61	61	A	0	61	A	0	61	61	A	0	61	A
Adjusted (Surplus)/Deficit for the purposes of system achievement relating to Trust core activity	**27,166**	**2,748**	**2,091**	**(657)**	**F**	**2,041**	**50**	**A**	**19,559**	**20,902**	**1,343**	**A**	**19,810**	**1,092**	**A**
MEOC	(594)	(50)	15	65	A	0	15	A	(296)	6	302	A	0	6	A
CDC	(348)	(7)	(257)	(251)	F	(60)	(198)	F	37	(1,067)	(1,103)	F	(578)	(489)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement (including MEOC & CDC)	**26,224**	**2,692**	**1,849**	**(843)**	**F**	**1,982**	**(133)**	**F**	**19,300**	**19,841**	**541**	**A**	**19,232**	**609**	**A**

Income: Over-achieved F; Under-achieved A

F = Favourable

Expenditure: Underspent F; Overspent A

Assurance report

ERF Position

Summary of challenges & risks	ERF is £4.9m behind plan YTD at month 6. This is mainly driven by Orthopaedics which is £4.7m behind plan (£2.6m core activity and £2.1m Independent Sector.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Recovery plan required for elective activity, particularly 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	M6 variance to ERF Target
Daycase	£1,954,989
Elective	£4,667,231
Outpatient First	£102,524
Outpatient Procedures	-£311,638
A&G / costing adjustment	-£1,510,867
Total	**£4,902,239**

Assurance report

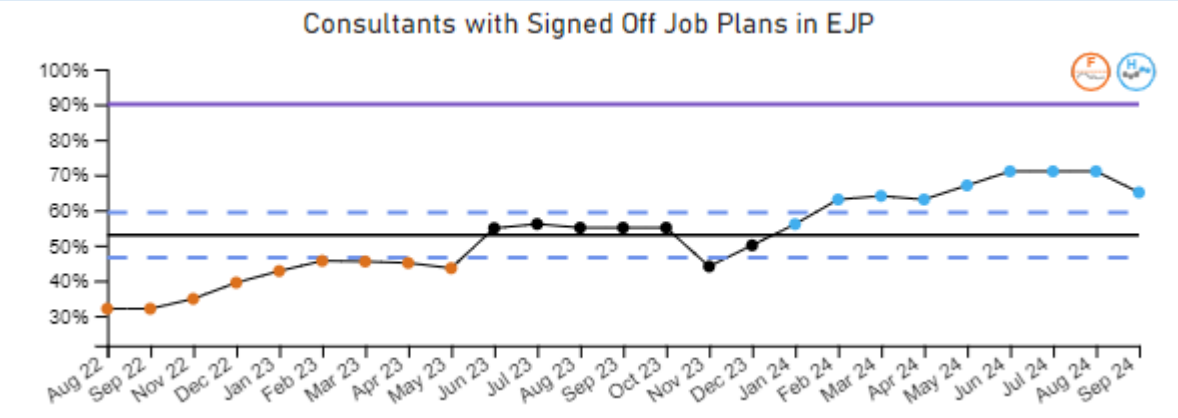
Pay spend against plan

Summary of challenges & risks	The Trust's core position (excluding MEOC & CDC), on pay expenditure is £1.1m 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 been closed. 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, commenced in August.
Action timescales and assurance group or committee	Ongoing
Risk register	

Assurance report

Consultants with Signed off Job Plans in EJP

Summary of challenges & risks	For September 2024 65% of Consultants had a signed off job plan
Actions to address risks, issues and emerging concerns relating to performance and forecast	Following a period of job plan pause during July to August 2024, to enable migration of data to the L2P job planning system, the job planning process has recommenced. Data quality checks have identified a number of anomalies following transfer of job plan data, some of these are due to language and reporting differences between Allocate and L2P systems. The DQ issues combined with the 2 month pause in job planning has led to a drop in performance. The job planning team continue to work closely with L2P to resolve DQ issues and this will be an ongoing process until all 362 job plans have gone through their annual review.
Action timescales and assurance group or committee	August 2025 – a realistic 12 month period taking into account ongoing data quality issues to be rectified, the backlog of outstanding job plans to be processed and prioritisation of remaining annual job plan reviews. Assurance route is via People Committee.
Risk register	Not on risk register as all senior medical staff are working to current job plans and process/plan in place to recover position.

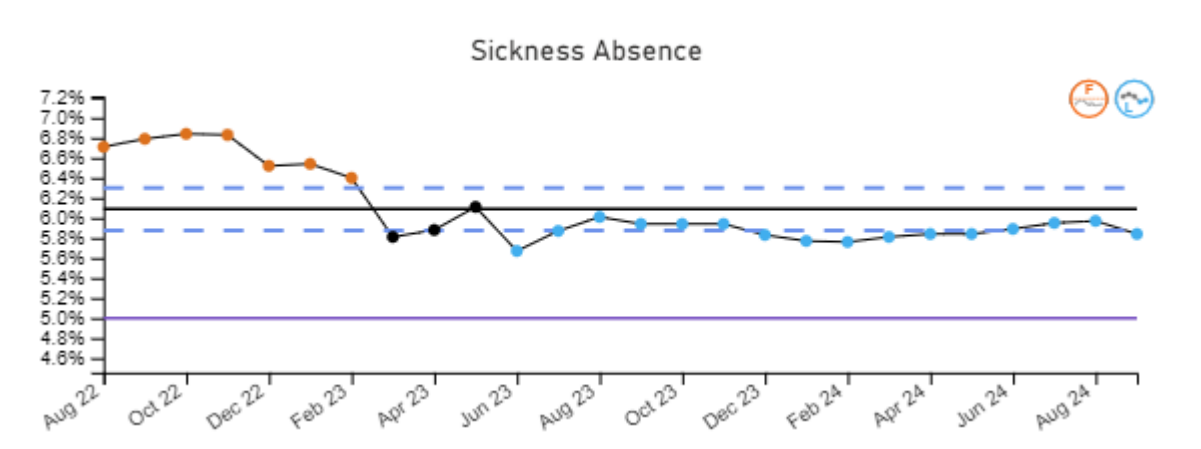


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Overall Sickness Absence

Summary of challenges & risks	For September 2024, the Trust sickness rate is 5.8% against a target for 5%.
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. • Actions monitored under Workforce Workstream with monthly review at Steering Group meetings • People Business Partnering team providing ongoing support to managers and KPI clinics • Impact of new sickness absence policy being reviewed • Deep dive on sickness absence data and analysis undertaken for one professional group, other groups identified for targeted approach • Training and support provided for medical leaders in managing sickness absence
Action timescales and assurance group or committee	Performance Review Meetings Workforce Workstream reports to Efficiency & Effectiveness Committee Trust Leadership Team People Committee
Risk register	Not recorded on Trust risk register

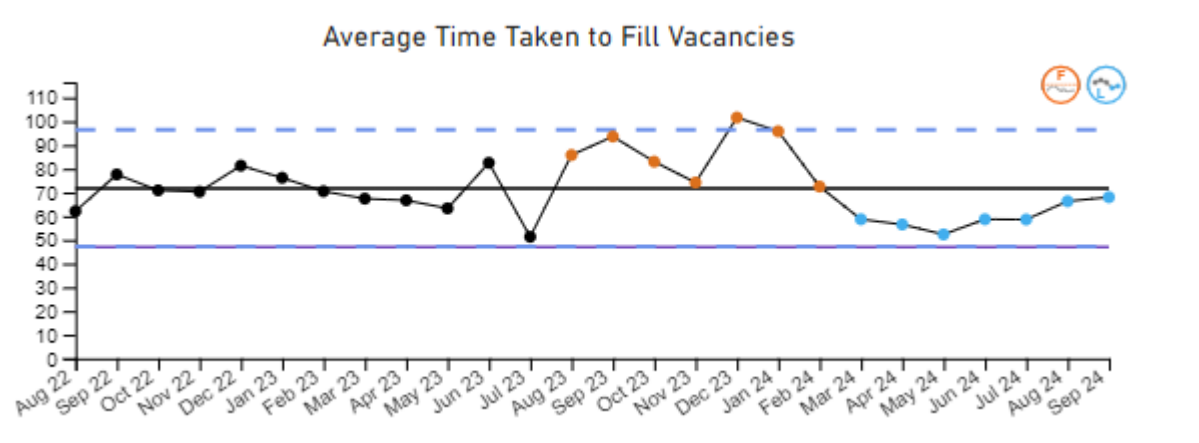


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Average Time Taken to Fill Vacancies

Summary of challenges & risks	The Trusts time to hire is 68 days for September 2024.
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 further 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	It has been recognised at Trust Leadership Team, People Committee and Board that the current mixed model of centralised and devolved recruitment impacts on ability to achieve time to hire KPIs.

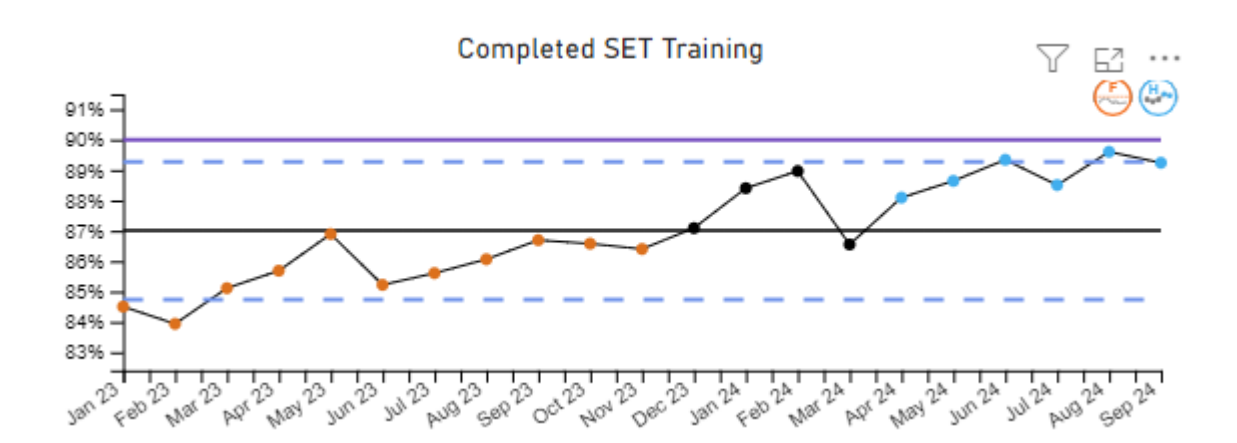


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Completed SET Training

Summary of challenges & risks	In September the Trust had a SET completion rate of 89.35% 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. • New functionality in Derrick dashboard developed to support oversight of compliance at individual and departmental level. • 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	Monthly review of actions – compliance has been at over 89% for two consecutive months. Performance Review Meetings CQC action plan Workforce & Education Committee Trust Leadership Team People Committee
Risk register	Not recorded on Trust risk register. Specific areas of risk are noted if they arise, e.g. access to specific subjects

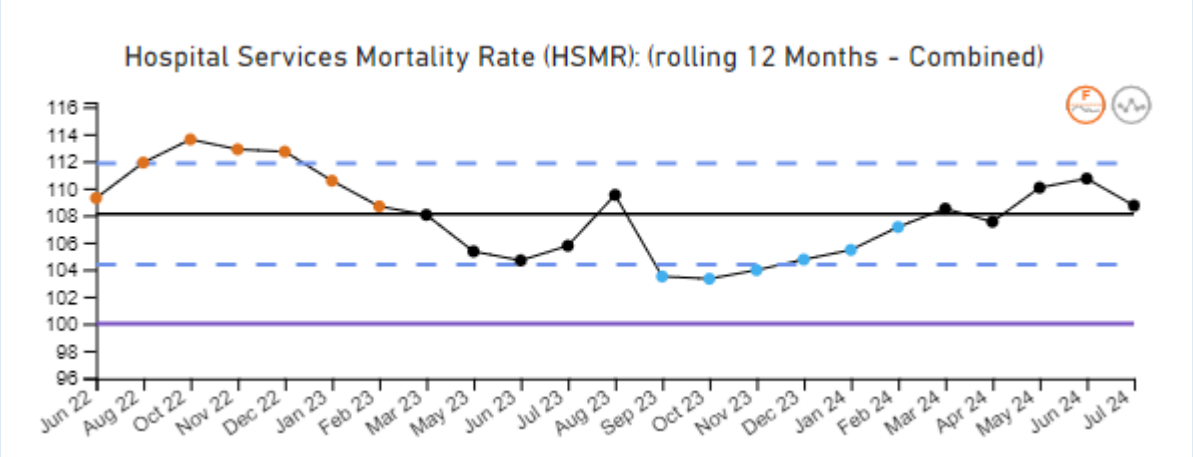


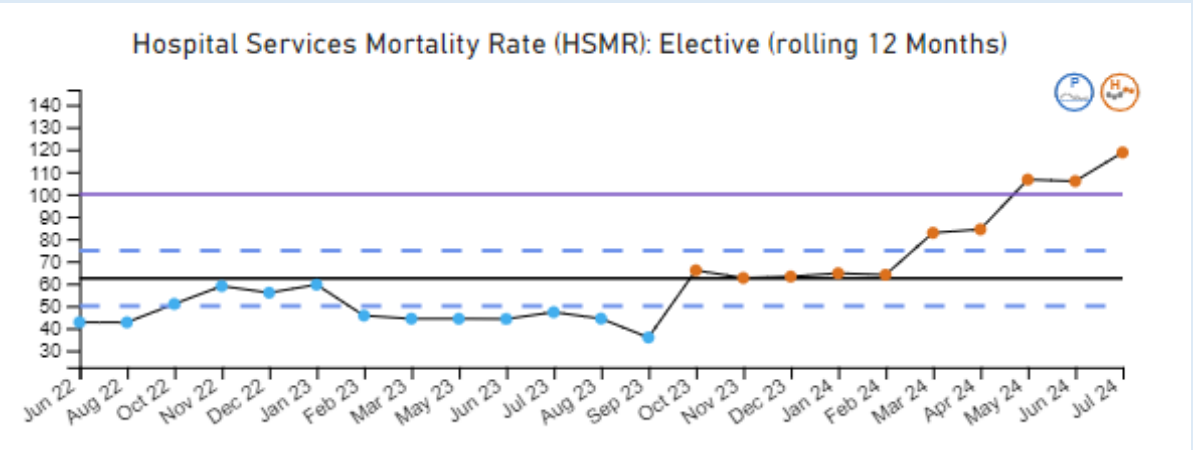
Source DBTH_IQPR_Dashboard_September_2024

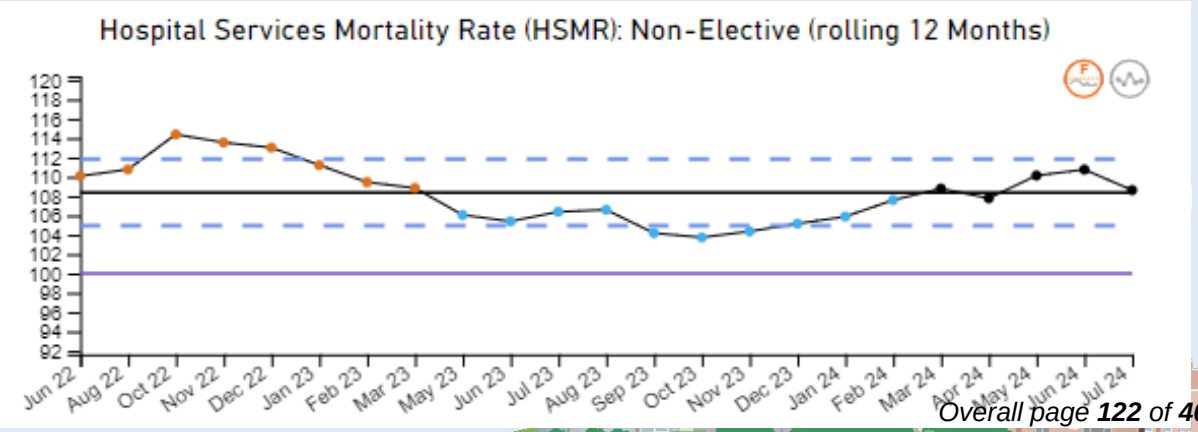
Assurance report

HSMR

Summary of challenges & risks	The Trusts combined HSMR rolling 12-month rate is 108.7 against a target of 100 for July 2024. The Trusts elective HSMR rolling 12-month rate is 118.7 against a target of 100 for July 2024. The Trusts non-elective HSMR rolling 12-month rate is 108.6 against a target of 100 for July 2024.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Action plan in place to address clinical coding and depth of coding, which affects the Trust's number of expected deaths (denominator). Structured Judgement Review (SJR) action plan in place. SJR process commenced with senior clinicians (medical and nursing) undertaking SJRs, SJR MDT established, focussing on areas where higher than expected number of deaths have occurred.
Action timescales and assurance group or committee	As mortality data is reported on a rolling 12 month period, it will take time for the improvement of planned actions to feed through the data. Assurance route through governance framework to Quality and Effectiveness Committee.
Risk register	



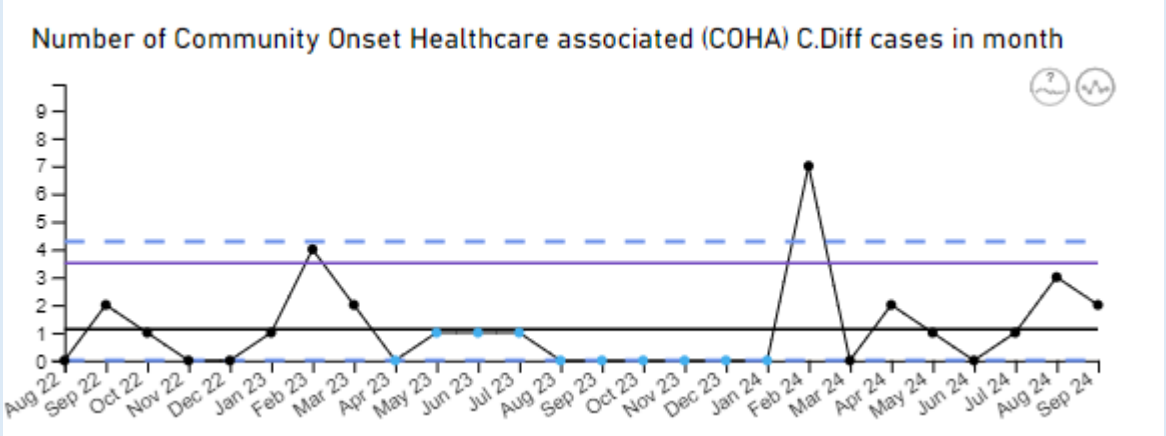


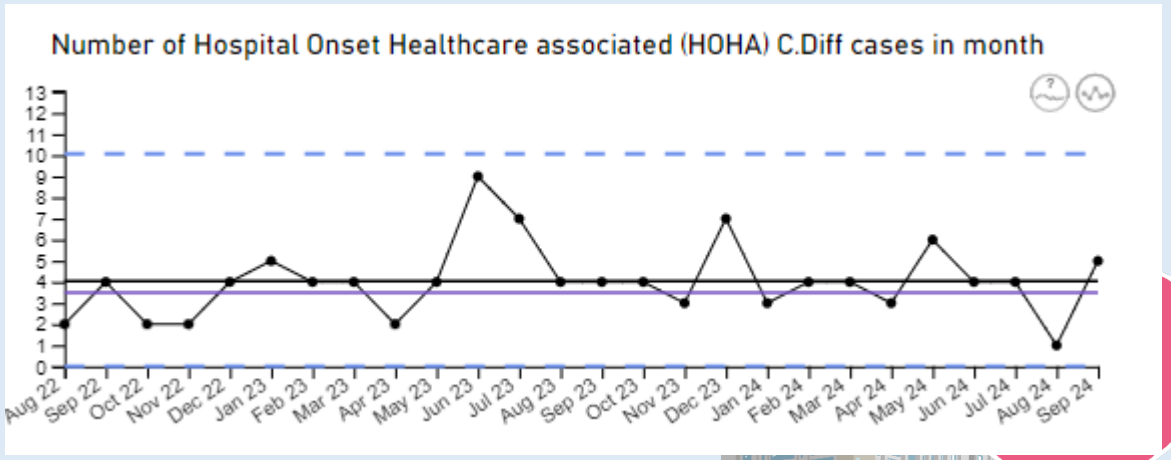


Assurance report

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 7 in September 2024
Actions to address risks, issues and emerging concerns relating to performance and forecast	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. Hot debriefs are undertaken for each case to identify learning and immediate actions required Anti microbial nurse specialist appointed await start date.
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

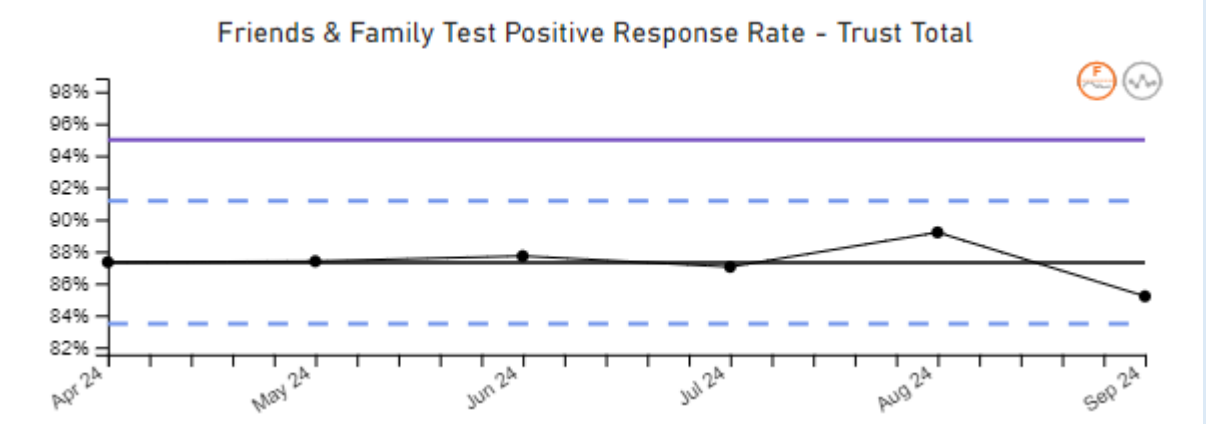




Assurance report

Friends and Family Test Positive Response Rate – Trust Total

Summary of challenges & risks	Friends and family positive response rates fell below the standard of 95% in September 2024 for the Trust – 85.2%
Actions to address risks, issues and emerging concerns relating to performance and forecast	There is work ongoing with the education team to consider introducing advanced communication skills training for nursing staff – communication is emerging as a key theme FFT compliance/Feedback now reviewed at care excellence meetings and as part of Matron 121s in line with the Chief Nurse Oversight framework.
Action timescales and assurance group or committee	Ongoing actions. Patient experience and involvement group and Caring Committee
Risk register	N/A

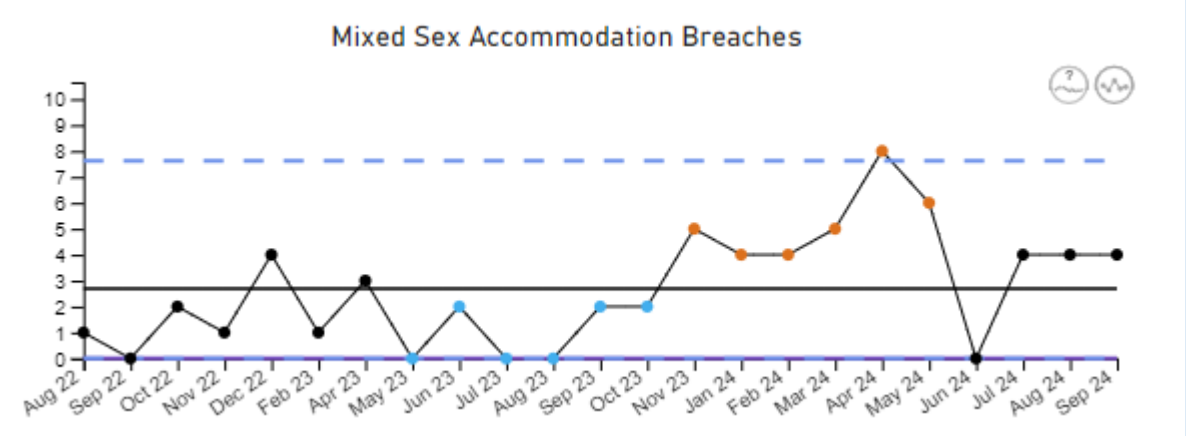


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Mixed Sex Accommodation Breaches

Summary of challenges & risks	There were 4 mixed sex accommodation breaches in September 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

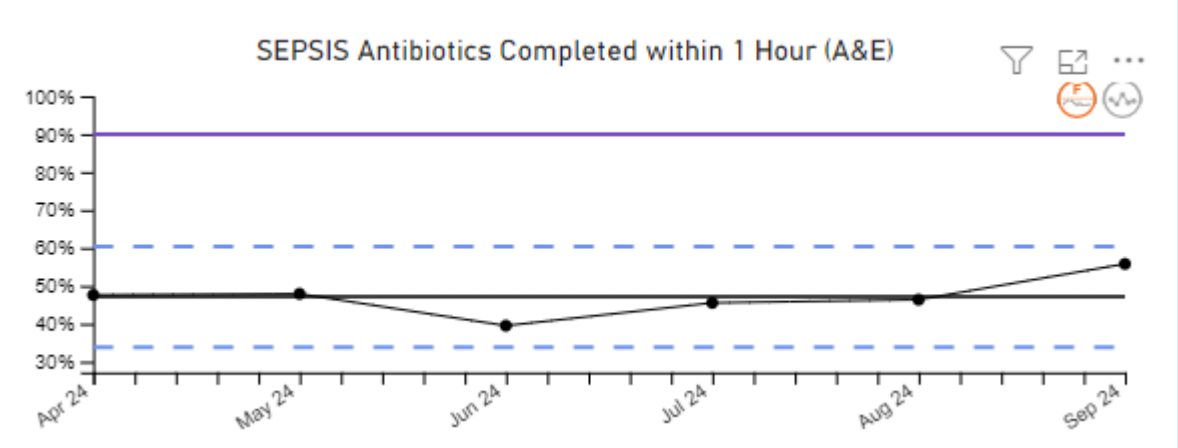


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Sepsis Antibiotics Completed within 1 hour (A&E)

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 55.8% compared to a target of 90%
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ongoing work with the Sepsis action group within ED., to reduce time to antibiotic. There has been improvement in the process measures of the sepsis 6 screening. One theme that has been identified is that the antibiotics are now being prescribed quicker however there is then a delay in delivery as they are not being prioritised by the electronic system over other general drugs. This is being worked through. Sepsis SHIMI remains below 100
Action timescales and assurance group or committee	
Risk register	

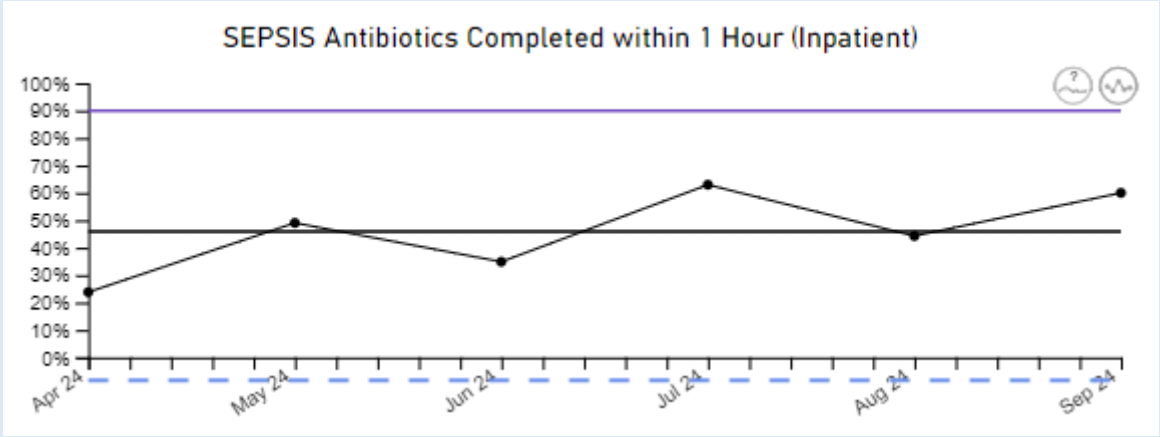


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Sepsis Antibiotics Completed within 1 hour (Inpatient)

Summary of challenges & risks	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 60% for September 2024.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Slowly improving general trend with more work needed through the sepsis action group within peads. There is also more work on identifying those who are flagged by the screening but then do not need antibiotics IV as clinically do not have sepsis. This is a recognised end to the pathway but needs more consistent documentation
Action timescales and assurance group or committee	
Risk register	

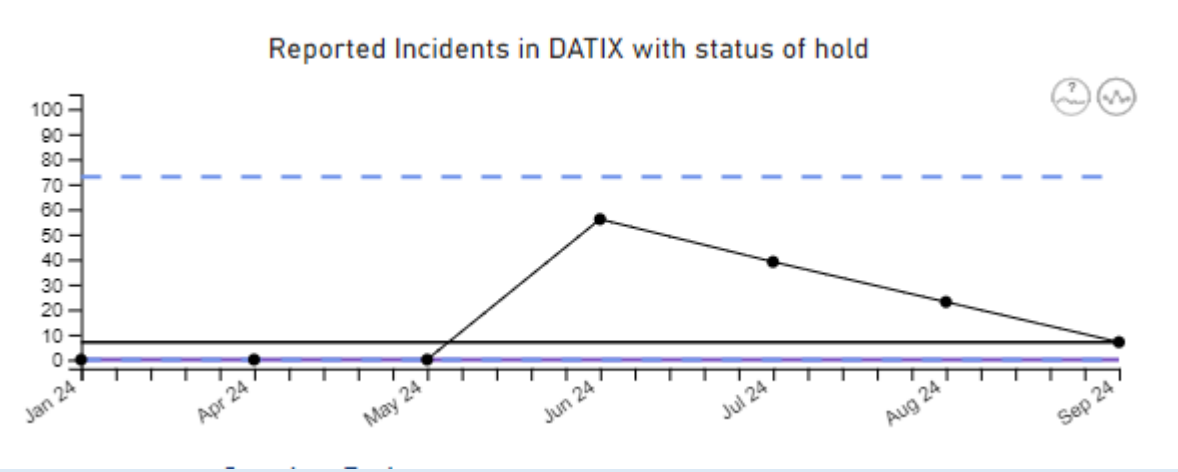


Source DBTH_IQPR_Dashboard_September_2024

Assurance report

Number of incidents over 48 hours in the holding area

Summary of challenges & risks	There were 7 incidents over 48 hours in the holding area for September 2024.
Actions to address risks, issues and emerging concerns relating to performance and forecast	All divisions now have a divisional quality and assurance lead who are supporting timely review Work ongoing with each department manager around datix review
Action timescales and assurance group or committee	Ongoing, monitoring by the patient safety committee by monthly via the highlight report.
Risk register	N/A



Source DBTH_IQPR_Dashboard_September_2024

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2411 - D2 FINANCIAL POSITION UPDATE

Discussion Item | Jon Sargeant, Chief Financial Officer | 10:50

10 minutes

REFERENCES

Only PDFs are attached

D2 - Financial Position Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**D2**
Report Title:	**Financial Position Update**		
Sponsor:	Jon Sargeant, Chief Financial Officer		
Author:	Rodney Muskett, Interim Deputy Director of Finance Finance Team		
Appendices:			

Report Summary

The Trust's reported deficit in month 6 was £1.8m, which was £0.8m favourable to budget, £0.1m favourable to forecast and £0.2m favourable to month 5. The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.5m adverse to budget and £0.6m adverse to forecast.

YTD variance to budget - £0.5m adverse

The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.5m adverse to budget. The key drivers of this are below:

- ERF is £4.9m adverse to plan, mainly relating to T&O performance (£4.7m), which is offset with a favourable variance of £2.0m on independent sector expenditure
- Pay (excluding one-off benefits) is £1.7m adverse to plan
- £1.3m of one-off benefits have been identified across pay and non-pay
- £0.9m favourable variance on Utilities
- CDC is £1.2m favourable due to delays in recruitment in relation to new pathways

YTD variance to forecast - £0.6m adverse

The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.6m adverse to forecast. The key driver of this is financing costs (£0.5m) relating to a timing difference which will correct itself by year-end.

Month 6 vs month 5 - £0.2m favourable

The Trust's reported deficit in month 6 was £1.8m, which was £0.2m favourable to month 5. The key drivers of this are below:

- ERF is £1.3m adverse to month 5
- Pay (excluding reserves, recharges and one-off benefits) is £0.3m adverse to month 5 with increases in substantive costs not being fully offset with reductions in temporary staffing costs
- Non-pay (clinical supplies and services and other costs, excluding those offset with income) is £0.6m favourable to month 5, mainly driven by a reduction in activity related consumables and a one-off benefit on the bad debt provision relating to Fresenius invoices (£0.3m)
- In month 6, £0.3m of one-off benefits have been identified across pay and non-pay
- In month 6 we received £0.5m of Industrial Action funding

Post close down event

The month 6 position has been adjusted in line with guidance from NHS England relating to the non-recurrent deficit funding of £23.8m. The annual plan has been reduced by £23.8m from £26.2m to £2.4m,

with £19.3m of this recognised in budget and actuals in month 6. The cash funding for this is to be received in October. The position including the £19.3m adjustment is below:

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	(585,885)	(66,937)	(65,183)	1,753	A	(300,977)	(298,780)	2,197	A
Pay	367,665	31,333	30,723	(610)	F	185,803	186,940	1,137	A
Non Pay	213,000	18,336	16,511	(1,825)	F	111,139	109,494	(1,645)	F
Financing Costs	8,590	716	679	(37)	F	4,295	3,888	(407)	F
(Profit)/Loss on Asset Disposals	0	0	61	61	A	0	61	61	A
Adjusted (Surplus)/Deficit for the purposes of system achievement relating to Trust core activity	**3,370**	**(16,552)**	**(17,209)**	**(657)**	**F**	**259**	**1,602**	**1,343**	**A**
MEOC	(594)	(50)	15	65	A	(296)	6	302	A
CDC	(348)	(7)	(257)	(251)	F	37	(1,067)	(1,103)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement (including MEOC & CDC)	**2,428**	**(16,608)**	**(17,451)**	**(843)**	**F**	**(0)**	**541**	**541**	**A**

Income: Over-achieved F; Under-achieved A

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

Expenditure: Underspent F; Overspent A

Capital

Year to date capital spend excluding donated assets/charitable funds is £8,598, compared to a YTD budget of £7,191k therefore showing an overperformance of £1,407k. YTD capital spend for charitable funds is £2,428k which relates to the Da Vinci Robot and the Stroke Rehab Robot. Therefore, the YTD total capital spend is £11,026k. The Board should the planned programme requires cash support to under pin the programme. The Trust are to submit a cash request by November and the National Team have confirmed they are expecting this request.

Cash

Cash has gone down by £1.8m to £17.7m. This is as a result of the Trust making the twice yearly PDC Dividend payment in month (£3.8m), which has been partially offset by £2.7m of PDC Revenue cash support and £0.9m of PDC Capital cash support in month as well as the deficit revenue position. However, the Trust is expecting cash of £19.3m from the ICB in October to support the change in 24/25 annual plan as directed by NHS England.

CIPs (Cost Improvement Programme)

In month, the Trust has delivered £1.5m of savings versus the plan submitted to NHSE of £1.8m and therefore is £0.3m adverse to plan. YTD, the Trust has delivered £6.0m of savings versus the plan submitted to NHSE of £6.2m and therefore is £0.3m adverse to plan.

Recommendation:	The Board is asked to note: • The Trust's reported deficit in month 6 was £1.8m, which was £0.8m favourable to budget, £0.1m favourable to forecast and £0.2m favourable to month 5. • The post close down event that has reduced the annual plan by £23.8m from £26.2m to £2.4m, with £19.3m of this recognised in budget and actuals in month 6.			
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**	
	NA		**NA**	

Implications			
Relationship to Board assurance framework: Indicate here if the report links to any relevant strategic risk on the 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 **YES/NO**		
Legal/ Regulation:			
Resources:	Please indicate any impact on resources.		
Assurance Route			
Previously considered by:			Finance and Performance Committee
Date:	29.10.2024		
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 6 – September 2024

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M06 September 2024

1. Income and Expenditure vs. Budget

Performance Indicator	Annual budget	Monthly Performance						YTD Performance					
		Budget	Actual	Variance to budget		Forecast	Variance to forecast	Budget	Actual	Variance to budget		Forecast	Variance to forecast
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000		£'000	£'000
Income	(562,089)	(47,637)	(45,883)	1,753	A	(45,360)	(523) F	(281,677)	(279,480)	2,197	A	(279,696)	216 A
Pay	367,665	31,333	30,723	(610)	F	31,719	(996) F	185,803	186,940	1,137	A	187,956	(1,017) F
Non Pay	213,000	18,336	16,511	(1,825)	F	14,945	1,566 A	111,139	109,494	(1,645)	F	107,379	2,114 A
Financing Costs	8,590	716	679	(37)	F	737	(58) F	4,295	3,888	(407)	F	4,170	(282) F
(Profit)/Loss on Asset Disposals	0	0	61	61	A	0	61 A	0	61	61	A	0	61 A
Adjusted (Surplus)/Deficit for the purposes of system achievement relating to Trust core activity	**27,166**	**2,748**	**2,091**	**(657)**	**F**	**2,041**	**50 A**	**19,559**	**20,902**	**1,343**	**A**	**19,810**	**1,092 A**
MEOC	(594)	(50)	15	65	A	0	15 A	(296)	6	302	A	0	6 A
CDC	(348)	(7)	(257)	(251)	F	(60)	(198) F	37	(1,067)	(1,103)	F	(578)	(489) F
Adjusted (Surplus)/Deficit for the purposes of system achievement (including MEOC & CDC)	**26,224**	**2,692**	**1,849**	**(843)**	**F**	**1,982**	**(133) F**	**19,300**	**19,841**	**541**	**A**	**19,232**	**609 A**

Income: Over-achieved F / Under-achieved A

Expenditure: F = Favourable; 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	113	0	A	500
Income (Other Operating Income)	438	46	A	686	311	A	992
Income (Patient Care Activities)	261	44	A	1,027	126	A	3,351
Non-Pay	229	224	A	1,095	1,193	F	5,288
Pay	21	42	F	125	203	F	250
Pay (Skill Mix)	422	579	F	1,751	2,291	F	5,350
Pay (WTE Reductions)	369	539	F	1,438	1,853	F	5,469
Total CIP	**1,779**	**1,474**	A	**6,236**	**5,976**	A	**21,200**

3. Statement of Financial Position

	Opening balance	Closing balance	Movement
	£'000	£'000	£'000
Non Current Assets	**296,256**	**296,517**	**261**
Current Assets	60,566	56,612	**-3,954**
Current Liabilities	-88,728	-83,532	**5,196**
Non Current liabilities	-14,129	-13,383	**746**
Total Assets Employed	**253,965**	**256,214**	**2,249**
Total Tax Payers Equity	**-253,965**	**-256,214**	**-2,249**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan
	Plan	Actual	Plan	Actual	
	£'000	£'000	£'000	£'000	£'000
Cash Balance		17,649		17,649	18,250
Capital Expenditure	925	1,738	7,191	8,598	38,531

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,793.02	6,142.62	345.12	69.09	6,556.83
Previous Month	6,752.10	6,152.30	370.63	84.99	6,607.92
Movement	40.92	-9.68	-25.51	-15.90	-51.09

1. Month 6 Financial Position Highlights

The Trust's reported deficit in month 6 was £1.8m, which was £0.8m favourable to budget, £0.1m favourable to forecast and £0.2m favourable to month 5. The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.5m adverse to budget and £0.6m adverse to forecast.

YTD variance to budget - £0.5m adverse

The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.5m adverse to budget. The key drivers of this are below:

- ERF is £4.9m adverse to plan, relating to T&O performance (£4.7m), which is offset with a favourable variance of £2.0m on independent sector expenditure
- Pay (excluding one-off benefits) is £1.7m adverse to plan
- £1.3m of one-off benefits have been identified from accruals across pay and non-pay
- £0.9m favourable variance on Utilities
- CDC is £1.2m favourable due to delays in recruitment in relation to new pathways

YTD variance to forecast - £0.6m adverse

The Trust's reported deficit YTD at month 6 was £19.8m, which was £0.6m adverse to forecast. The key driver of this is financing costs (£0.5m) relating to a timing difference which will correct itself by year-end.

Month 6 vs month 5 - £0.2m favourable

The Trust's reported deficit in month 6 was £1.8m, which was £0.2m favourable to month 5. The key drivers of this are below:

- ERF is £1.3m adverse to month 5
- Pay (excluding reserves, recharges, and one-off benefits) is £0.3m adverse to month 5 with increases in substantive costs not being fully offset with reductions in temporary staffing costs
- Non-pay (clinical supplies and services and other costs, excluding those offset with income) is £0.6m favourable to month 5, driven by a reduction in activity related consumables and a one-off benefit on the bad debt provision relating to Fresenius invoices (£0.3m)
- In month 6, £0.3m of one-off benefits across pay and non-pay have been identified.
- In month 6 we received £0.5m of Industrial Action funding

Post close down event

The month 6 position has been adjusted in line with guidance from NHS England relating to the non-recurrent deficit funding of £23.8m. The annual plan has been reduced by £23.8m from £26.2m to £2.4m, with £19.3m of this recognised in budget and actuals in month 6. The cash funding for this is to be received in October. The position including the £19.3m adjustment is below:

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	(585,885)	(66,937)	(65,183)	1,753	A	(300,977)	(298,780)	2,197	A
Pay	367,665	31,333	30,723	(610)	F	185,803	186,940	1,137	A
Non Pay	213,000	18,336	16,511	(1,825)	F	111,139	109,494	(1,645)	F
Financing Costs	8,590	716	679	(37)	F	4,295	3,888	(407)	F
(Profit)/Loss on Asset Disposals	0	0	61	61	A	0	61	61	A
Adjusted (Surplus)/Deficit for the purposes of system achievement relating to Trust core activity	**3,370**	**(16,552)**	**(17,209)**	**(657)**	**F**	**259**	**1,602**	**1,343**	**A**
MEOC	(594)	(50)	15	65	A	(296)	6	302	A
CDC	(348)	(7)	(257)	(251)	F	37	(1,067)	(1,103)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement (including MEOC & CDC)	**2,428**	**(16,608)**	**(17,451)**	**(843)**	**F**	**(0)**	**541**	**541**	**A**

Income: Over-achieved F | Under-achieved A

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

Expenditure: Underspent F | Overspent A

Capital

Year to date capital spend excluding donated assets/charitable funds is £8,598, compared to a YTD budget of £7,191k therefore showing an overperformance of £1,407k. YTD capital spend for charitable funds is £2,428k which relates to the Da Vinci Robot and the Stroke Rehab Robot. Therefore, the YTD total capital spend is £11,026k. The Board should note the risk to the planned programme relating to the cash support requirement to under pin the programme. The Trust were to submit a cash request by November however the change in the ICB deficit support means the Trust will now receive an extra £19.3m in October and it is not yet clear if or when DHSC support received in prior months will be recovered and whether this will impact on the capital cash support bid.

Cash

Cash has gone down by £1.8m to £17.7m. This is because of the Trust making the twice yearly PDC Dividend payment in month (£3.8m), which has been partially offset by £2.7m of PDC Revenue cash support and £0.9m of PDC Capital cash support in month as well as the deficit revenue position. However, the Trust is expecting cash of £19.3m from the ICB in October to support the change in 24/25 annual plan as directed by NHS England.

CIPs (Cost Improvement Programme)

In month, the Trust has delivered £1.5m of savings versus the plan submitted to NHSE of £1.8m and therefore is £0.3m adverse to plan. YTD, the Trust has delivered £6.0m of savings versus the plan submitted to NHSE of £6.2m and therefore is £0.3m adverse to plan.

Recommendations

The Board is asked to note:

- The Trust's reported deficit in month 6 was £1.8m, which was £0.8m favourable to budget, £0.1m favourable to forecast and £0.2m favourable to month 5.
- The post close event that has reduced the annual plan by £23.8m from £26.2m to £2.4m, with £19.3m of this recognised in budget and actuals in month 6.

BREAK 11:00 - 11:10

?

2411 - D3 AUDIOLOGY SERVICE UPDATE

Discussion Item | Zara Jones, Deputy Chief Executive | 11:10

20 minutes

REFERENCES

Only PDFs are attached

D3 - Audiology Service Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**D3**
Report Title:	**Audiology Service Update**		
Sponsor:	Zara Jones, Deputy Chief Executive Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Zara Jones, Deputy Chief Executive		
Appendices:	N/A		

Report Summary

Purpose of the report & Executive Summary

A National Paediatric Hearing Improvement Programme has been established by NHS England to support providers and Integrated Care Boards (ICBs) with improving the quality of Paediatric Audiology services following safety concerns raised in relation to the newborn hearing screening programme.

As part of this process, and following an independent review, Doncaster and Bassetlaw Teaching Hospitals (DBTH) was found to have quality related issues in the paediatric service which need to be subject to an improvement programme. More recently further concerns have been raised across the breadth of the service, including adult provision requiring the Trust to limit the service offer until improvements can be made.

This paper provides the background and context to this challenged position including the initial service review findings and subsequent actions.

Whilst at the time of writing no patient harm has been confirmed, the Trust is sincerely sorry for the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically.

The service is undergoing a necessary and complex recovery and improvement process which will be completed as soon as possible ensuring that improvement actions are undertaken carefully, and robustly to ensure we can safely provide an effective audiology service in the future.

Regular updates will be provided to the public Board of Directors to update Board, our patients, partners and stakeholders on progress.

Recommendation:	The Trust Board is asked to review and discuss the content of the report.			
Action Required:	~~Approval~~	**Review and discussion**	~~Take assurance~~	~~Information only~~
Healthier together – delivering exceptional care for all				
Relationship to 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.***

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
		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.		
Resources:	Resources associated with the quality improvements and recovery actions stated.		
Assurance Route			
Previously considered by:		Executive Team, Trust Leadership Team, Quality and Effectiveness Committee, Finance and Performance Committee	
Date:	Various dates 2024		
Any outcomes / next steps	• Deliver the improvement plan • Ongoing communications with patients and stakeholders • Prioritising urgent patients for mutual aid • Stand service back up when safe to do so		
Previously circulated reports to supplement this paper:	N/A		

National Context

A review of NHS Paediatric Audiology services in England has been undertaken following an incident which occurred at NHS Lothian where children were found to have a delayed diagnosis of hearing loss.

An Independent Review of their Paediatric Audiology service was requested by the NHS Lothian Health Board, in response to recommendations of the Scottish Public Services Ombudsman in a report published in May 2021. An audit of the Health Board's Paediatric Audiology caseload covered 2009 to 2018, with some areas extended to include patients up until August 2021.

Audit findings identified a series of serious issues particularly within the early years (under 5) age groups of the Paediatric Audiology service which had adversely impacted the early years spoken language acquisition of numerous children, affecting a number of these children for life. The root causes of these failures were a lack of scientific leadership, knowledge, reflection and enquiry in the presence of a lack of routine and robust quality assurance processes.

The Review Panel made 36 recommendations to ensure that the services in Lothian were safe and fit for purpose.

In August 2023, a National Paediatric Hearing Improvement Programme was established by NHS England to support providers and Integrated Care Boards (ICBs) with improving the quality of these services in England following safety concerns raised in relation to the newborn hearing screening programme. NHS England commenced work to understand the scale of the problem and the number of children affected, and to develop the strategic tools and interventions to support sustainable improvements.

A letter to ICBs on 31st August 2023 from Professor Dame Sue Hill, Chief Scientific Officer for England, set out the assessment process to be undertaken by ICBs with all providers by 30th October.

As part of this process, NHS England established regional level oversight of Paediatric Hearing Services to review and discuss provider self-assessment submissions, collate a national overview of the local plans, identify common issues and areas of good practice. This group was to work with the national team to determine the scale of the issues arising and to ensure national consistency in the approach to risk stratification and intervention.

Local Context

<u>The Service</u>

The Doncaster and Bassetlaw Teaching Hospital's (DBTH) audiology service sees patients of all ages and is provided across 5 sites:

- Doncaster Royal Infirmary (DRI)
- Bassetlaw District General Hospital (BDGH)
- Retford Hospital
- Mexborough Montagu Hospital
- The Sandringham Centre, Sandringham Road, Doncaster

<u>The Paediatric Service</u>

Paediatric Audiology is only provided at the DRI in the Children's Outpatient Department and BDGH in the Main Outpatient Department.

Newborn Hearing Screeners work on the Maternity Wards at DRI and BDGH to screen babies hearing on the maternity ward just after birth or in an outpatient clinic, required within 4 weeks of birth. At DRI and BDGH this takes place in the Children's Outpatient Departments as they do not require soundproof rooms.

Babies that don't get clear responses on the hearing screen are referred to Paediatric Audiology. They have a diagnostic Auditory Brain Stem Response (ABR) test, required within 4 weeks of referral. The test is easier to conduct on a younger baby when they are most likely to be sleeping.

Children can be referred from the Hearing Screening Programme, by GPs, ENT, Health Visitors, School Nurses or Paediatricians. They can be referred from Audiology to ENT at any point as and when required. We run a joint ENT and Audiology clinic.

For older babies there is a free-field test called Visual Response Audiometry (VRA) where they are distracted by a toy in front of them and conditioned to turn to a sound by giving a visual reward.

From around 3.5 years play audiometry is utilised which may be free-field or using headphones depending on the child and what they are willing/able to do. By 5 years the hearing test is more like a standard hearing test of pressing a button when a sound is heard.

Any child found to have a permanent hearing loss (PCHI) are offered hearing aids and booked in as quickly as possible to be fitted within 1-2 weeks or up to a maximum of 4 weeks. Once they have hearing aids they are reviewed every year.

If the child is still wearing hearing aids by the time they are 16-19 years, they will be transitioned over to the adult service. The age they transition depends on the child's education and if they have any other complicating factors.

Doncaster and Bassetlaw Teaching Hospitals Paediatric Quality Review

In September 2023, the Trust received a letter from the ICB, outlining a set of system recommendations for immediate action, informed by stakeholders including regional and ICB clinical and quality leads as well as the outcomes of the reviews of root cause analyses of the incidents and other pilot service assessments by the UK national accreditation body, UKAS. As part of this process all paediatric audiology services were requested to complete a self-assessment template for submission to NHS England and South Yorkshire ICB 27 October 2023.

The DBTH self-assessment template was completed within the requested timeframe and the Acting Executive Medical Director received a letter with the outcome of the DBTH self-assessment review in December 2023. The overall rating was RED based upon the assessment of key areas;

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	
Audit domain	Score
Calibration	D
Documentation	B
Visual Reinforcement Audiometry (VRA) rooms	B
Audit	D
Incidents/risks	D
Staffing	A
Auditory Brainstem Response (ABR)	D
Overall rating	D

Following receipt of this information the Acting Executive Medical Director convened an urgent meeting with the clinical division and service to review the ratings given and discuss plans for immediate action to recover

this position. In addition, Dr David Crichton, South Yorkshire ICB Chief Medical Officer, wrote formally to the Acting Executive Medical Director to confirm that an independent review visit would be undertaken.

Independent Review Visit

The independent review clinical team was comprised of subject matter experts and senior quality/patient safety colleagues from the ICB and NHS England. Informal feedback was provided on the day with formal feedback following on 6th February 2024.

Feedback and recommendations included:

- Leadership and quality governance to strengthen executive oversight and reporting through the organisations' governance structures. Also ensuring staff can escalate concerns effectively.
- Needing a plan to achieve UKAS IQIPS accreditation scheme
- Paediatric audiology quality standards including calibration of equipment and audit requirements.
- Peer review of diagnostic Auditory Brain Stem Response (ABR) – process in place needs to continue.
- External evidence-based peer assessment to be put in place.
- Patient safety – environment and infection, prevention and control improvements required.
- Data – need to upgrade operating system to ensure efficiency of service and processes.
- Workforce competency and ensuring staff are working to protocols and recognised practice.
- Staff health and wellbeing – the staffs' dedication to provide the best service possible and a commitment to continue to improve the service was evident. Work related sickness absence linked to environment and more structured education, training and support required.

Some immediate service mitigations were proposed as part of the feedback. This included practice related to the undertaking of double reported ABRs and Otoacoustic Emissions (OAE) testing prior to discharge any patients. There were also further recommendations made to work through over the months ahead.

Over the next few weeks Standard Operating Procedures (SOPs) were developed to ensure clear and consistent processes were followed in the service. Audiologists also undertook visits to neighbouring providers to observe and learn, supporting improvements in clinical practice. Work was also undertaken to address IT and data related issues.

We were informed that with the agreed mitigations completed by DBTH the service was safe to continue while this review is being undertaken.

The South Yorkshire ICB developed a formal incident response and management of the position. Due to our geographical coverage across two integrated care systems, the Nottingham and Nottinghamshire ICB have been actively engaged in the South Yorkshire-led work. This level of engagement and management has continued at least fortnightly and at times weekly, through to the current time.

Paediatric Case Reviews

As part of the independent review process a sample of case notes were examined and it was subsequently recommended that all children who had attended the service over the past 5 years were reviewed. At the time DBTH also undertook a triangulation exercise to review if any complaints have been put forward to indicate family concerns about developmental delays or other concerns and at the time we did not find any supporting evidence to aid prioritisation of the recall process.

The 5-year case review process was undertaken by subject matter experts external to the Trust who remotely reviewed a total of 368 case notes. We received the final report on 25th July 2024. 137 children were recommended for recall and prioritised into categories of urgency. It was agreed that 40 children needed to be

recalled initially and through a managed and externally supported process, communications were undertaken with families to explain the situation, undertake Duty of Candour both verbally and in writing and to seek consent to be seen for a follow-up appointment at Sheffield Children's Hospital. At the time of writing, many of the children have had appointments and all those who have family consent to be seen will have had an appointment by 1st November. We await formal outcomes to be shared from these appointments, but to date we have not been told that any discrepancies in outcomes or harm have been found in these children.

PSIRF, Harm Reviews and Quality

Patient safety incidents are unintended or unexpected events which have or potentially have resulted in some harm to a patient. Our aim is to learn from incidents and to promote a culture of openness and honesty. The duty of candour is a statutory and professional duty to be open with service users and their families when something goes wrong that appears to have caused or could lead to harm in the future. The trust has therefore undertaken a structured duty of candour process to ensure all 40 children recalled have had duty of candour applied and incident reports completed on our trust incident response system (DATIX). Following their individual reassessment the external experts will consider if any children have come to harm.

In the event that any harm is identified, the trust internal patient safety process will review each case. The trust has a contractual requirement to adhere to the NHS patient safety incident response framework. This framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The key principles are the compassionate engagement and involvement of those affected, and supportive oversight focused on strengthening response system functioning and improvement.

Wider Service Issues

<u>IT Database and Operating Systems</u>

Progress in implementing some of the required service changes have been hampered by challenges with the IT Infrastructure. Specifically, computers running on older versions of Windows, which has now been addressed and a difficult mobilisation and implementation of a new audiology database. Migration of existing patient records, which took place between January and April 2024, proved challenging with extended periods of testing required and some of the clinical equipment was found not to work properly with the system without IT workarounds being put in place which were time consuming, and did not always resolve the issue, or it did not work for other clinic rooms. The service faced significant delays in achieving a 'go live' status in the Spring of this year, resulting in the cancellation of booked appointments and delays in running clinics. The issues have been complex and multifactorial to resolve.

<u>Access and waiting times</u>

Prior to the paediatric quality related concerns emerging, the adult audiology service has been challenged for a significant time with regards to waiting times. The diagnostics and waiting times report, called the DM01 has a national standard across 15 key diagnostic tests and procedures (for adults and children). The contractual standard is that no more than 1% of patients should waiting 6 weeks or more for a hearing assessment. National planning guidance for 2024/25 asked providers to increase the proportion of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%. Our performance tracks significantly higher for audiology diagnostic tests and we are an outlier regionally. Linked to this issue are factors we have been actively working on as part of our overall improvement work, including the establishment of more robust

process and data recording for appointment bookings, prioritisation of appointments and monitoring of waiting times via a Patient Tracking List (PTL).

Ear, Nose and Throat (ENT) Pathway

As described in our access standards reporting, ENT is a challenged specialty for DBTH in achieving the required national standards for waiting times in the context of 78 weeks and 65 weeks performance. A significant proportion of the ENT service is reliant on audiology input to outpatient services and prior to particular surgical interventions and treatments. We are working with our ENT service to ensure as far as possible we put measures in place to enable continued support to be provided by the audiology team.

Follow up Review September 2024 and Service Limitation Decision

As part of the Paediatric Quality Review process, Subject Matter Experts (SMEs) who are audiologists by background, have been appointed by NHS England to support challenged Trusts. In September linked to our IT issues and impact on service delivery, we invited our two appointed SME colleagues to visit the Doncaster Royal Infirmary (DRI) site and Bassetlaw District General Hospital site. The visits occurred on separate days and each SME visited one site only. There were some clinical observations undertaken at the DRI site and across both sites, team members were spoken with and the rooms and facilities visited.

Feedback from both visits indicated ongoing concerns with the IT, physical estate, equipment and compliance with expected standards in some of the clinical observations. The findings were discussed in detail with DBTH Executive Directors and as part of the Paediatric Incident Management governance. Whilst Paediatrics was the focus, it was observed that the concerns raised would be applicable to delivery of the adult service in many instances.

It was not a decision taken lightly, but on the balance of risk, it was decided that a significant amount of activity across both the paediatric and adult service should be temporarily paused, offering only a limited service across areas where there was confidence that safety could be maintained. One of the key drivers of this decision was that the observations at the visits suggested that some of the original service mitigations from the formal inspection report at the start of the year, were not fully embedded.

Offering a limited service is not a position the service nor the organisation wishes to be in, but this will allow a focus on implementing the key improvement actions in a safely managed way.

Communications have been issued to patients and stakeholders to explain the position and indicate that we expect services to resume in the new year. We are receiving a high volume of enquiries and complaints regarding cancelled appointments and long waiting times via either our Patient Advice and Liaison Service (PALS), or directly into the Service or via other stakeholders including local MPs and the local media. We are working hard to respond to each query and where possible to give a personalised response to indicate the current position for the individual who is waiting or had their appointment cancelled.

Actions and decisions taken

This is an extensive and detailed programme of work to recover our service and to enable patients and families to have access to a safe and effective audiology service. We have already taken and continue to take a number of actions to alleviate the pressures, mitigate the risks and to improve the service. A summary for the Board of key actions and activities is set out below.

Recruitment of a clinical head of service – a permanent appointment has been made to bolster leadership and technical expertise in the team, whilst also increasing clinical capacity. The post holder has significant paediatric experience.

Outsourcing – we have established a pathway with the High Street Optometrist and Audiologists Scrivens to take some of our adult diagnostic waiters on a 3-year pathway which includes diagnostic testing, fittings and repairs. Patient consent was obtained prior to transfer. We are scoping the potential expansion of this in line with our prioritisation process below.

Repairs clinics – prior to limiting the service activity, we ran a successful 'drop-in' clinic for adults on a weekend who were requiring repairs and could be seen on the day. We continue to be able to offer simple repairs and have run further clinics in recent days to work as quickly as we can through our existing waiting list of those in need of support with their hearing aids.

Mutual aid and prioritisation process – the South Yorkshire and Bassetlaw Acute Federation is a collaboration of the 5 Acute Foundation Trusts across South Yorkshire. This Federation is supporting the provision of mutual aid support, and we have agreed pathways for the most urgent activity to be seen at another Trust. Sheffield Children's Hospital is already supporting us with seeing children who require recall appointments and have offered support with Baby fittings which are particularly time critical and urgent repairs. The Rotherham Foundation Trust and Barnsley Hospital NHS Foundation Trust have offered support with urgent adult repairs. As part of this process a Standard Operating Procedure has been developed which sets out the agreed pathways and process for transferring patients, including definitions of the Priority Codes which determine how urgent a case is.

Estates capital investment – to enable urgent works to be undertaken in the clinic rooms across our sites we have prioritised a level of capital investment to support the work to be undertaken over the coming months. This includes investment in required equipment alongside. A detailed project plan has been developed to set out the milestones and timescales.

Management oversight and governance

DBTH executive oversight and leadership was strengthened at the time of the initial inspection in January 2024. The Deputy Chief Executive has played an overall co-ordination role in managing the overall improvement plan with clinical leadership via the Acting Executive Medical Director. The Chief Operating Officer leads the mutual aid and patient access related elements.

A decision was made to move the audiology service from the Surgical Division to the Clinical Specialties Division in July of this year. It was recognised that whilst there is a clear link between ENT (which is a surgical specialty) and audiology, there were opportunities to strengthen governance and support to the service through aligning with a division which has responsibility for other diagnostic services.

In advance of the divisional management changes, weekly Exec-led recovery group meetings were set up enable regular monitoring of the recovery actions and early escalation of issues from the divisional leadership team to the executive team. These will remain in place whilst the service recovers and resumes services.

Further scrutiny has been provided through relevant executive and non-executive led committees, including the Trust Leadership Team, Quality and Effectiveness and Committee and Finance and Performance Committee. All groups have received recent updates on relevant areas of the recovery plan.

We have updated the CQC on the current position and responded to a request for information made in April 2024 about paediatric audiology, which had been issued nationally to all providers of audiology services about our accreditation status, Board assurance of the service and any incidents and severity of harm.

Overall, our work to address the challenges within audiology service centre around the five key areas of:

1. Seeing high risk and urgent patients in a timely manner
2. Resolving IT / data and equipment issues
3. Staff training, education and development
4. Addressing high risk and urgent Estates issues
5. Effective governance

Learning

We are still learning as an organisation from the things described in this report. Whilst the timeline is predominantly related to 2024, we know that the challenges have been in existence over a longer time period. A fuller review of the learning and changes we may wish to make as a result within this service and perhaps across other areas of the organisation will be undertaken when we have addressed the most urgent action to bring the service back to operating safely and effectively.

We are exploring different data metrics to triangulate intelligence across our services to aid earlier escalation and visibility of warning signs to indicate problems. For example, the annual staff survey for the audiology service indicates concern from a colleague perspective within the team. Executives have been meeting regularly with the Team and our Freedom to Speak Up Guardian has been supporting individuals and the wider team since the formal inspection in January. We know this is more to do to embed required cultural change within the team and to ensure all colleagues feel supported and heard.

The first part of this report outlined the significant issues found in NHS Lothian paediatric services. This has prompted us to develop our horizon scanning through our governance processes to apply a “could this happen to us” approach to our own internal visits and conversations on wards and within departments.

Next steps

A range of work continues to be undertaken to deliver against the 5-point plan set out above. In summary the key next steps include:

- Prioritisation of the waiting list – new referrals, booked appointments, cancelled appointments.
- Ensure urgent patients are seen in a timely manner via mutual aid process.
- Deliver recovery and improvement plan including key actions across IT, Estates and Clinical / workforce aspects.
- Regular reports to Board and Committees
- Ongoing communications with patients, partners and stakeholders
- Follow up paediatric independent review – expected in February 2025.

Recommendations

Whilst at the time of writing no patient harm has been confirmed, the Trust is sincerely sorry for the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and

historically. The service is undergoing a necessary and complex recovery and improvement process. We will deliver this as soon as we can, but we must ensure the actions are undertaken carefully and robustly to ensure we can safely provide an effective audiology service in the future.

The Board of Directors are requested to note the report and discuss its content and implications.

2411 - D4 FREEDOM TO SPEAK UP BI-ANNUAL REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 11:30

Paula Hill, Freedom to Speak Up Guardian
10 minutes

REFERENCES

Only PDFs are attached

- D4 - Freedom to Speak Up Bi-annual Report.pdf
- D4 - FTSU Presentation.pdf
- D4 - Appendix 1 - Speak Up Strategy Delivery Plan.pdf
- D4 - Appendix 2 - Speaking Up R&P Tool.pdf
- D4 - Appendix 3 - Speaking Up Data Infographic 23 to 24.pdf
- D4 - Appendix 4 - Speaking Up data infographic Q1 & Q2 24 to 25.pdf
- D4 - Appendix 5 -Speak Up Month Activity Plan - October 2024.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**D4**
Report Title:	**Freedom to Speak Up Bi-annual Report**		
Sponsor:	Zoe Lintin, Chief People Officer & Executive Lead for Speaking Up		
Author:	Paula Hill, Lead Freedom to Speak Up Guardian		
Appendices:	Appendix 1 – Speaking Up Strategy Delivery Plan – July 2024 Appendix 2 – Reflection & Planning Tool Assessment – Updated August 2024 Appendix 3 – SU Data Infographic – Annual -2023-2024 Appendix 4 – SU Data Infographic – Q1 & Q2 2024-2025 Appendix 5 – Speak Up Month Activity – October 2024		

Report Summary

The purpose of this Bi-annual report is to provide a comprehensive account of Speaking Up (FTSU) activity and performance against the 2024-2028 Speaking Up Strategy, from January 2024 to October 2024.
To support the launch of the revised Speaking Up Strategy, this report introduces a robust Strategy Delivery Plan (appendix 1), with 4 phases to ensure the delivery of key enablers in years 1 and 2, followed by actions to allow growth, resilience and sustainability in years 3 and 4.

This report presents the 2024 DBTH Speaking up Reflection & Planning Tool (Appendix 2) and looks to demonstrate the symbiotic nature of the above documents in influencing future Speaking Up workstreams throughout the next few years.

The report also discusses the national Speaking Up (FTSU) picture and the themes and trends in national reporting, considering theses comparatively against the trends at DBTH. It further explores how we can use this insight to learn and improve.

The report goes on to explain the work that has been undertaken and milestones that have been achieved, against the 2024-2028 Speaking Up Strategy, highlighting areas of success and work that remains ongoing or requires further development.

Recommendation:	The Board of Directors are asked to acknowledge and take assurance from the work that is presented in this Bi-annual 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		**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
		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 the 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:	This paper relates to the H&SC Act under the regulation of the Care Quality Commission. It also demonstrates compliance with the mandated FTSU requirements of the NHS contract for acute trusts.		
Resources:	-		
Assurance Route			
Previously considered by:	This full report was presented to People Committee on the 22nd October 2024. Committee members considered and challenged all areas of the report taking assurance and recommending its presentation to the Board as part of the wider assurance process.		
Date:	22nd October 2024		
Any outcomes/next steps	Presentation to Board on 5th November 2024		
Previously circulated reports to supplement this paper:			

1. Introduction

This paper provides an update on DBTH Speaking Up (FTSU) activity since the last Bi-annual Report to Board in February 2024. It uses the results of the National Guardian's Office (NGO) data collection, DBTH FTSU Guardian activity, NGO Case Review analysis and performance against the DBTH FTSU Reflection and Planning Tool actions, and the CQC Action plan in conjunction with wider information to provide an overview of organisational performance and assurance.

Following the ratification of the revised Speaking Up Strategy in February 2024, the paper introduces the DBTH Speaking up Strategy Development Plan (appendix 1) as an enabler for improvement alongside the revised annual self-assessment of the Speaking Up Reflection & Planning Tool (appendix2).

The paper also provides an insight into Speaking Up Guardian and Partner activity, including data themes and trends, which are also considered against local and national perspectives for comparison.

Finally, the paper discusses the key national and local influences on Speaking Up over the last nine months and considers the impact of these on our performance to date and future direction.

2. National Context and Local Response

Nationally the Speaking Up (FTSU) profile has remained high throughout the year, and this is evident through the publication of a number of reports, high profile cases, reviews, formal enquiries and combined processes to consider NHS culture.

The "Too hot to handle report" (brap & Kline R – February 2024) suggested that racism is prevalent in the NHS due to a culture of avoidance, defensiveness and minimisation. NHS England has responded to this with widespread engagement to consider the NHS response to racism, what Trusts and healthcare organisations are doing to prevent it, and how effective they are at addressing it. At DBTH, we have made a commitment to being an anti-racist organisation and to working towards the anti-racism framework developed by NHS organisations in the North West. The Chief People Officer is involved in the South Yorkshire EDI leadership group where consideration is given to how partners can work together on this aim, and in a new anti-racism steering group with Doncaster Place partners. The Team Doncaster leadership group is supportive of this work.

In addition, sexual safety has been a key focus for the NHS following the findings of the Working Party on Sexual Misconduct in Surgery (WPSMS) in September 2023. This resulted in the introduction of the NHSE Sexual Safety Charter, which DBTH has pledged to deliver. This has resulted in the introduction of a Sexual Safety Policy, process, and resources for all Speak Up partners to utilise when supporting colleagues who raise sexual safety concerns. These concerns will be featured in this report under an additional Speak Up reporting theme.

Considering the findings of the 2023 staff survey we should acknowledge that nationally, 8.67% of colleagues said they had experienced sexual harassment or misconduct from patients, visitors, or family, whilst 3.84% of colleagues stated they had experienced sexual harassment or misconduct from other colleagues. Given the positive % of colleagues who completed the staff survey for Team DBTH in 2023, this could indicate that up to 412 or 183 colleagues (retrospectively) could have been impacted whilst working at the Trust.

Multiple reviews and enquires into NHS care and services and the ongoing enquiry into the Post Office Scandal, have also meant that Speaking Up has maintained a high profile across the summer. The Thirlwall Statutory Enquiry (considering the Lucy Letby case) commenced in September 2024, and once again highlights the importance of not only "Speaking Up" but, "Listening Up" and "Following Up" too.

Following the change of Government in July 2024 there is also an expectation that the revised Whistleblowing Bill will once again be considered by parliament in late 2024 or early 2025.

Whistleblowing protections continue to be a conversation for some of the colleagues who Speak Up through the Guardians service, and advice has been provided on who to contact to explore this and on how to make a protected disclosure to a prescribed person.

The new government has also recently commissioned an independent investigation of the NHS in England by Lord Darzi and its final report highlighted open and transparent cultures, and the ability to listen and learn as being both part of the problem and the solution, to "fixing the NHS".

The National Guardian, Jayne Chidgey-Clark, in her response to the Lord Darzi report stated:

"The people who work in the NHS are passionate about delivering great care, but for too long they have been Speaking Up about systemic issues – infrastructure, resources, equipment, staffing, but feel that nothing is changing as a result". "Lord Darzi identifies the cultural challenges in the NHS and has – with candour – identified what is needed to learn and improve". Jayne also commits in her response to support this work going forward, through the National Guardians office and the FTSU Guardian network.

The findings above are also reflected in the NGO annual report for 2023/2024 (Culture is a patient safety issue). The report highlights that over 30,000 cases have been brought to Freedom to Speak Up Guardians throughout 2023/24 and that this is the highest ever recorded and shows a 27.6% increase on the previous year. Nearly two in every five cases (38.5%) reported to the NGO, involved an element of inappropriate behaviours and attitudes. This correlates to the picture seen at DBTH over the last two years with a significant shift in reporting of incidents relating to a lack of civility and respect and Bullying. The national report also asks us to acknowledge that this matters due to its impact on quality and safety, staffing, retention, and a lack of innovation in ways of working. It also identifies that importantly this represents 30,000 opportunities for learning and improvement for the benefit of patients and colleagues and the wider Trust overall.
The report also considers the increase in case reporting through SU Guardians in alignment to CQC rating, identifying that the highest number of cases are reported in Trusts that are rated as "Requires Improvement" and "Inadequate".

3. Local Speaking Up Activity

Locally, the number of colleagues accessing FSTU Guardian services continued to grow in 2023/2024, resulting in 104 colleagues raising concerns, in 60 cases. This is reported nationally as 104 cases due to the NGO guidance on reporting concerns. This number is reflective of the national picture, with the average number of cases per 1,000 colleagues in acute Trusts, being reported as 17.5 in 2023/2024. This would mean an anticipated total of 122.5, for 7,000 colleagues.

The number of reported cases for 2023/2024 was influenced by a large collective number of individuals who spoke up in three cases. This impacted on the overall number of patient safety/quality and process concerns, due to the inability of the colleagues to effect change by Speaking Up locally, which then led to a negative impact on service delivery and the wellbeing of colleagues. Most cases (52%) were raised by Nurses and Midwives and Patient Safety (61%), Systems & Processes (68%) and Worker Safety & Wellbeing (76%) were the predominant themes discussed. The number of themes reflects higher than the individuals reported as many colleagues spoke up about multiple themes at the same time. The length of time taken to explore and resolve concerns continued to be an issue in 2023/2024, with some cases remaining open for up to a year.

Feedback responses continued to be low during 2023/2024 too, with only 15 responses being received, from the 51 invitations to provide feedback that were sent out. However, of those who did provide feedback, 93% (14) stated that based on their experiences, they would Speak Up again. This is much higher than the national picture although is based on a very low feedback rate at present. Feedback figures are also

impacted by the number of cases that remained open at the time of end of year reporting. Full details can be found in appendix 3.

Quarter 1 of 2024/2025 continued to see a rise in individuals raising concerns, with 39 colleagues raising concerns in 19 cases. This increase was again attributable to multiple individuals raising concerns in teams or groups. This trend reduced in Quarter 2 with less multiple reports, meaning 24 individuals raised concerns about 16 cases. Both quarters saw concerns being raised predominantly by Nurses and Midwives (57%) and the three most predominant themes discussed continued to be Patient Safety (29%), Systems & Processes (46%) and Worker Safety & Wellbeing (44%). However, when raising their concerns about worker wellbeing, colleagues also spoke about the impact of team cultures, leadership, and behaviours. The number of themes continues to reflect higher than the total number of reports due to colleagues highlighting more than one theme when they speak up. Feedback continues to be low at the end of Quarter 2, however some cases have not yet been closed, so this will feed into future reports. Full details can be found in appendix 4.

In line with the CQC Action plan and the revised Speaking Up strategy, a revised feedback process was launched in July 2024. However, it is important to note that further engagement and time is still required to ensure they are embedded into practice and return rates are improved.

In addition to the cases raised with the Speak up (FTSU) Guardian service, five colleagues have raised concerns in Quarter 1 and 2 of 2024/2025 relating to sexual safety. These include:

Number & Type of case	Specific Detail	
4 Cases of inappropriate or unwanted behaviour	3 Cases involving behaviour towards a colleague by patient, family, or visitor	1 Case involving behaviour towards a colleague by a colleague
1 Case of sexual harassment	0 Cases involving harassment towards a colleague by patient, family, or visitor	1 Case involving harassment towards a colleague by patient, family, or visitor
No cases of sexual assault were raised during either quarter		

In line with the DBTH Sexual Safety Policy these concerns are highlighted to the secure guardian inbox, via the DATIX reporting tool, for the purpose of data capture and reporting only. However, the Guardian has provided manager support in some of these cases. Full details can be found in appendix 4.

Performance against Strategy

The DBTH 2024-2028 Speaking Up Strategy, States that our Vision for Speaking Up at DBTH is to embed a cultural environment where, Speaking Up, Listening Up and Following Up are integral to providing outstanding care and colleague experience, and where, Speaking Up results in learning and improvement.

The revised Speaking Up Strategy Delivery Plan (appendix 1) was devised through extensive engagement with all professional groups across all sites and divisions. This allowed broad consideration of key actions in the strategy and the Reflection and Planning Tool (appendix 2) to establish the key focus for phases one and two of the four phase plan. All actions in phase one have been achieved and a strong position has been achieved in phase two. These achievements and further actions required are presented below.

Key:

- ✓ Speaking Up work that has been completed and is being strengthened to become BAU.
- ❖ Speaking Up work that remains ongoing or requires further development.

Raising the profile of Speaking Up.

- ✓ This theme has been a key focus in phases 1 & 2 of the SU Strategy delivery plan. However, it is important to note that activity has not just been around raising awareness, as raising the profile of Speaking Up is also about ensuring Speaking up is a priority for all leaders, becoming an integral part of the leadership role.
- ✓ SU Leadership champions, sharing leadership stories in line with Just Culture work.
- ✓ A wide range of engagement and roadshow activities for October's Speak Up Month, including a "Power of Listening" Leadership Assembly and a Leadership – listening & Learning Seminar to listen to and reflect on the experiences of our internationally trained colleagues and our neurodiverse colleagues. Full speak Up Minth activities can be found in appendix 5.
- ✓ Increased engagement through the Speak Up Strategy Launch used to enable the development of the SU Strategy Delivery Plan.
- ✓ Increased awareness and communication through continued SU and Just Culture roadshows, visible resources, increased stories, and the introduction of the 'Sharing what we have heard and what we have learnt' information as part of the Sharing how we care publication.

Providing easily accessible, consistent, high quality Speak Up services.

- ✓ Introduction of the revised SU Process, Managers resources and peer support/learning. This has also led to the pilot of the Leadership Peer Support offer, to establish if this would have greater impact as a formal Leadership Champion role.
- ✓ Increase in Speaking Up activity through the SU Guardian service (appendix 3 & 4) and wider partners, including Patient Safety, People Business Partners, PNAs & PMAs, Leadership &OD, EDI lead and Safeguarding teams. It is anticipated that some of this increase is in response to the extensive engagement and activity detailed above and due to wider activity including the Just Culture work program, PSIRF and the launch of the Sexual Safety Charter in June 2024.
- ✓ Successful recruitment of a development Guardian role to support increased SU activity for six months from September 2024 to February 2025.

Embedding an open and transparent Speak Up culture.

- ✓ 49 SU Champions have now been trained and are actively being supported to raise awareness and support Speaking Up locally in their teams and departments.
- ✓ Monthly Speaking Up Roadshow held across all three sites, working with colleagues and leaders to establish what we need and what we should do to embed a culture of psychological safety.
- ✓ Pilot of Leadership Champions, helping to support new and developing leaders with their Speaking Up journey.
- ❖ Although the Trust now has 49 trained Speak Up Champions who are active in their own areas, further work is still required to recruit consistently across all areas and divisions. This will be a key focus in October's Speak Up Month (activity listed in appendix 5), with recruitment taking place across all three sites.
- ❖ Increased enhanced training relating to behaviours and relationships in line with the Just Culture workstream and DBTH Way.

Identifying and tackling barriers to Speaking Up.

- ✓ Increased engagement with our internationally trained colleagues, supporting their newly formed network with speaking up opportunities, processes, and resources.
- ✓ Speak Up Month Seminar to listen to and reflect on the experiences of our internationally trained colleagues and our neurodiverse colleagues, providing an opportunity to learn and develop new systems and process to support speaking up across these groups.
- ✓ Increased number of partners and champions supporting colleagues appropriately at local or speciality level.
- ❖ Agreement for the next targeted sessions of Speaking up training and mangers support to be provided to Estates & Facilities and the newly strengthened site team. This will help to address support out of hours and for those in different ways.
- ❖ Further work to increase the number of colleagues who share their protected characteristics when Speaking Up.

Education, learning and improvement.

- ✓ Agreement for all three levels of SU training "Speak Up, Listen Up & Follow Up" to be included in SET+ training from September 2024
- ✓ Speak Up, Listen Up & Follow Up training has been delivered to leaders (and their teams) who have sought support to strengthen their understanding of speaking up and its systems and processes. This has also been provided to targeted areas where multiple concerns have been raised and support has been offered to increase skills and confidence.
- ✓ This work has seen completion of the following training to date:

Level 1 – Speak Up – 524,	Level 2 – Listen Up – 399,	Level 3 – Follow Up – 253

Governance and assurance processes

- ✓ Board Development Session in May 2024 demonstrating strong commitment and buy in from all members during the discussion.
- ✓ Achievement of the Speaking Up elements of the CQC Action Plan. However, it is important to note that although revised feedback processes have been implemented, further engagement and time is still required to ensure they are embedded into practice and return rates are improved.
- ✓ Revised DBTH Speaking up Reflection & Planning Tool for 2024, supported by leaders and wider SU partners.
- ❖ Although much engagement has taken place with divisions to explore SU assurance processes, further work is still required to ensure consistency and compliance. A listening into action event took place on 11 October, to explore this work as part of SU Month 2024.
- ❖ The development of a robust audit tool to measure the data collection, collation and feedback processes for SU cases supported by SU Partners.
- ❖ Exploration of the increase in SU activity to ensure the reasons correlate to those described above and to improve understanding of the overlap between themes that are raised.
- ❖ Completion of the Speaking Up Peer Review in January 2025.

4. Final note and recommendations

The information in this report demonstrates the increased profile of Speaking Up both nationally and locally and considers the impact of this profile and the launch of the revised strategy on the rise in Speaking Up activity at DBTH. The paper also explains the vast amount of work that has been undertaken to deliver the key enablers for the foundations of the Speaking Up Strategy delivery plan. It further identifies the work that is still underway and needs strengthening, and finally considers the process to assess the success of this work prior to agreeing the final processes required to achieve success in phases 3 and 4.

The Board of Directors are asked to acknowledge and take assurance from the extensive work that is presented in this Bi-annual report.

Appendix 1 - SU Strategy Delivery Plan – July 2024

DBTH Speaking Up Strategy Delivery Pla

Appendix 2 - Reflection& Planning Tool Assessment – Updated August 2024

Speaking Up R&P Tool June 2024.pdf

Appendix 3 - SU Data Infographic - Annual -2023-2024

Speaking Up data infographic 23 to 24

Appendix 4 - SU Data Infographic - Q1 & Q2 2024-2025

Speaking Up data infographic Q1 & Q

Appendix 5 - Speak Up Month Activity Plan – October 2024

Speak Up Month Activity Plan - Octob

Further reading:

National Guardians' Office (NGO) Annual Report 2023-2024 – "Culture is a patient safety issue"

FTSU-Case-Data-Annual-Report-23-24-1

Government review of Whistleblowing practice and framework

https://www.gov.uk/government/news/government-reviews-whistleblowing-laws#:~:text=The%20full%20terms%20of%20reference%20have%20been%20published%20on%20gov.uk%20%3A%20https%3A//www.gov.uk/government/publications/review%2Dof%2Dthe%2Dwhistleblowing%2Dframework

Too hot to handle report, brap & Kline R, February 2024

Too Hot to Handle? (brap.org.uk)

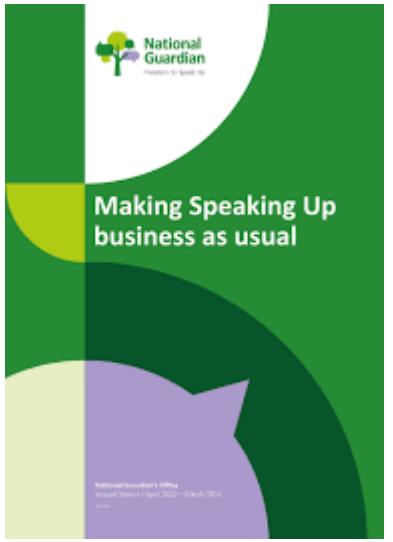
Too Hot to Handle Report.pdf

Workforce and patient safety: temporary staff - integration into healthcare providers - HSSIB 2024

https://nationalguardian.org.uk/2024/09/09/response-to-hssibs-report-workforce-and-patient-safety-temporary-st

Speaking Up (FTSU) Bi-annual Report

National & Local Context



DBTH Speaking Up Data Summary

2023-2024

104

Registered Nurses and Midwives	52%
Raised their concerns anonymously	2
Worker safety or wellbeing	76
Systems and processes	68
Patient safety/quality	61
Feedback and Speak up again	98%

2024-2025

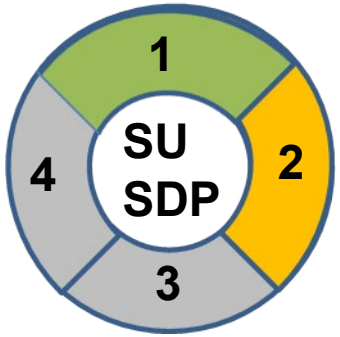
63

Registered Nurses and Midwives	57%
Raised their concerns anonymously	0
Worker safety or wellbeing	40
Systems and processes	19
Patient safety/quality	26
Feedback and Speak up again	86%

Performance against Strategy

Governance and assurance processes

Raising the profile of Speaking Up



Education, Learning and Improvement

Providing easily accessible, consistent, high quality Speak Up services

Identifying and tackling barriers to Speaking Up

Embedding an open and transparent Speak Up culture

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Questions & Feedback

DBTH 2024-2028 Speaking Up Strategy Delivery Plan

Strategy Overview	
The DBTH 2024-2028 Speaking Up (FTSU) Strategy, is a revised strategy designed to help improve what we do in relation to Speaking Up, how we tell you about its impact and how this work will contribute to and support positive cultural influence at DBTH. Our aim is to embed a cultural environment where, Speaking Up, Listening Up and Following Up are integral to providing outstanding care and colleague experience, and where, Speaking Up results in learning and improvement. We aim to achieve this vision by delivering across the following six themes. 1. Raising the profile of Speaking Up. 2. Providing easily accessible, consistent, high quality Speak Up services. 3. Embedding an open and transparent Speak Up culture. 4. Identifying and tackling barriers to Speaking Up. 5. Education, learning and improvement. 6. Governance and assurance processes. Both the strategy and this delivery plan have been developed through direct consultation with Speak Up Partners and informed by discussions with divisional/directorate leadership teams and engagement with a wide range of colleagues through cross site engagement sessions, training events and feedback processes. Engagement has also taken place with Staff Side representatives, Equality, Diversity & Inclusion (EDI) leads and staff networks, to ensure fairness and inclusion throughout the process. The delivery plan will be considered in 4 phases focusing on planning and consultation, staged implementation, and evaluation. This will ensure the delivery of key enablers in years 1, and 2, followed by actions to allow growth, resilience, and sustainability in years 3 and 4. External validation and evaluation of our performance against the strategy will be sought to ensure robust methodology is used to assess best practice and the achievement of the identified criteria for success.	
Phase 1	**Delivery Planning – April 2024 – July 2024**
Strategy Theme	**Detailed Description**
Overall Strategy	❖ Launch the SU Strategy for 2024-28, through launch events across all sites. ❖ Engage with leaders, managers, and wider colleagues across the trust to explore how the strategy should best be delivered. This engagement would also look to identify the key enablers to support early success and those actions that will later allow growth, resilience, and sustainability. ❖ Strengthen capacity and improve professional representation at the SU Forum. ❖ Grow our team of SU champions to increase diversity

	and enable greater support for the SU Strategy implementation. ❖ Look to mandate all three levels of SU training as ReST or SET+ and enable it to be accessed via online learning and enhanced by face-to-face training.
Phase 2	**Strategy Implementation – key enablers**
Strategy Theme	**Detailed Description – August 2024 – March 2026**
Raising the profile of Speaking Up	❖ Develop a robust communication plan to raise the profile of Speaking Up, ensuring visibility and reach across all colleagues, learners, and volunteers. ❖ Roll out the revised DBTH Speaking Up Policy and publicise our range of SU partners, through the provision of a local best practice 'process on a page' to make this easily accessible. Include visible pledges from leaders and managers to demonstrate that they welcome speaking up. ❖ Further develop and support a team of Speak Up Champions who will raise awareness in their local areas, ensuring up to date information and resources are available for colleagues who explore speaking up.
Providing easily accessible, consistent, high quality Speak Up services.	❖ Provide a framework (process) for how concerns should be responded to, when raised to different partners, to ensure a consistency in approach, actions, and behaviours. This to be supported by the information in the managers/partner's handbook. ❖ Ensure that all managers and wider Speak Up partners are clear about their roles and responsibilities in relation to Speaking Up and have the competence and confidence to receive and respond to concerns consistently and compassionately. ❖ Provide timely, ongoing support to all managers and wider Speak Up partners to enable the above. ❖ Devise a process for partners to provide anonymised numbers, themes and learning to enable the triangulation of data as part of the wider governance and assurance process. ❖ Strengthen the process for learning from concerns and ensure all partners know their responsibilities in following this through to improvement and that all learning and improvement informed by Speaking Up is celebrated.
Embedding an open and transparent Speak Up culture.	❖ Work with our Speak Up partners and leaders across the Trust to raise awareness of and embed our Just Culture principles, utilising these to explore and implement improvements in Speak Up services. ❖ Provide Just Culture development sessions linked to our revised NHSE aligned Speak Up training at levels

	1, 2 and 3. ❖ Facilitate focussed discussions on creating a healthy Speak Up culture and a culture of psychological safety, where healthy, early conversations are encouraged and welcomed as a learning opportunity. ❖ Encourage colleagues to talk about their Speak Up experiences (positive and negative), sharing these stories in line with the wider Just Culture work programme and learn from listening to these stories and share how we use this insight to improve our Speak Up offer. ❖ Work with our L&OD partners to ensure we consider individual restoration and team building in a way that is holistic and people centred. ❖ Recruit, train, and support a diverse group of Speak Up Champions (across all divisions) who will play a crucial role in encouraging colleagues to Speak Up at the earliest opportunity to embed a culture of openness and honesty.
Identifying and tackling barriers to Speaking Up	❖ Use varied communication methods and tools to connect with all DBTH colleagues including operational leads, to ensure our messages reach all groups. Including those working across multiple sites and shift patterns. ❖ Explore how barriers to Speaking Up are developed, how they can be prevented and removed as part of our revised training offer. ❖ Continue to enable a diverse range of colleagues to share their stores about combating barriers to Speaking Up to allow learning and improve Speak Up services. ❖ Continue to work with the EDI lead and staff networks to support those who, for whatever reason, may find it harder to Speak Up, ensuring that their voice is heard. ❖ Work with the lead for Organisational Development, EDI and Wellbeing to improve our understanding of information in relation to the diverse colleagues who access Speak Up services.
Education, Learning and Improvement	❖ Review the delivery of the HEE levels, 1, 2 and 3 training ensuring that joint DBTH cultural messages are delivered in line with national recommendations. ❖ Mandate all three levels of SU training as ReST or SET+ and enable it to be accessed via online learning and enhanced by face-to-face training. ❖ Revise our Speak Up Service Feedback processes, enabling easier, anonymous access and therefore looking to increase response rates and allowing greater learning and improvement.

	❖ Ensure that all new colleagues to DBTH receive Speaking Up information in line with the National Guardian's Office awareness raising toolkit as part of their corporate or local induction. ❖ Hold Quarterly Engagement sessions to ensure ongoing learning from SU cases across Guardian and wider partner services.
Governance and Assurance Processes	❖ Introduce a consistent method of reporting and recording concerns raised with wider Speak Up Partners, in line with the revised Speak Up process. ❖ Review all Freedom to Speak Up feedback evaluations following conclusion of any concerns raised and at 3 - 6 - & 12- month intervals post closure. ❖ Provide bi-annual high-level figures to the People Committee and Trust Board, reflecting themes and trends, making recommendations regarding changes to policy and practice in line with any associated learning. ❖ Explore the role of the Speak Up NED and or SID in relation to supporting concerns that relate to the Board and those that suggest and or evidence detriment. ❖ Monitor percentage completion of the revised Speak Up, Listen Up and Follow Up training packages. ❖ Review number of contacts, themes, and trends in order to understand the cases raised with SU Champions and Partners. ❖ Review the annual staff survey results to identify 'hot spots' or blind spots and support leaders in the identified areas to share success or learn and improve. ❖ Regularly monitor delivery against the national FTSU reflection and planning tool 10 key actions through a process of peer review. ❖ Review national case reviews (when published) to ensure that any recommendations and learning are implemented, where appropriate. ❖ Using QI methodology, work with divisional SLTs and wider leaders to strengthen methods to provide assurance in relation to SU learning and improvement at divisional and organisational level. ❖ External Peer Review of (FTSU) Speaking Up service provision in January 2025. This will be conducted using robust methodology, successfully piloted in other areas across the NEY region. ❖ Biannual review of the all of the above actions in order to inform dynamic review of activity and actions as required.

Phase 3	**Strategy Implementation – growth and resilience**
Strategy Theme	**Detailed Description – April 2026 – March 2027**
	Us the Biannual review of the actions carried out in Phases 1 & 2 in order to inform a dynamic review of activity and actions as required in Phase 3.
Phase 4	**Strategy evaluation – sustainability and review**
Strategy Theme	**Detailed Description – April 2027 – March 2028**
Overall Strategy	Plan and conduct a formal evaluation of strategy activity and successful outcomes, supported by DBTH colleagues external to SU processes. This work to also be supported by external experienced Guardians inline with previous Peer reviews in January 2025 & 2026. Engage with colleagues across the trust to share the successes and challenges identified by the evaluation and review, working to explore the strengths, opportunities, threat, and challenges to be considered and addressed in the Strategy for 2028 – 2032.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Version 2 – Annual Review July 2024 (updated August 2024)

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5

Enter summarised commentary to support your score.

The Executive Lead for Speaking Up has extensive experience of and transferable skills for all of the above, with particular strengths in providing support for the FTSUG and reviewing arrangements for ensuring effective service delivery. They also ensure collaboration with wider Just Culture, leadership & OD programmes and the engagement of key stakeholders and SU partners at local and system level.

As the second Speak Up service review is now completed (June 2024), and the third planned for June 2025, the Executive lead continues to demonstrate transferable knowledge and best practice from reviews in a previous acute trust and has facilitated continuous learning from a local and systems perspective.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Peer Review of (FTSU) Speaking Up service provision planned for January 2025. This will be conducted using robust methodology, successfully piloted in other areas across the NEY region (to be rolled out nationally).
Evaluation (Annual review) of performance against the Speaking Up Strategy, considering actions in the year 1 delivery plan.

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	4
I challenge the board to develop and improve its speaking-up arrangements	4
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	4/5
I am involved in overseeing investigations that relate to the board	N/A to date
I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

The NED for SU has been in post now for 2 years and continues to strengthen their knowledge and skills in relation to speaking up through attendance at the NGO training, seminars and webinars and has been instrumental in the development of the national NED network.

Quarterly Speak Up Meetings take place between the Executive Lead, NED and FTSUG to allow reflection and support. The NED is also available for appropriate level independent advice.

The NED is an integral part of the local Integrated Care Boards. This will work to support their SU improvement journey as well as their wider understanding of cultural impact of Speaking Up.

The NED is also a key member of the People Committee, the Board sub-committee that considers the Bi-annual Speak Up Assurance Report.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Explore the role of the Speak Up NED and or SID in relation to supporting concerns that relate to the Board and those that suggest and or evidence detriment

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3/4
We regularly and clearly articulate our vision for speaking up	4/5
We can evidence how we demonstrate that we welcome speaking up	4
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	3/4
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3/4
We regularly discuss speaking-up matters in detail	4/5

Enter summarised evidence to support your score.

Some senior leaders who hold key speak up roles, are key members of the Speak Up Forum, or old key Speak Up Partner roles, continue to consistently demonstrate that Speaking Up is encouraged and welcomed through their engagement in the delivery of our revised Speaking Up Strategy, associated pledges to support an open Speak Up Culture and a strong commitment to a Speak Up Partners approach. However, a variable picture is still evident across our wider senior leaders, with the acknowledgement of pockets of good or excellent practice alongside areas for improvement is still evident from our 2023 Staff Survey results and in the stories shared in teams and through Speak up communication channels and wider methods of sharing how we learn from speak up cases, processes, and impact.

Speaking Up continues to be regularly discussed at the People and Organisational Development and Education and Research (PODER) Senior Leadership Team, as well as at the Bi-Monthly Speak Up Forum, Monthly Chief Executive meetings and the Quarterly Speak Up Catch Up meetings with the Executive Lead and NED for Speaking Up. It is also discussed at some divisional quarterly governance

forums, sharing reciprocal themes and learning to aid improvement or identify the need for support. This still needs strengthening across some divisions.

Increased engagement and training sessions have taken place throughout 2023/2024 which has seen attendance from senior leaders increase and participation become more meaningful. This is strengthening our ability to share good leadership stories in relation to just culture and speaking up and allow a peer impact across those leaders who require further support and encouragement.

The variability is also still considered to be linked to those who have experience of speaking up or supporting those who speak up or have an active role as a Speak Up or cultural improvement partner, therefore, some leaders are providing peer endorsement and validation to assist in raising the profile of Speaking Up. Further work is still required to strengthen the profile of speaking Up to gain equity across Divisional Boards and with wider senior leadership teams.

Speak Up, Listen Up & Follow Up training has been delivered to leaders (and their teams) who have sought support to strengthen their understanding of speaking up and its systems and processes. This work has seen completion of the following training to date:

Level 1 – Speak Up – 487
Level 2 – Listen Up – 372
Level 3 – Follow Up – 226
Champions training – 49

This work also links to the skills and confidence of our SLTs in relation to wider leadership and cultural perspectives.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

Pilot & evaluate the Leadership Peer Support to establish if this would have greater impact as a formal Leadership Champion role.

Continue and strengthen cultural roadshows, including creating a culture of psychological safety and embedding consistent speaking up practice.

Continue to strengthen our Speaking Up leadership offer, working to maximise the introduction of all three levels of SU Training as part of SET Plus, for all colleagues. This will also see the programs being delivered face to face and included in the DBTH Leadership Prospectus for 2025.

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	5
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3/4
We support our guardian(s) to make effective links with our staff networks	3/4
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	4

Enter summarised evidence to support your score.

The lead for Organisational Development has a strength in supporting compassionate and productive leadership and has evidenced this through supporting senior leaders to consider their ability to create a culture of psychological safety and learning for service / quality improvement. The lead is also launched a behaviours framework that works to support colleagues to understand behaviours that are and are not acceptable and provides a tool for leaders and managers to address consistently poor behaviours.

The lead for OD is a strong integral Speak Up partner and is a key member of the Just Culture Group, supporting the wider Speak Up improvement journey. This is an integral part of the People Strategy and has a plan to embed speaking up as business as usual, developing robust relationships across all colleagues at the Trust.

The DBTH Just Culture work sees the lead for OD, FTSUG, PSIRF Lead and People Business Partner lead for culture, utilising a roadshow style system of engagement to allow wider exploration of what support is required by leaders and managers, to enable consistency in approach and experience when colleagues speak up to wider partners.

The FTSUG is an active member of the EDI group and works alongside the lead for L&OD and the Lead for EDI to explore, understand and resolve barriers to speaking up.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Using internal Just Culture (PSIRF, Employee Relations and SU) metrics and wider national data, establish a baseline of Speaking Up behaviours across the trust. Use this baseline to benchmark our position nationally and consider how this new insight can be used to explore learning and improvement for our wider cultural journey.

Continue and strengthen cultural roadshows, including creating a culture of psychological safety and embedding good Speaking Up practice.

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
We have reviewed the ringfenced time our Guardian has in light of any significant events	3
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	3
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	3

Enter summarised evidence to support your score.

The strategic focus of the FTSU Guardian, combined with the revision of the strategy and level of improvement work has been discussed and considered by the People Committee (Board subcommittee) as part of the biannual presentation of SU assurance process.

The guardian role is integral to the Just Culture network and capacity and strength is increased through this process and the partnership model for delivering speak up services. However, increased work to drive forward the 2024-2028 Speaking Up Strategy and respond appropriately to the increased cases, and requests for management support, is having an impact of the ability to meet the identified timeframes. This was explored during a specific Speaking Up Board Development Session in May 2024.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Review the activity and demand of the service, considering the impact of the additional time limited resource on our timely ability to respond to and support colleagues who speak up as well as delivering on all of the wider element in the SU Strategy and identified in this review. Review this in line with benchmarking data for other medium sized acute trusts.
Continue to consider the speak up service structure and delivery model, including maximising SU Partner ability, capacity and resources, including the further growth of the SU Champions network and the introduction of SU Leadership Champions.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	4/5

Enter summarised evidence to support your score.

The DBTH Speaking Up Policy "Speak up to make a difference" has been revised to demonstrate the adoption of the 2022 National policy template and has been launched in June 2023, alongside a local best practice policy on a page to allow easily visible information to be accessed across a wider range of communication mediums, including planned visibility across all departments.

The process to support the Speak Up Policy has been reviewed to allow learning from the experience of those who have accessed Speak Up services and those who struggle with consistency when speaking up to wider SU partners. This was launched in March 2024. Visual Speaking Up process boards have been procured and placed in wards and departments across the trust with approximately 50% in place by July 2024.

We can demonstrate access to the policy through intranet and social media activity and through activation of the QR code on the policy posters across the site and through the feedback we receive form those who access services.

We acknowledge that some areas still report not knowing about Speaking Up or how to access support, and this is being addressed in the first theme of the strategy, which includes a robust communication plan.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Roll out all revised speak up resources, ensuring this is included in the revised Speaking Up communication plan as part of phase one of the strategy delivery plan.
Continue to address the feedback that some colleagues are unaware of how to access the policy and its process, through publications, roadshows, training and the completed roll out of SU process boards in every ward and department.

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	5
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3/4

Enter summarised evidence to support your score.

FTSUG's meet all new colleagues as part of the induction and welcome process during the delivery of SU awareness and cultural training. Speak Up Guardians are publicised across all sites and visits and visibility sessions are held at all sites on a regular basis.

Social media is used to publicise Speaking Up activity, and this is measured and monitored by the Communications team.

The Speak Up communication plan is being refreshed as part of the 2024-2025 strategy delivery plan.

There is also a robust communication plan for the introduction of the revised strategy and October's Speak Up Month.

Extensive engagement has taken place to influence our strategy review and further focussed work is taking place to inform our strategy delivery plan.

We are learning from listening to stories about speak up experience (positive and negative) and sharing how we use this insight to improve our speak up offer. These stories are also informing our detailed speak up process, ensuring we consider restoration and return to Business as Usual (BAU) in a way that is holistic and people centred.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Consider how we will measure the activity and outcomes of the revised communications plan, as part of the Strategy delivery plan prior to October 2024
Continue to share stories of SU experiences in line with the wider Just Culture work programme and annual Staff Survey results.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	5
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	3

Enter summarised evidence to support your score.

Utilising the NGO awareness raising toolkit and the content of level 1 HEE training, we ensure all new colleagues receive an induction that includes speaking up and wider cultural themes.

As an organisation, in 2023/2024, we have continued to see the challenges of time and resource and the priorities on training, particularly across clinical teams in relation to levels 2 and 3 of the HEE Speak Up training. Therefore, a formal application was made to mandate all three levels of training in July 2024. This was approved and will be rolled out as SET + from September 2024.

In addition, we also understand that good conversations that tie in speaking up to our wider people and cultural plans, have a greater impact on staff engagement, learning and practice. Therefore, we remain committed to the delivery of the HEE levels, 1, 2 and 3 training in a road show style, allowing delivery of the mandated content alongside, wider local key topics and identified learning. This will be in addition to the online training available nationally as part of SET+.

This work will also see the development of a managers and leaders handbook/toolkit to support understanding, skills, experience, and confidence to support speaking up. This will also be included as taught sessions in the 2024/2025 leadership prospectus.

This work will be developed collaboratively with partners at Rotherham, Doncaster and South Humber Trust (RDASH), South, West Yorkshire Partnership NHS Foundation Trust and Leeds Teaching Hospitals Trust to demonstrate wider learning and evidence the benefits of different delivery models.

2023/2024 has seen the delivery of a multiple robust Board Development Sessions, incorporating the content of HEE level 3 speak up training alongside local data and learning and wider Just Culture Principles. This has seen all Board attendees completing “Follow Up” training. The impact of speak up training (and associated just culture work) will be measured and monitored by the Speak Up Partnership Forum and overseen by the People Committee (Board Sub-committee).
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
In addition to the online training available as part of SET+, we will continue to deliver, combined face to face training sessions, allowing delivery of the mandated levels, 1, 2, and 3 content alongside, wider local key topics and shared experience learning. This will also be included as taught sessions in the 2024/2025 leadership prospectus.
Develop a revised induction and welcome offer that will complement Level 1 “Speak Up” training and explore the development of the Speaking Up Champions to support this delivery. Ensure this work embeds SU in all local induction programmes.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3/4
All managers and senior leaders have received training on Freedom to Speak Up	3
We have enabled managers to respond to speaking up matters in a timely way	3/4
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3

Enter summarised evidence to support your score.

There is variable evidence of good speak up practice across our management/leadership teams. The uptake of training and associated engagement remains variable, however, 372 managers and leaders have completed level 2 “Listen Up Training” and work to support colleagues through improvement programmes and strive to apply the same positivity to learning from concerns or incidents.
We are working with managers across the Trust through a revised PSIRF and other partnership programmes of work and encourage managers to use the same SU process to thank colleagues for speaking up and ensure they respond with curiosity and a focus on learning and restorative practice.

Further engagement has taken place to understand what support managers would like and find beneficial. This has been considered as part of the revised strategy delivery plan and includes the managers toolkit, drop-in sessions and local training options to allow learning at different paces and focussed on specific teams and departments.

Focused manager support sessions are now delivered, supporting managers to support colleagues in their teams. Best practice and peer support to increase understanding and confidence is now built into planned engagement events. These are supported by the FTSUG, and so far in 2024 have focussed on the revision of the Speak Up Strategy, improving feedback processes and in October they will focus on “The Power of Listening”, in line with the 2024 Theme for National Speak Up Month.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Embed the focused manager support sessions and strengthen engagement events including improving feedback processes and “The Power of Listening”, in line with the 2024 Theme for National Speak Up Month.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	4
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

The Speak Up Partnership Forum has representation from a wide range of Speak Up Partners which allows robust understanding of patterns and themes from speaking up and where barriers may exist to providing good, consistent speak up practice.

Areas who may need focussed support for potential concerns are offered support proactively, both for managers, leaders and all colleagues in those areas. This work is considered collaboratively with the OD Team and uses methodology from the PNA/PMA evidence base in relation to debrief and restorative practice. The FTSUG works with divisional teams and SLTs to ensure learning from these situations.

Staff survey results have continued to be explored and areas of best practice have shared their thoughts and learning and other have embarked on improvement programmes to create stronger speak up cultures and improvements in patient care and colleague experience.

Triangulated data is considered by the Speak Forum and wider metrics are now also a key focus of the Just Culture group. Both of these streams of work have considered the recommendations from NGO Case reviews and are working to consider how improvements can be made in relation to retention, exit interviews, levels of suspension and formal processes.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Strengthen our collection, collation and analysis of specific Speaking Up Guardians Service data to explore the trend in increased speak up cases to the FTSU Guardians and look to consider areas of high visibility and training input to establish links and patterns, which would indicate that this is positive impact of increased awareness and understanding of what good speaking up should look like.

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	4
We use this information to add to our Freedom to Speak Up improvement plan	3/4
We share the good practice we have generated both internally and externally to enable others to learn	3/4

Enter summarised evidence to support your score.

The FTSU Guardian is an integral member of the regional Guardian Network and takes part in peer discussion and the sharing of best practice.

We consider all case reviews and use the recommendations to explore and challenge our own processes and performance. Any gaps in compliance or concerns in relation to the recommendations are addressed in the biannual assurance report to Board.

All learning has been built into the Speak Up strategy for 2024-2028 and its associated delivery plans.

We are learning from internal and external engagement and use this to inform our Speak up practice too.

Qi methodology has been applied to consider key elements of the SU strategy revision, including focussed engagement to consider barriers, experience and restorative practice. QI processes have also been used to develop the Strategy delivery plan.

A Peer Review of (FTSU) Speaking Up service provision is planned for January 2025. This will be conducted using robust methodology, successfully piloted in other areas across the NEY region (to be rolled out nationally).

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Ensure all internal and external learning and gap analysis findings are used to inform the annual self-assessment and evaluation/review of the strategy delivery plan in May 2025.

Continue to use Qi methodology during engagement events to identify areas of best practice internally, allowing us to share our learning and celebrate improvements. This includes further submission of speak up stories for the 100 voices campaign and NGO annual report.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5

Enter summarised evidence to support your score.

The Lead FTSUG was recruited through an external competitive process, in line with NGO recommendations. The guardian works to the NGO & NHSE universal Job Description and has completed all training to meet the updated criteria in the revised Guardians Training Programme. This training is up to date, so NGO registration is active.

The Guardian also functions as a National FTSU Guardian Mentor under the CQC umbrella, which allows reciprocal sharing of models, practice and stories, which also enhance FSTU development at DBTH.

In June 2024 the trust appointed a FTSU Guardian into a development role, allowing personal growth and opportunity, whilst strengthening trust resources and building resilience within the service. This post was appointed through a robust selection process following internal expressions of interest and was open to all colleagues across the trust. The Guardian will work to key elements of the NGO & NHSE universal Job Description building the portfolio as confident and capability allows. The Guardian will complete the National Guardians foundation training in August 2024.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
To maintain annual training and development portfolio.
To work with the NGO to influence revised training modules for use nationally.

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	4
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

The FTSU Guardians performance objectives are cross cutting, ensuring speaking up is embedded in wider just culture and organisational development principles and workstreams. The Guardian is a member of the Chief People Officers Senior Leadership Team which provides strong connections into P&OD and E&R Leaders.

The Guardian receive monthly 1-2-1 support from the Executive Lead for Speaking up and the Chief Executive. The Executive lead for speaking up and SU NED meet with the FTSU Guardians on a quarterly basis to ensure assurance is considered and challenged where appropriate. These meetings also function as an opportunity for support. Further meetings are held with wider NEDs and with the Chair of the Board periodically.

The FTSU Guardians have access to a full suite of emotional and wellbeing support through the Trust Employee Assist Program. They are also aware of the ability access further support through the NGO.

The Lead FTSU Guardian is also registered with the NHS Leadership Academy to receive coaching support. The Guardians also accesses Guardian mentorship from other senior guardians within the Y&H region as required.

In the absence of the guardian alternative options are provided through the partnership approach and the screening of calls for signposting by experienced champions. All confidential methods of communication are populated with the changes to practice so all colleagues are aware of the changes so that informed decisions can be made and confidentially can be maintained.

The FTSU Guardian submits data to the NGO on a quarterly basis and shares this data as part of the bi-annual assurance report to People Committee and Board.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Provide robust support to the Developing FTSU Guardian to ensure transition, in line with the revised NGO starting out and moving on guidance.

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	5
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4/5
We are assured that confidentiality is maintained effectively	3/4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3/4
We are confident that if people speak up within the teams or directorates, we are responsible for, they will have a consistently positive experience	3/4

Enter summarised evidence to support your score.

The DBTH Speaking Up Policy “Speak up to make a difference” has been revised to demonstrate the adoption of the 2022 National policy template and has been launched in June 2023, alongside a local best practice policy on a page to allow easily visible information to be accessed across a wider range of communication mediums, including planned visibility across all departments.

The process to support the Speak Up Policy has been reviewed to allow learning from the experience of those who have accessed Speak Up services and those who struggle with consistency when speaking up to wider SU partners. The process also explains what should happen when cases are raised with FTSU Guardians, when they are raised with partners and the escalation process for all cases. Finally, it provides templates and information guides to allow greater consistency. This was launched in March 2024 and visual Speaking Up “Process on a page” boards have been procured and placed in wards and departments across the trust with approximately 50% in place by July 2024.the remaining boards will be in place by 30th September 2024.

The length of time taken to resolve speak up cases (and wider employee relations cases) has previously been identified as an area for improvement from Speaking Up and wider cultural engagement. The above process clearly provides a timeline for good SU responses and for cases supported by the FTSUG service, it provides an escalation process when each timeframe is breached.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Revise and strengthen the Speak Up policy and process, demonstrating learning from experience and best practice from partner organisations.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	3/4
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	5
We have evaluated the impact of actions taken to reduce barriers?	3/4

Enter summarised evidence to support your score.

The FTSU Guardians continue to work alongside the EDI and Organisational Development Lead to consider vulnerable and less represented groups. There has been extensive engagement with all colleagues, managers and senior leaders, to understand the barriers to speaking up and how these barriers can be explored and reduced or eliminated. This work has also included discussions at learner inductions and the Junior Doctors Forum. The FTSU Guardians attend the EDI Forum and support the internationally training colleagues network and the LGBTQ+ Network to ensure all colleagues feel heard and are enabled to speak up.

Further work is underway to share stories from specific groups which will enable us to understand how barriers are created, even when this is unintentional.

The trust now has 49 trained Speak Up Champions who are active in their own areas. This allows for greater focus on enabling the voice of all colleagues in their safe environment. Some champions are still developing, and others are more experienced in supporting colleagues and will now also form part of the group to roll out the level one "Speak Up" training program. Although further work is still required to recruit consistently across some areas and divisions, significant progress has been made and there is strong support for this element of the strategy. The SU Champion role was revised in line with the NGO revised guidance in 2023 and further work has also been completed to further enhance this role to raise awareness of the wider Just Culture programme.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Continue to provide quarterly specific engagement conversations to share feedback and experiences from those who wish to improve understanding across their colleagues and peers. Octobers 2025, SU month focus will see these sessions focus on “The Power of Listening” and will be supported by our Internationally educated colleagues and external representatives who will enable us to explore and better understand neurodiversity on or workplace.
Continued expansion and strengthening of the SU Champions Network, to ensure they can attend and access the required support and development that is required to fulfil their role.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	3/4
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3/4
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	2/3

Enter summarised evidence to support your score.

Recent engagement has explored the detriment experienced by colleagues involved in speak up processes. This feedback is being considered as part of the wider culture program and has been used to enhance the Speak Up Process to ensure a holistic approach to restorative practice.

All colleagues who speak up are asked about detriment and this is explored to establish if detriment has occurred and how this can be resolved. Our Speak Up policy and processes clearly explain that detriment should not be experienced and is not an acceptable response to speaking up. All cases of detriment are included in our national reporting to the NGO.

We are further developing the role of the NED and SID in the process for looking into instances where a worker has felt they have suffered detriment at Guardian and Speak Up Partner level, although we acknowledge this requires further work to provide consistency in experience and process when colleagues speak up across our divisions and departments.

Where cases of detriment have been identified, colleagues have been signposted to the NHS Support programme.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Further develop the role of the SID and NED in the oversight of cases of detriment.
Continue to signpost colleagues who experience detriment to the NHS support programme.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
We routinely evaluate the Freedom to Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	4
Our improvement plan is up to date and on track	4
Enter summarised evidence to support your score. The DBTH Speaking Up Strategy for 2024-2028 is a revised strategy designed to help improve what we do in relation to Speaking Up, how we tell you about its impact and how this work will contribute and support positive cultural influence at DBTH. This strategy has been developed through direct consultation with Speak Up Partners and informed by discussions with divisional/directorate leadership teams and engagement with a wide range of colleagues through cross site engagement sessions, training events and feedback processes. Engagement has also taken place with Staff Side representatives, Equality, Diversity & Inclusion (EDI) leads and staff networks, to ensure fairness and inclusion throughout the process. The Speak Up Strategy is linked to the wider People Strategy and associated delivery plan, and its associated Leadership and OD and Just Culture workstreams.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
Develop robust Strategy Delivery Plan with 4 phases to ensure the delivery of key enablers in years 1, and 2, followed by actions to allow growth, resilience and sustainability in years 3 and 4.	
As part of the above process, embed the PDSA method to ensure all new initiatives are reviewed in revised as part of process of ongoing learning.	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	4

Enter summarised evidence to support your score.

Staff survey results are used to consider the level of psychosocial safety and confidence to identify concerns, suggest improvement and report incidents. This is used alongside data from the patient safety Care Accreditation Recognition of Excellence (CARE) Framework and wider just culture metrics.

In order to understand and demonstrate our performance against the 2024-2028Speaking Up strategy, we have committed to a process of ongoing governance and assurance, ensuring that data trends are appropriately considered by the Speaking Up Forum, Just Culture Group and PSIRF Implementation Group, with triangulated anonymous data submitted to the People Committee and Board as part of the assurance process. In addition, feedback and story sessions are used to explore on a more individual basis.

Speak Up data reduced from 2021 to 2023 but this has seen a significant increase in 2023-2024 and this continues to be seen in 2024-2025. As part of the assurance section of the strategy, further work is underway to explore this change in greater detail. This will be used to strengthen Board assurance reporting going forward.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Ensure robust monitoring and compliance measures are built into the 2024-2025 strategy delivery plan. These will also need to include compliance measures required for wider internal and external partners and regulators.

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4/5
We have evaluated the content of our guardian report against the suggestions in the guide	5
Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	4/5
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3/4

Enter summarised evidence to support your score.

The Speak Up assurance report to Board is structured in line with regional best practice template and the 2022 revised NGO guidance. The assurance report includes a wide variety of assurance forums, including data, activity, outcomes and impact. From July2024 the report will follow the format of the 6 themes of the 2024-2028 Speaking Up strategy.

The Guardian provides bi-annual assurance reporting to Board in person and provides timely exception reporting where required.

The Trust has supported extensive Speaking Up Programme reviews as part of the engagement to inform the revised strategy, working with senior leaders to ensure learning and improvements for patients, colleagues and wider organisational partners.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Using QI methodology, work with divisional SLTs and wider leaders to strengthen methods to provide assurance in relation to learning and improvement at divisional and organisational level.

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Peer Review of (FTSU) Speaking Up service provision planned for January 2025. This will be conducted using robust methodology, successfully piloted in other areas across the NEY region (currently being considered for national roll out).	January 2025	Zoe Lintin & External Guardian
2. Evaluation (Annual review) of performance against the Speaking Up Strategy, considering actions in the year 1 delivery plan.	April 2025	Paula Hill + Forum Members
3. Explore the role of the Speak Up NED and or SID in relation to supporting concerns that relate to the Board and those that suggest and or evidence detriment	January 2025	Zoe Lintin
4. Pilot & evaluate the Leadership Peer Support to establish if this would have greater impact as a formal Leadership Champion role.	October 2024	Paula Hill
5. Continue to strengthen our Speaking Up training offer, by mandating all three levels of SU Training as part of SET Plus, for all colleagues. This will also see the programs being included in the DBTH Leadership Prospectus for 2024/ 2025.	September 2024 & April 2025	Paula Hill & Education Partners
6. Develop a revised induction and welcome offer that will complement Level 1 “Speak Up” training and explore the development of the Speaking Up Champions to support this delivery.	November 2024	Gavin Portier & Paula Hill
7. Review the activity and demand of the service, considering the impact of the additional time limited resource on our timely ability to respond to and support colleagues who speak up as well as delivering on all of the wider elements of the SU Strategy and those identified in this review. Review this in line with benchmarking data for other medium sized acute trusts and teaching hospitals.	January 2025	Zoe Lintin & Paula Hill
8. Continue to consider the speak up service structure and delivery model, including maximising SU Partner ability, capacity and resources, including the further growth of the SU Champions network in line with year 1 of the Strategy Delivery Plan.	April 2025	Paula Hill

9. Strengthen our Speak Up Service Feedback processes, enabling easier, anonymous access and therefore looking to increase response rates and allowing greater learning and improvement.	June 2025	Paula Hill
10. Develop a robust Strategy Delivery Plan with 4 phases to ensure the delivery of key enablers in years 1, and 2, followed by actions to allow growth and resilience in years 3 and 4.	July 2024	Paula Hill

Development areas to address in the next 12–24 months	Target date	Action owner
1. Repeat the Peer Review of (FTSU) Speaking Up service provision in January 2026. Looking to identify progress and areas for improvement and learning.	January 2026	Zoe Lintin & External Guardian
2. Evaluation (Annual review) of performance against the Speaking Up Strategy, considering actions in the year 2 delivery plan.	June 2026	Paula Hill + Forum Members

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. The Executive Lead for Speaking Up has extensive experience of and transferable skills, with particular strengths in providing support for the FTSUG and reviewing arrangements for ensuring effective service delivery. They also ensure collaboration with wider just culture, leadership & OD programs and the engagement of key stakeholders and SU partners at local and system level.	Ongoing	Zoe Lintin
2. Revised, mandated, Speak Up training, levels 1,2 & 3, allowing delivery of wider behavioural and cultural principles alongside nationally recommended competencies. This is delivered face to face allowing greater conversation, exploration, and learning.	April 2025	Paula Hill & Education Partners
3. The Lead Guardian is knowledgeable and experienced in all areas of FTSU work, developing and leading on strategy, training as well as operational planning. They are a registered CQC/NGO FTSU Guardian Mentor and frequently share DBTH work and learning regionally and nationally.	Ongoing	Zoe Lintin & Paula Hill
4. Use of Staff survey data to celebrate areas of good practice and support teams who need development in relation to speak up culture.	May 2025	Paula Hill & Gavin Portier
5. Speak Up Forum and Partnership Model to share with NGO/NHSE and regional partners.	October 2024 + ongoing	Zoe Lintin & Paula Hill
6. Development of a complementary suite of documents and tools to support speaking practice. This includes SU strategy, revised policy and associated local process, managers toolkit, revised feedback process and visible awareness/process boards and leadership pledges to raise the profile of Speaking Up.	October 2024 +ongoing	Paula Hill

7. Development and growth of SU Champions including, governance and assurance processes to aid recruitment, training, data security, and ongoing support. This work has been recognised and shared by NHSE and replicated by regional partners.	September 2024 + ongoing	Paula Hill

DBTH Speaking Up

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

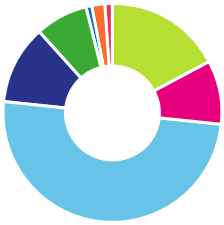
A summary of data from 2023-24

How Speaking Up cases compare year-on-year:

104	45	97
cases in 2023/24	cases in 2022/23	cases in 2021/22

Cases grouped by professions:

Allied Health Professionals	18%	Additional Clinical Services	8%
Medical and Dental	10%	Corporate Services	1%
Registered Nurses and Midwives	52%	Not known	2%
Administration and Clerical	12%	Other	1%



Themes of concerns

Number of people who raised concerns about...

Raised their concerns anonymously	2
Patient safety/quality	61
Worker safety or wellbeing	76
Bullying or harassment	17
Inappropriate behaviour	9
Disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment')	6

Internal data capture identified the following additional themes:

Fairness	28
Relationships	24
Systems and processes	68
Leadership	22

Summary of learning

- A large collective number of individuals in three cases has impacted on the overall number of patient safety/quality and process concerns due to their inability to effect change by speaking up locally, which has then led to a negative impact on service delivery and the wellbeing of colleagues.
- Increased communication and engagement is required when processes are changed or implemented to reduce or prevent a negative impact on the wellbeing of colleagues.
- Data protection and breaches of confidentiality concerns are increasing. Some of these are linked to process changes relating to new systems.

Receiving feedback

Of those asked: 'Given your experience, would you speak up again?'

Out of 15 responses: **14 responded 'Yes'** **1 responded 'I don't know'**

Common themes from feedback

- Service easy to access.
- Guardian and Partners very supportive.
- Information on accessing services was easily found on the Hive.
- Not always equitable when trying to access additional or restorative support.
- I felt listened to and that my concerns were taken seriously.
- It was good to make a difference to patients, but I felt that I was treated differently for speaking up even though it was initially done anonymously.
- Very supportive, this can change for cases that are open for some time.
- The service was very helpful and I felt supported by the Guardian.
- Felt supported to have conversations and make changes.
- It feels good to know the learning has been shared and to feel my speaking up has made a difference.

DBTH Speaking Up

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

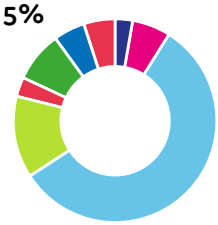
A summary of data from Q1 and Q2 2024-25

Number of cases brought to FTSU guardians in Q1 and Q2: 63

Cases grouped by profession level:

Worker	58
Manager	1
Leader	4
Not disclosed	0

Allied Health Professionals	3%
Medical and Dental	6%
Registered Nurses and Midwives	57%
Administration, Clerical	13%
Additional Professional Scientific and Technical	3%
Additional Clinical Services	8%
Estates & Ancillary	5%
Healthcare Scientists	5%



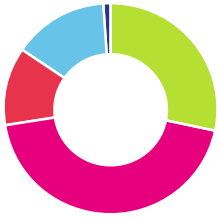
Themes of concerns

Number of people who raised concerns about...

Raised their concerns anonymously	0
Patient safety/quality	26
Worker safety or wellbeing	40
Bullying or harassment	11
Inappropriate behaviour	13
Disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment')	1

Internal data capture identified the following additional themes:

Fairness	5
Relationships	6
Systems and processes	19
Leadership	11



Summary of learning

- Multiple groups speaking up in Q1 impacted the overall number of concerns received, responded to, and reported. This was however, less in Q2.
- Most cases were raised by Nurses and Midwives in both Q1 & Q2, however this was not consistent across areas.
- The predominant themes spoken up about are the impact of team cultures, leadership, systems and processes and behaviours on worker wellbeing.
- The potential for negative impacts on patient safety and or experience, also continues to be a strong theme in both quarters, particularly where teams are going through change and systems and processes have been or need to be revised.
- Uncertainty around escalation routes and processes.
- Restorative interventions are essential to repair the impact on individual and team relationships, enabling colleagues to move on following speaking up experiences.

Receiving feedback

Of those asked: 'Given your experience, would you speak up again?'

Total number of responses = 7
completed the first part of the questionnaire with only 5 completed the rest.

6 responded 'Yes'

1 responded 'Maybe'

Common themes from feedback

Guardian service is very easy to access

Guardians response was helpful, concerns were taken seriously, and they supported confidentiality throughout.

All colleagues who provided feedback felt that their concerns had been resolved either fully or in part.

Mixed feelings in relation to the provision of and timing of feedback and a focus on ensuring early feedback even if no improvement can be made.

Speak Up Month Activity Plan – October 2024

Every year in October we celebrate Speak Up Month – a month to raise awareness of Speaking Up (Freedom to Speak Up) and make speaking up business as usual for everyone.

For this October's Speak Up Month, the theme is "Listen Up" and we will be focusing on the power of listening, and the important part that listening plays in encouraging people to feel confident to speak up.

We want everyone who works at DBTH to feel confident to speak up. Confidence to speak up comes from knowing that if you speak up, you will be listened to, and that appropriate action will be taken. We all have a part to play in listening to one another with respect and compassion and being an ally when others need support.

To demonstrate our commitment to supporting our colleagues this October we will be holding the following events and activities.

Tuesday 1st October – 8.45am - Signing of the Executive SU Boards & Pledges

Tuesday 1st October – 1-4pm – SU Month Launch Event – DRI Boardroom & MS Teams

Thursday 3rd October – 9am –12 noon – SU Roadshow & Department Visits – MMH

Thursday 3rd October – 2-4pm – SU Managers Support Session – Boardroom MMH

Friday 4th October – 9am –12 noon – Speak Up Level 3 Training – DRI Midwifery

Tuesday 8th October – 9am –10am – Leadership Assembly – The power of listening – MS Teams

Tuesday 8th October – 1-4pm – SU Roadshow & Department Visits – DRI

Wednesday 9th October – 9am -12 noon – Speak Up Level 3 Training – Blyth Room Bassetlaw HUB

Wednesday 9th October – 12-1pm Speak Up wellbeing Wednesday – MS Teams

Friday 11th October – 1pm -4pm – Divisional SLTs Speaking Up listening into action – DRI EC rm 3 & 4.

Tuesday 15th October – 9am 12 noon – Speak Up Level 3 Training – DRI Midwifery

Wednesday 16th October – 9am – 12 noon – Listening & Leadership Seminar – DRI Lecture Theatre

Friday 18th October – 9am –12 noon – SU Roadshow & Department Visits – Bassetlaw

Friday 18th October – 2-4pm – SU Managers Support Session – Bassetlaw HUB

Wednesday 23rd October – 9am –12 noon – SU Roadshow & Department Visits – DRI

Wednesday 23rd October – 2-4pm – SU Managers Support Session – DRI

Tuesday 29th October – 9-4 – Speak Up Champions Training – Boardroom Bassetlaw HUB

In addition to the above events and activities we will launch and close the month with a SU Blog and will be providing weekly communication through BUZZ, Managers Brief and All User Messages, sharing key SU messages relating to listening and celebrating the activities and events that take place.

For further information please contact Paula Hill on 07769287407

We will also be using 31 Listening and leadership quotes published on the internal communication pages and via social media.

If you are interested in attending any of the highlighted events, please contact Natalie Plant on Natalie.plant@nhs.net to book a place.

If you would like to arrange Speak Up (level 1), Listen Up (Level 2) or Follow Up (Level 3) training for your area and team please contact Paula Hill or Jon Ginever on dbth.guardian@nhs.net

For further information please contact Paula Hill on 07769287407

2411 - D5 BOARD ASSURANCE FRAMEWORK

Discussion Item | Zara Jones, Deputy Chief Executive | 11:40

Executive Directors
20 minutes

REFERENCES

Only PDFs are attached

- D5 - Board Assurance Framework.pdf
- D5 - Appendix 1 BAF.pdf
- D5 - Appendix 1 BAF.xlsx
- D5 - Appendix 2 Risk Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**D5**
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 – Risk register report and Trust Risk Register		

Report Summary

Purpose of the report

This report presents the Board Assurance Framework (BAF) for 2024-25 up to and including reviews into October 2024. The Board Assurance Framework (Appendix A) is presented to the Board of Directors for further discussion and assurance.

Executive Summary

The Board Assurance Framework brings together the Trusts agreed strategic objectives and identifies and quantifies the risks to achieving those objectives. It is aligned to the Trust 4 P's strategy and the risk register to ensure that any emerging risks, either internally or externally are effectively managed. It summarises the controls in place to mitigate / manage the risks. It sets out the assurance, including 3 lines of defence in line with the agreed risk appetite and tolerance levels for the Trust. Whilst risk cannot be eliminated completely the Trust understands the importance of managing risk effectively to reduce any likelihood of a negative impact to the Trust, its people and the patients we care for.

The Board Assurance Framework has been considered by the Board of Directors by way of a review by delegated individual Executive owner(s) and detailed consideration or its content through the Board's assurance committees (People Committee, Quality & Effectiveness Committee, Finance and Performance Committee). The risk management process is considered through the Audit and Risk Committee in terms of its compliance against the policy.

A detailed review is scheduled to take place in December 2024 with the whole board to ensure that all the strategic risks identified remain in line with the Trusts strategy, with the named executive director owners and the lead assurance committees.

This is in line with best practice where reporting of the BAF to Board forms part of the Trust compliance with the Code of Governance 2023 which is also considered in the context of the risk register, financial & operational reporting, and other forums across the Trust.

2.7	The Board of Directors should carry out a robust assessment of the trust's emerging and principal risks.
2.8	The Board of Directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the annual governance statement in the annual report.

BAF Summary:

- Assurance levels have been agreed by respective lead committees – see highlight reports from each committee
- Audit and Risk Committee reviewed the BAF and risk management process at their meeting on 26 October 2024 with partial assurance provided for the risk management report. Further work has been asked to be undertaken to ensure this provides the committee with what it wants.
- Risk 3 (service demand) was discussed within the Finance and Performance Committee in reference to its current risk score. The committee felt this should be increased from the current score of 12 to 16 which more accurately reflects the presenting risks, and evidence from the supporting papers within the F&P agenda. Although there was assurance on the controls that were in place, their effectiveness in closing the gap was not evident from the information shared in the committee.
- Risk 6 (partnerships and collaboration) has had a full executive review, which has resulted in updates to effectiveness of controls, gaps in current controls and actions to close the gaps. It is proposed that the current risk score is reviewed by the board and that the board takes ownership for the partnership strategic risk elements.

Conclusion

The Trust continues to undertake a review and implement enhancements of the BAF for 2024-25 in line with published guidance, internal audit suggestions and best practice benchmarking etc.

The Board Assurance Framework is enclosed in appendix 1 for Board review, discussion and assurance. The BAF will continue to mature 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.

A review of neighboring ICB trusts (SYB and Notts), showed that DBTH are in line with these providers in terms of the top 3 risk themes on Trust Risk Registers, these 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 and continue to be managed through the monthly Risk Management Group.

Recommendation:	The Board of Directors are asked to: **Receive** the report. **Decide** on the change to the current risk score of Risk 3, **Discuss and decide** on the risk score of Risk 6 and where this is monitored. Take **assurance** from the approach taken to further develop the 2024-25 BAF. **Note** that the BAF is a live document which will be reviewed and updated regularly throughout the year.			
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
	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 and risk management process in place and regularly reviewed within its governance arrangements		
Resources:			

Assurance Route	
Previously considered by:	Delegated Committees of the Board
Date:	Finance and Performance, 29 October 2024 People committee, 22 October 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

Our vision is:

Healthier together – delivering exceptional care for all.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our four strategic priorities are:

BOARD ASSURANCE FRAMEWORK

October 2024

BOARD ASSURANCE FRAMEWORK SUMMARY

Oct-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	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	Quality	12	16	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	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	Finance and Performance	9	12	12	12	12	12	12	16	4 (L) x 4(C)	16	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	Finance and Performance	20	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	Finance and Performance	12	16	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	Board	6	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?)	Finance and Performance	6	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	Sources of assurances relating to effectiveness of the controls & associated Line of Defence (and dates)	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

It was agreed at a previous People Committee meeting that the target score on the Risk Assessment would be changed to 12 for 2024, recognising the external factors impacting on this.

Overseeing Committee

People Committee

Date of last Committee review

People Committee - 22 October 2024

Risk Assessment	Consequen	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) Reports to every People Committee meeting (2) Annual staff survey results and learner surveys (3) Internal audit on health & wellbeing undertaken Q4 - Significant Assurance (3) Recognised as Employer of the Year at Doncaster Business Awards Dec 23 (3) Recognition and award nominations at national level (3)	Assured Assured Assured Assured Assured 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) Reports to every People Committee meeting (2) Internal audit report - Recruitment (22/23) (3) Internal audit report - Return to work interviews (22/23) (3) Internal audit report - Bank & agency controls (2024/25) (3)	Assured Assured Partial Assurance Moderate assurance In progress
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) Reports to People Committee (2) Annual staff survey results and learner surveys - further significant improvements seen in 2023 staff survey results (3)	Assured Assured Assured
4	Equality, diversity and inclusion action plan including NHS England high impact actions	EDI Committee (1) Reports to People Committee (2) Annual staff survey results and learner surveys (3) NHS England Dashboard, Workforce Race Equality Standard/Workforce Disability Equality Standard (3)	Assured Assured Assured Assured
5	Provision of quality education, learning and development	Workforce & Education Committee (1) Reports to Trust Leadership Team (1) Reports to every People Committee meeting (2) Education quality visits and outcome reports - positive feedback in NHSE report Q4 23/24, positive feedback from University of Sheffield visit Q2 24/25 (3) Learner surveys (3)	Assured Assured Assured Assured 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 (93.52%). Succession planning and Scope for Growth to be recommunicated in Q3/4
3. Retention data requires review through exit interview themes	3. New format for capturing exit interview data launched Q2 2023/24 to increase amount of data received. Renewed focus in Q4 2023/24 to increase amount of data being collated centrally, to be reported at WEC in October 2024. Further work needed to increase data recording, Qii approach being considered

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 within 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. EDI annual report presented to PC on 16 April, committee 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 23, aligned with the Quality Strategy. Positive feedback received from NHS England education quality visit and report. Positive feedback from University of Sheffield quality visit (awaiting report).

Links to Operational Risks

Ref	Consequer	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 standards	16

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** Oct-24

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	**16**
Current Risk Assessment	4	4	**16**
Target Risk **(Plan for Dec-24)**	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 & associated Line of Defence	Current Assurance Level Assigned
1. Urgent and Emergency Care Improvement Programme which includes maximising same day emergency care and reducing length of stay in order to reduce inpatient bed demand and bed occupancy	Monthly SRO oversight through the Programme Board (1) Monthly highlight reports to Doncaster UEC 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)	Significant Assurance - with minor 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)	Significant Assurance - with minor 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)	Significant Assurance - with minor 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)	Significant Assurance - with minor improvements required
6. Elective Care Improvement Programme to ensure the fundamentals of good elective care management and governance are in place across the Trust	DQ Steering Group (1)	Partial Assurance - with improvements required

Significant gaps in current controls	Areas where further assurance against controls is required
Elective Care Improvement Programme on hold currently as senior leadership capacity is directed to elective recovery plans and theatre / outpatient utilisation	
	Standardised Corporate PTLs for RTT and Cancer, in line with best practice
	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	Complete
2	Corporate PTL meeting refresh for RTT and Cancer	COO	Q2	Complete for RTT.
3	Divisional action plan to deliver LoS improvements	COO	Aug-24	Complete
4	Weekly oversight of activity vs plan (forward look)	COO	Aug-24	Theatre and Outpatient planning / scheduling / utilisation meetings in place
5	Weekly Patient Flow meeting to provide oversight of BAU actions	COO	Aug-24	Delayed - implementation deferred to Q3

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) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
2	Full Asset capture 2022/23 - informing business case to increase Planned Preventative Maintenance schedule to reflect infrastructure risks in line with industry standard SFG 20. Review included all sites. 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. 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) Board report (2) F&P Paper (2)	Partial Assurance - with improvements required 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
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 (requires review)

Key issues

Ineffective working and capacity constraints - spanning 2 ICS footprints
Some services require multiple organisations to deliver safely and sustainably
Challenges outside of the organisation or beyond the NHS impacting on ability to deliver safe and accessible services
Financial and shorter term operational delivery constraints hinder progressing longer term partnership solutions
Organisations making decisions in their own best interest rather than that of a wider system or population
Lack of clinical or operational incentives to drive change

Overseeing Committee

To be reviewed with proposal to have the Board to manage responsibility for strategic partnerships

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	Prioritisation of DBTH participation in ICS activities and ensuring proportionate balance of time and input in relevant work.	Chair and CEO input and attendance at key South Yorkshire and Nottinghamshire forums to influence and advise on strategic direction and priorities. (1) CED Partner member SYICB Board and reporting outcomes from this. (2) DCEO leadership in Nottinghamshire and Bassetlaw Place, regular dialogue with ICB, Place and Provider Collaborative leadership to ensure DBTH inclusion in opportunities for service development and reported externally. (2)	Significant Assurance - with minor improvement opportunities
2	Acute Federation (AF) / Acute Trusts engagement to support development of partnership approaches to sustain and protect key services and pathways	AF Clinical sustainability review work involvement (2) DBTH Audiology Service mutual aid agreements with partners (3) Review of collaborative opportunities with other SY DGH (2)	Partial Assurance - with improvements required
3	Connecting DBTH strategic priorities to Place-based developments	Capital development work to develop the Doncaster Royal Infirmary site is connected to wider partnership work with Doncaster Place to improve access, facilities and socio-economic growth, this is monitored through place and ultimately through NHSE for capital spend. (2) (3)	Significant Assurance - with minor improvement opportunities
4	Developing DBTH's strategic intentions for partnership working	Trust Strategy is being developed. Will identify key strategic ambitions to ensure the organisation has a clear direction for partnership working and a consistent decision making framework for investment in collaborative opportunities. (2) Strategy will be reviewed by Internal Audit (3)	Partial Assurance - with improvements required Under review
5	Strengthening our partnership governance arrangements	Internal audit review of partnership governance will support delivery of improvement actions in Q4. (3) Board agenda development to strengthen partnership assurance. Trust Leadership Team and Divisional level horizon scanning.(2)	Under review Under review

Significant gaps in current controls	Areas where further assurance against controls is required
Some of the plans outlined above are yet to deliver / demonstrate outcomes.	Across the board where there is evidence of plans and dialogue but lack of evidence of improvement or impact of delivery actions.
Operational challenges demonstrate lack of progress where partnership actions required e.g. UEC and flow through the system impacting ambulance handovers, time in Emergency Department, bed capacity and length of stay and discharge.	Impact of actions or lack of action on health inequalities and DBTH's role in prevention in the wider context of delivering on the government's strategic shifts, specifically treatment to prevention and hospital to community.

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
5	Deliver recommendations from internal audit review of partnership arrangements when this has been completed	Associate Director Strategy, Partnerships and Governance	TBC	Audit not yet commenced.
4	Completion of Trust Strategy	Deputy CEO	Mar-25	On track. Board development session December 2024 to review position.
2	Engagement in Acute Federation workstreams to drive change and improvements	Executive Directors	Mar-25	Clinical Sustainability Review workstreams established. Outcomes to be delivered by defined timescales in programme mandates.
2	Completion of DGH collaboration opportunities report	CEOs	Nov-24	Work commissioned and opportunities being compiled.
2	Wider clinical engagement in Place-based developments	Executive Directors	Ongoing	Priorities set and plan developing. Business case approved for Critical Care

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title

Extreme 3296, 2873, 3467, 3562 High 2839, 2977, 3056, 3186, 3242, 3305, 3397, 3412			6	3409 Failure to gain partnership solutions to deliver services safely for the community
				Services where joint rotas are required to deliver in or out of hours care.
				Services where mutual aid is required and relied on to ensure access to timely care.
				Delivery of key national standards e.g. 4 hour performance, ambulance handovers

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	6 Aug 2024 QEC

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 improvement opportunities
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 strategy)	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 – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

Trust Risk Register

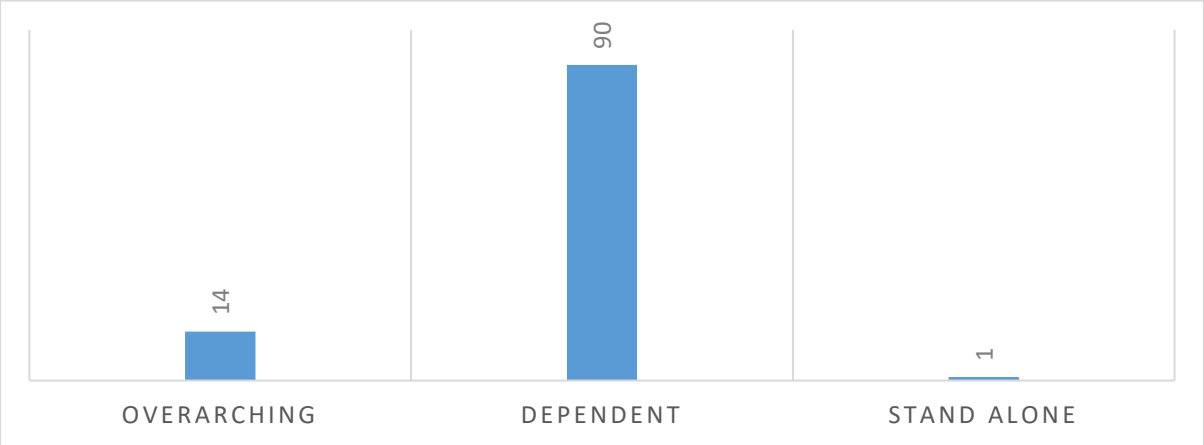
The Trust Risk Register is compiled of Overarching Operational Risks linked with the Trust Strategic Risk and the 15+ stand-alone risks and notates the dependent risks. Dependent risks are available on the linked records field of the Overarching risk. See **Appendix 1** for the Trust Risk Register details.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



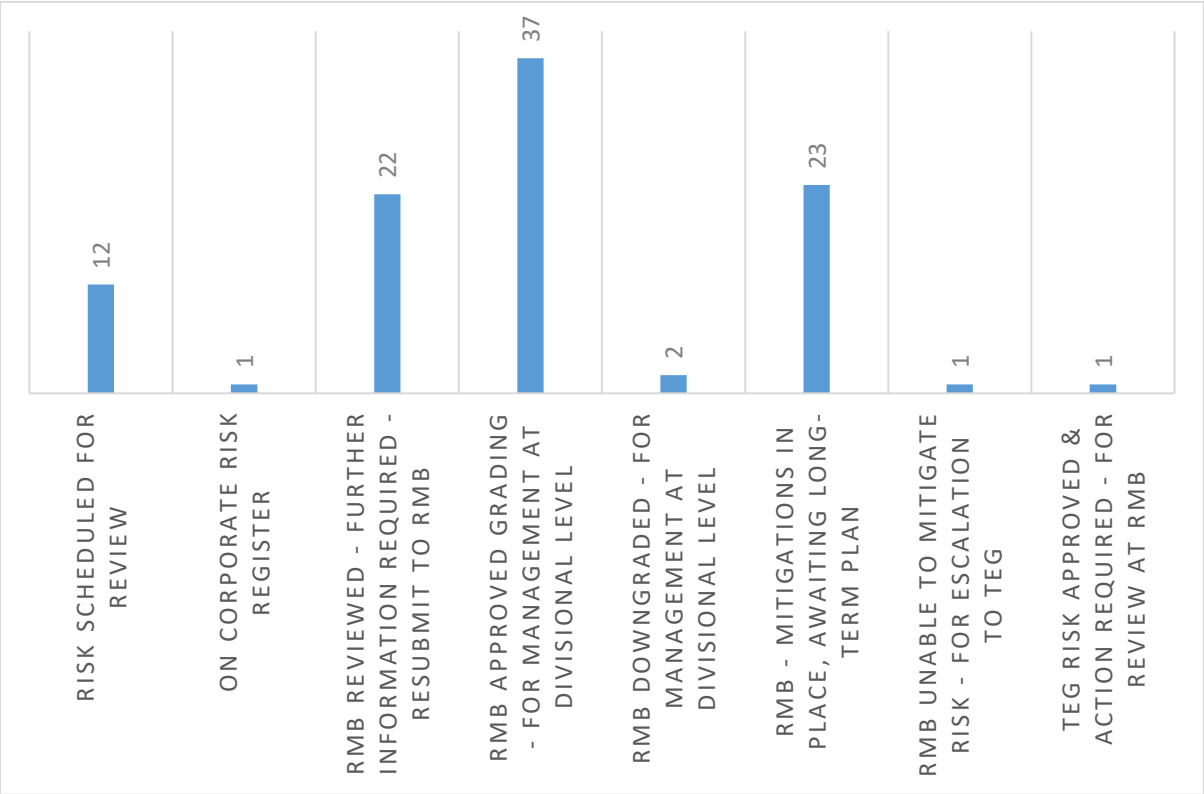
There are 14 overarching risks with 90 dependent risks and 1 standalone risk.

[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 – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

Risks by RMB Status (15+ Risks only)



There are 99 Risks rated as Extreme (15+); an increase of four since September 2024.

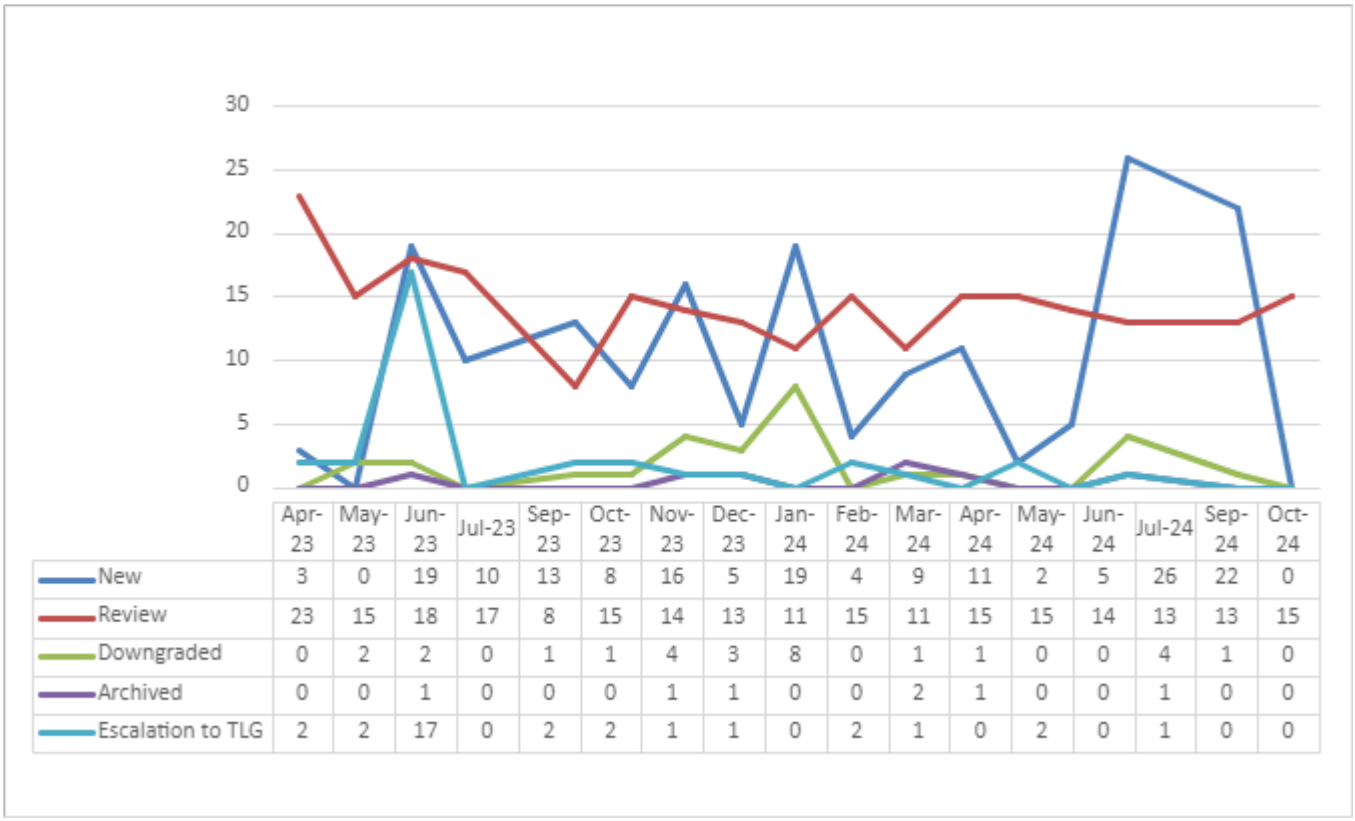
There are nine new 15+ risks included in this total. Since the last report, two Extreme risks have been closed and three have been downgraded.

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 / Directorate Governance.

Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

Cumulative RMB Status (12+ Risks discussed)



	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	Sep-24	Oct-24
New	3	0	19	10	13	8	16	5	19	4	9	11	2	5	26	22	0
Review	23	15	18	17	8	15	14	13	11	15	11	15	15	14	13	13	15
Downgraded	0	2	2	0	1	1	4	3	8	0	1	1	0	0	4	1	0
Archived	0	0	1	0	0	0	1	1	0	0	2	1	0	0	1	0	0
Escalation to TLG	2	2	17	0	2	2	1	1	0	2	1	0	2	0	1	0	0

[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]

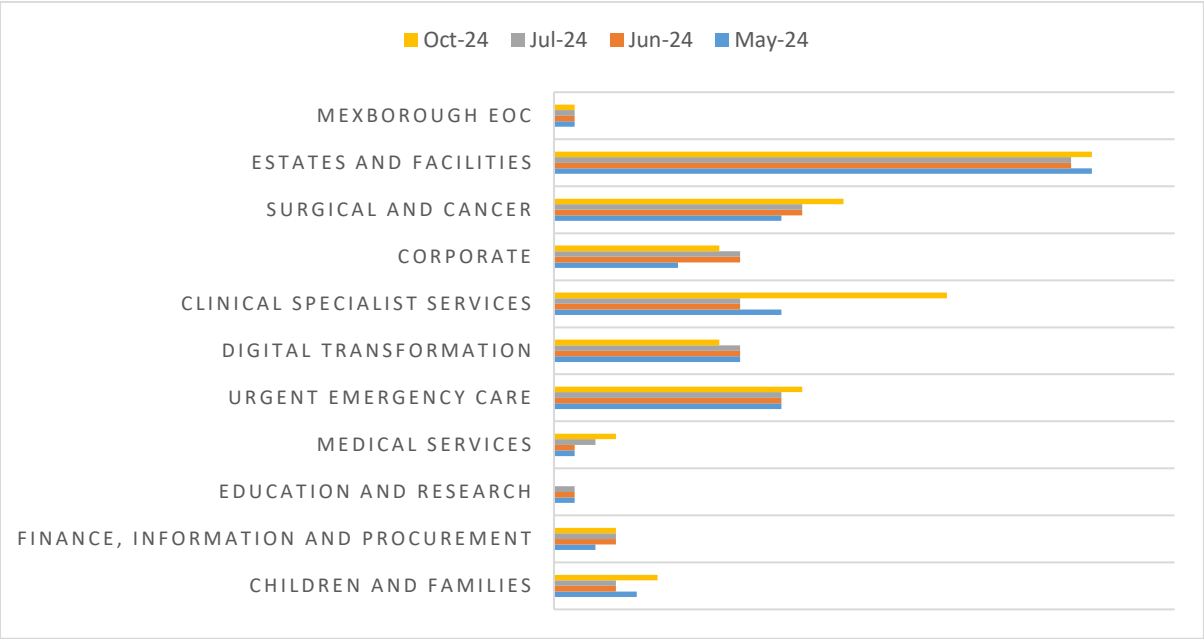
September saw 22 new risks discussed, and one was downgraded and the remaining were approved for onward management at Divisional / Directorate level. A further 13 risks were reviewed and progress on the risks and any actions were discussed and logged. There were no escalations to TLT this month.

October had no new risks scheduled for discussion with 15 risk reviewed. There were no escalations to TLT.

Trust Risk Report – October 2024

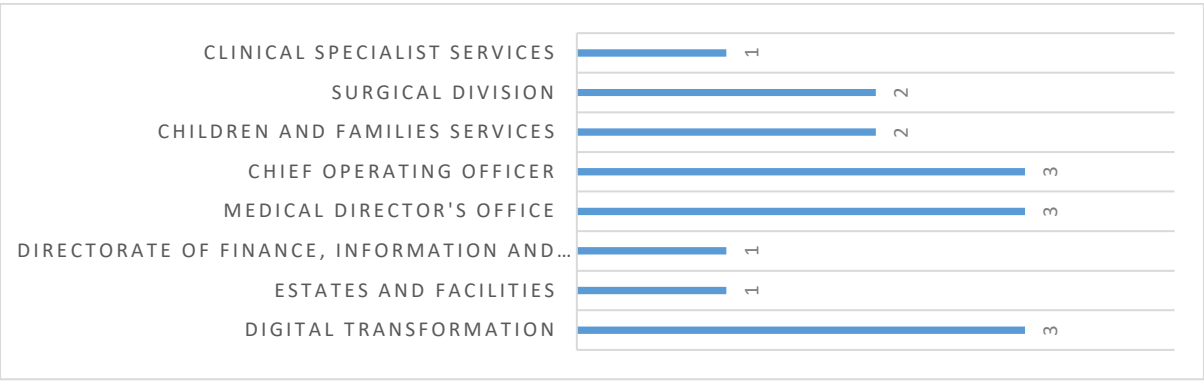
Summary of data pulled from Datix Risk Management System 29th October 2024.

15+ Risks per Corporate and Division over time



There is an increase (since the latest July data) of 10 risks in Clinical Specialist Services, following the transfer of Audiology to this service. An increase in two risks in both Children and Families and Surgical and Cancer Divisions, and increase of one risk in each of the following areas: Medical Services, Urgent and Emergency Care, Digital Transformation and Estates and Facilities. Education and Research have a reduction of one risk.

Overdue 15+ Risks



There are 16 overdue 15+ risks.

Action Plan Status on 15+ Risks

There are 99 Extreme Risks within DBTH. Of the 99 risks, 25 risks do not have an action plan in place to treat the risk (25.3%).

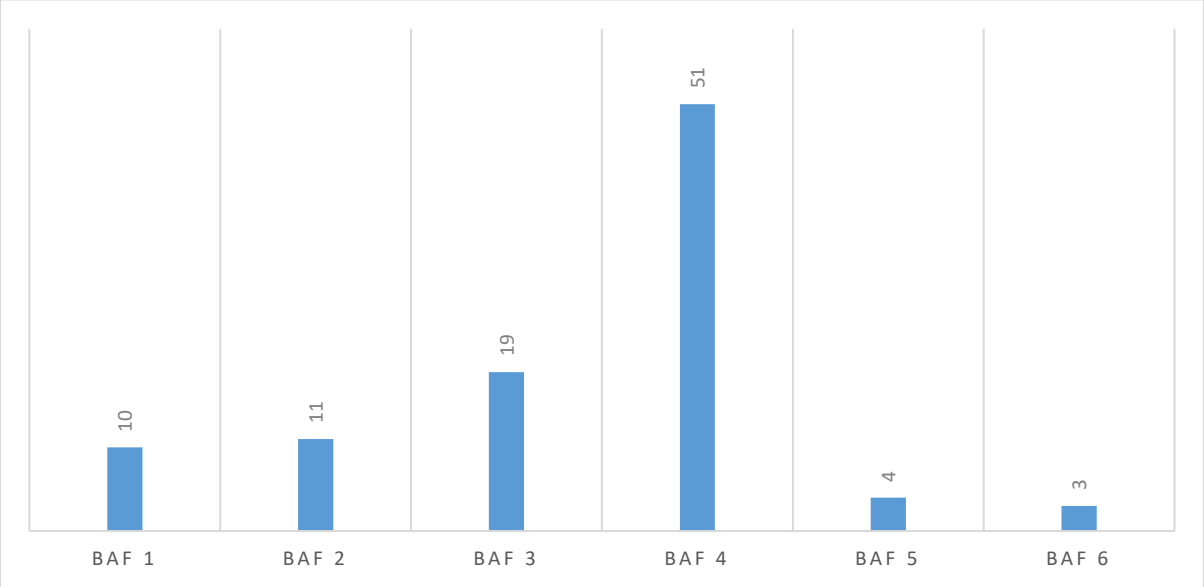
The 74 risks (with actions) have 149 Action plans between them; 96 actions are active (64.4%) and 53 with actions completed (35.6%). Of the active actions, 35 are overdue (36.5% of the active actions).

Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

Two spreadsheets highlighting a list of overdue risks/actions and risks due for review during that calendar month (split by directorate / Division) is distributed via the Executive Medical Director to the Divisions / Directorates on the First working day of the month. It is the responsibility of the Division / Directorate to ensure that all risk is updated by the due date.

15+ Risk relationship with BAF Risks

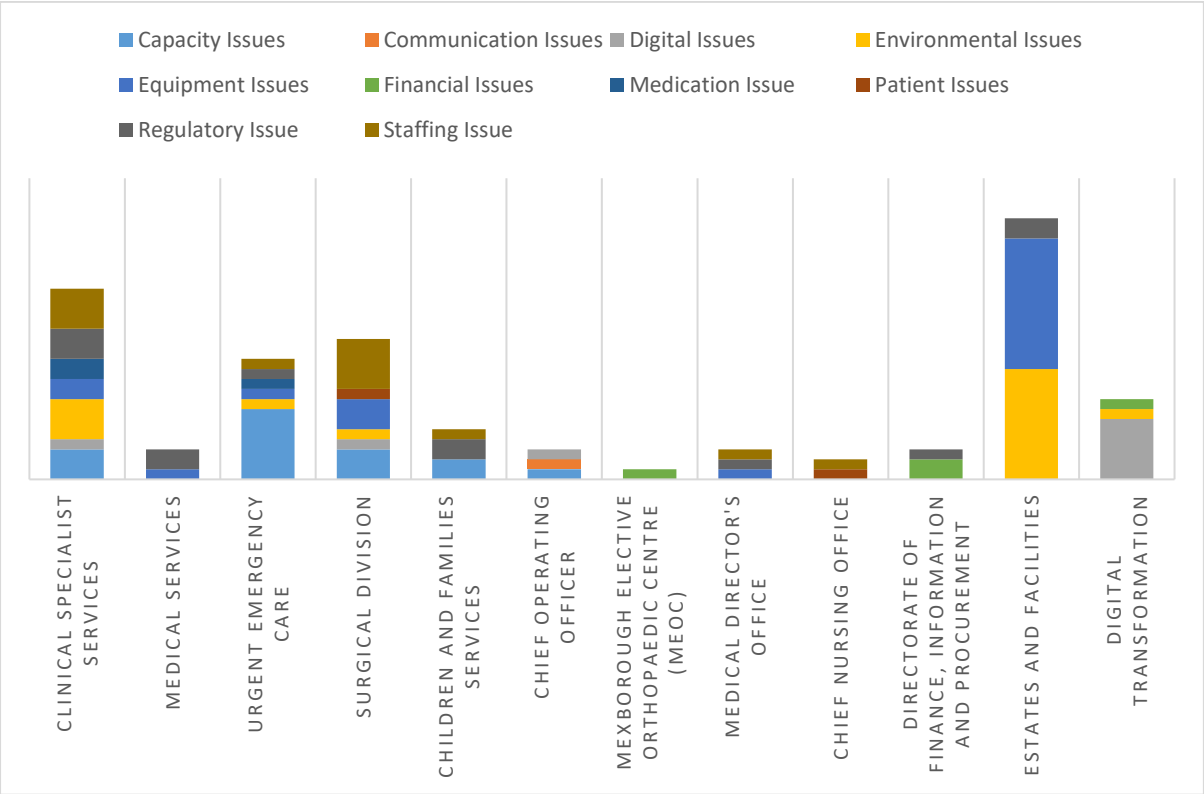


52% of the 15+ risks are related to BAF 4, the DBTH Estate which includes Estate Infrastructure, Digital Infrastructure and Equipment, 19% pertaining to BAF 3, Capacity, and Workforce BAF 2 has 11% of the risks.

Trust Risk Report – October 2024

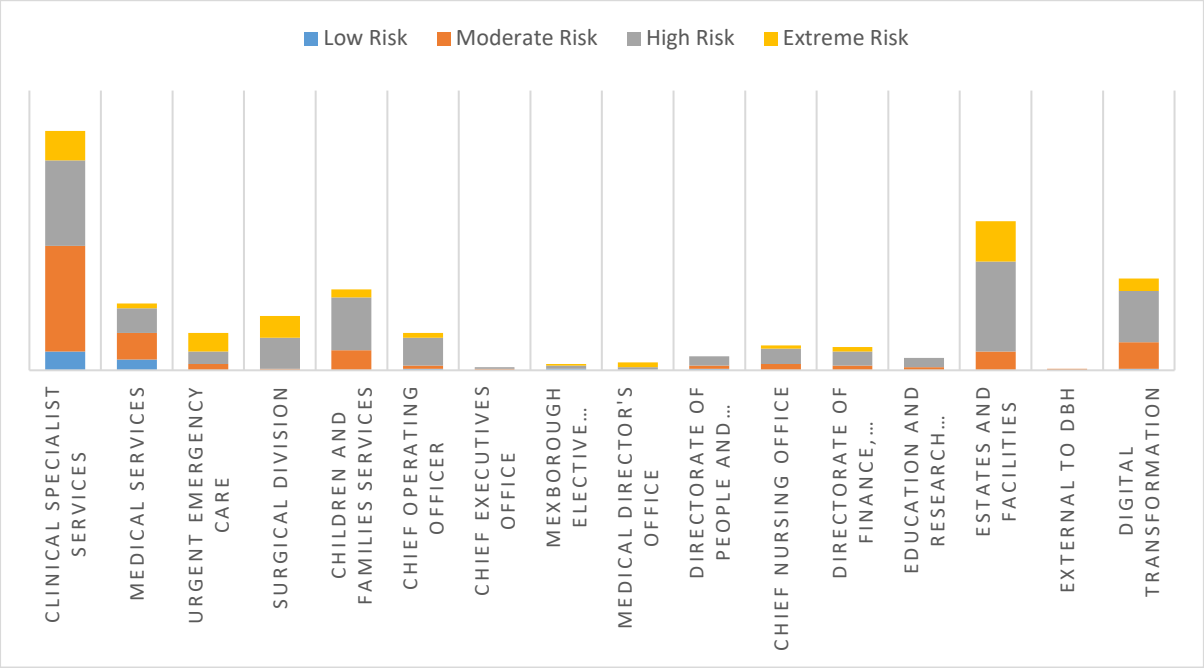
Summary of data pulled from Datix Risk Management System 29th October 2024.

Risk Themes



The greatest number of risk issues link to equipment, with 21.2% of the risk profile. Environmental issues has risen to the second highest category with 18.2% and Capacity issues rising to the third highest category with 16.2%. Staffing issues has dropped to fourth highest with 13.1% and Regulatory issues rising to fifth highest with 12.1%.

Complete Trust Risk Profile

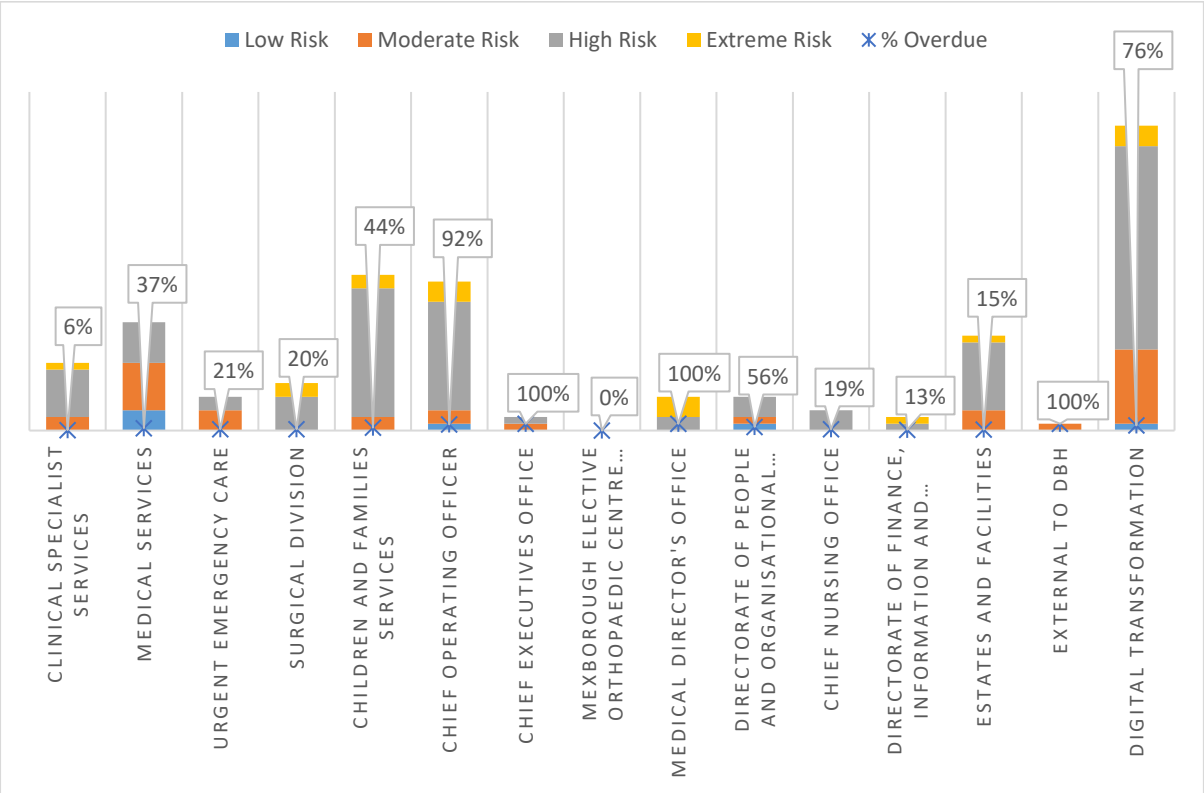


Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

Overall, there are 547 risks on Datix, of which there are 23 low risks, 147 Moderate risks, 278 High Risks and 99 Extreme Risks.

Overall, there are 160 overdue risks across the Trust, 30% 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 in their Division/Directorate and not out of the total number of risks.



Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	BAF number	ACTION ID	Description	Due date	Done date
11	Sargeant, Jonathan	Failure to achieve compliance with financial performance and achieve financial plan	22/23 achieved financial plan. 23/24 - trust has a significant CIP target which will have a decreasing effect on the organisational run rate. This sets a significant risk to operational & financial position. The trust is mitigating this with the following actions: 1. Review of financial controls including authorised signatory list 2. Review of staff grip & control to cover rota compliance, sickness management, use of temporary staff and vacancy control process. 3. Strict management of cost pressures 4. Complete an analysis of the drivers of deficit with Deloites 5. Enhanced scrutiny of CIP programme 6. Enhanced working with partners at both Place and System level.	19/07 2024	16	Extreme Risk	8	Overarching	Extreme 3439	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
											16844	Review of overdue actions	20/10 2023	05/01 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	30/05 2025	20	Extreme Risk	10	Overarching	Extreme 1078, 1082, 1083, 1095, 1096, 1097, 1208, 1209, 1246, 1264, 1274, 1277, 1782, 2335, 2863, 2868, 3506, 3533	BAF 4	1914	Maintain CSR 3 or above	31/03 2020	10/10 2016
											6207	Development of Estates condition operational risk and investment requirements – 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 – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	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 Further fire improvement works programmed for FY23/24 as part of the Capital programme.	30/06 2025	15	Extreme Risk	10	Overarching	Extreme 1077, 1214, 1216, 1221, 1225, 1786, 2941,	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	
1517	Wilson, Rachel	Risk of patient harm as a result of unavailability and Supplies of Medicines	Pharmacy team is continued working with regional and national teams in reviewing the availability and supplies of medicines. There is evidence that current demand peaks have outstripped supply - Strep A Mutual aid, via NHSE across country. Alternative medicines and preparations sourced	07/02 2025	15	Extreme Risk	6	Stand alone			15708	Identify the true financial impact of this risk	17/04 2023	28/04 2023
1807	Hutchins on, 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. Work on Lift 7 complete.	31/10 2024	15	Extreme Risk	8	Overarching	Extreme 1224, 1239, 2682,	BAF 4	10218	Maintain CSR 3 or above	31/03 2020	10/10 2016
											10219	Development of Estates condition operational risk and investment requirements – 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 – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	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	Onboarding of new staff is still in progress, and a robust training plan is in place, however due to staff turnover the team currently still have 2 vacancies (DQA Officers). The DQA Harm Lead post is now filled. PPMS significant amount of data cleansing, clinical engagement though the Business Manager.	09/09 2024	20	Extreme Risk	6	Overarching	Extreme 3051,	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
											18338	Project Milestones	09/08 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	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 – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	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. 4 HOURS - Reviewed and amended roles and responsibilities of key leadership positions within the ED department. - Simplified triage to red, amber and green with medical team's rota'd to each area. 12 HOURS - Monitoring of bed availability and movement of patients within 30 minutes of the bed space becoming available. - Divisional leadership and oversight of to ensure patient flow to ward beds by 4:00pm so that capacity is available in assessment areas prior to the daily peak in demand. - Emergency Department dashboard created which shows the waiting time to see a doctor for each area within the department and the number of patients with treatment plans in place. This was fully implemented in April 2024. AMBULANCE - Collaborative working with YAS and the Trust continues, an Ambulance Resilience Co-ordinator is now in post and is based at DRI (in hours) 7 days a week. - Proactive capacity preparation to create capacity for forecasted peeks in demand - Collaborative working with YAS to increase of the direct ambulance to SDEC / UTC at Doncaster and Bassetlaw	05/08 2024	16	Extreme Risk	12	Overarching	Extreme 3386, 3398, 3437, 3400, 3401, 3402, 3403, 3405, 3556	BAF 3	18259	Operational management Cover	07/10 2024	
											18260	Funding request	07/10 2024	

Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	BAF number	ACTION ID	Description	Due date	Done date
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 of the incident reporting system following LFPSE implementation the new risk Folder for environmental risks has been implemented Ambient room temps for medication is already on risk register and has been downgraded Big drive on Statutory and Mandatory training which includes safeguarding Appraisal season is commencing IPC - bare below elbow, cleaning awareness Reviewing and maintenance of risks and how to guides - Buzz / HIVE articles Prioritising patients in ED - risk on Datix Working towards ePR for records	14/10 2024	16	Extreme Risk	8	Overarching	Extreme 3246, 3336, 3398, 3521, 3540, 3542, 3544	BAF 1	18076	CQC Action Plan on Monday .com	31/05 2024	28/05 2024
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. Procurement of extended contracts and sourcing of third-party companies providing support where manufacturers are unable Purchase via second hand market of parts for repair and replacement South Yorkshire Federation wide procurement where possible Sharing of services across the SY Federation / support as necessary	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	BAF 4	17439	Weekly Risk Review Meeting (23/24)	29/03 2024	05/04 2024
											17440	Weekly Risk Review Meeting (24/25)	28/03 2025	05/04 2024
											17918	Create Action Tracker for EOL Services/Systems	17/05 2024	

Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	BAF number	ACTION ID	Description	Due date	Done date
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 and proactive support to our partners to support reciprocated help and building of relationships. Development of Place plans to support targeted investment in prevention and ensuring 'Every Contact Counts' across our services in identifying opportunities for secondary prevention or sign-posting to other support. Delivery of Health Inequalities strategy and prioritisation according to need when delivering Health care e.g. addressing waiting list backlogs.	29/02 2024	6	Moderat e Risk	6	Overarching	Extreme 3296, 2873, 3467	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
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, 3538	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 – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	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 to ensure patients are treated in order of clinical priority and long waiting times - Individual patients tracked by teams, with daily updates and escalations provided to DCOO - 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 to maximise any necessary optimisation time - Utilisation of capacity for clinically urgent and longest waiting patients - Senior operational oversight of any proposed cancellation of long waiting patients - Focussed work to ensure all long-wait patients have a pre-operative assessment as early as possible to maximise any necessary optimisation time	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 grafts	07/10 2024	
											18257	Request NHSE Support	07/10 2024	
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	27/11 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	

Trust Risk Report – October 2024

Summary of data pulled from Datix Risk Management System 29th October 2024.

RISK ID	Risk Owner	Title	Existing controls	Review date	Rating (current)	Risk level (current)	Rating (Target)	Risk Authority	Depend-ent Risk	BAF number	ACTION ID	Description	Due date	Done date
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	

2411 - D6 COMMITTEE TERMS OF REFERENCE & DATES PROPOSAL

Decision Item | Rebecca Allen, Associate Director Strategy, Partnerships & Governance | 1

10 minutes

REFERENCES

Only PDFs are attached

- D6 - Committee Terms of Reference & Dates Proposal.pdf
- D6 - Finance and Performance Committee Draft TOR V1.5.pdf
- D6 - People Committee Draft TOR V2.0.pdf
- D6- Audit and Risk Committee Draft TOR V1.6.pdf
- D6 - Quality Committee Draft TOR V1.5.pdf
- D6 - Charitable Funds Committee Draft TOR V1.3.pdf
- D6 - Nominations and Remuneration Draft TOR V1.3.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**D6**
Report Title:	**Committee Terms of Reference and dates proposal**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen Associate Director Strategy, Partnerships and Governance		
Appendices:	**Appendix 1** Proposed dates and times of board and committees 2025-26 **Appendix 2** Proposed dates and times of board and committees 2026-27 **Enclosures:** Draft Terms of Reference Finance and Performance Committee Version 1.5 Draft Terms of Reference People Committee Version 2.0 Draft Terms of Reference Audit and Risk Committee Version 1.6 Draft Terms of Reference Quality Committee Version 1.5 Draft Terms of Reference Charitable Funds Committee Version 1.3 Draft Terms of Reference Nomination and Remuneration Committee Version 1.3		

Report Summary

Purpose of the report

This report provides the Board of Directors with draft Terms of Reference that have been reviewed at each committee, by each Chair and committee members so that the Board are able to ratify these as final approved versions.

Background analysis

Following the Governance Internal Audit review in May 2024, there were several recommendations to align and clarify some items in the Terms of Reference (TOR) and work plans. This work has been continuing over the summer, working with Committee Chairs, non-executive and executive directors and internal audit. Work plans across committees have been aligned and some changes have been made to reporting routes. The draft ToR proposed here are a result of that work. It is planned that although signed off late for this year, a review in the new year will still commerce as per the usual annual cycle of reviews and include feedback of how the changes have supported board effectiveness.

To Note, the name of the Quality and Effectiveness Committee (QEC) is proposed to be amended to Quality Committee, following identified duplication with the Finance & Performance and People Committees, therefore this name amendment will be made to all ToR, including the structure charts contained therein following the Board agreement to these versions.

In addition to the documents, the dates for these meetings have been proposed for the next 18 months. This will support forward planning and diary management, especially for those who may have additional external commitments, but these dates will remain part of the annual review cycle to ensure they still meet the needs of the Board of Directors. To note, three board dates have been diarised as in person meetings at each of the hospital sites. Exact room locations to be confirmed nearer to the time.

Recommendation:	The Board of Directors is asked to: 1. Approve the set of Terms of Reference for: The Audit and Risk Committee, The Finance and Performance Committee, The Quality Committee, The People Committee, The Charitable Funds Committee and

	The Nomination and Remuneration Committee. 2. To Approve the suggested dates, times and locations for Board and Committee meetings for the next 18 months (to review annually)			
Action Required:	**Approval**	~~Review and discussion~~	~~Take assurance~~	~~Information~~
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 and the NHS Code of Governance requires committees of the board to have effective Terms of Reference and provide sufficient time resource for its work, which the forward planning of dates supports with.		
Resources:			

Assurance Route	
Previously considered by:	N/A
Date:	N/A

Any outcomes/next steps	If approved, these Terms of Reference will be the final versions and dates will be added to all Board Dairies.
Previously circulated reports to supplement this paper:	N/A

Appendix 1: Proposed Board and committee dates 2025 - 2026

Board of Directors Meeting Full Agenda	
Date	Time
Tuesday 06 May 2025 Held at Doncaster Royal Infirmary, Doncaster	09:30 - 16:30
Tuesday 01 July 2025 Held at Bassetlaw Hospital, Worksop TBC	09:30 - 16:30
Tuesday 02 September 2025	09:30 - 16:30
Tuesday 04 November 2025 Held at Montagu Hospital, TBC	09:30 - 16:30
Tuesday 06 January 2026	09:30 - 16:30
Tuesday 03 March 2026	09:30 - 16:30

Board of Directors Development Sessions (Face to face)	
Date	Time
Tuesday 01 April 2025	10:00 - 16:00
Tuesday 03 June 2025	10:00 - 16:00
Tuesday 07 October 2025	10:00 - 16:00
Tuesday 02 December 2025	10:00 - 16:00
Tuesday 03 February 2026	10:00 - 16:00

Finance and Performance Committee	
Date	Time
Thursday 24 April 2025	09:30 - 12:30
Thursday 29 May 2025	09:30 - 12:30
Thursday 26 June 2025	09:30 - 12:30
Thursday 31 July 2025	09:30 - 12:30
Thursday 25 September 2025	09:30 - 12:30
Tuesday 30 October 2025	09:30 - 12:30
Thursday 27 November 2025	09:30 - 12:30
Thursday 29 January 2026	09:30 - 12:30
Thursday 26 February 2026	09:30 - 12:30
Thursday 26 March 2026	09:30 - 12:30

Quality Committee	
Date	Time
Thursday 03 April 2025	13:00 - 16:00
Thursday 05 June 2025	13:00 - 16:00
Thursday 07 August 2025	13:00 - 16:00
Thursday 09 October 2025	13:00 - 16:00
Thursday 04 December 2025	13:00 - 16:00
Wednesday 05 February 2025	13:00 - 16:00

People Committee	
Date	Time
Tuesday 15 April 2025	09:30 - 12:30
Tuesday 17 June 2025	09:30 - 12:30
Tuesday 19 August 2025 – Extraordinary – only if required	09:30 - 12:30
Tuesday 21 October 2025	09:30 - 12:30
Tuesday 16 December 2025	09:30 - 12:30
Tuesday 17 February 2026	09:30 - 12:30

Audit and Risk Committee	
Date	Time
Thursday 17 April 2025	09:30 - 12:30
Thursday 19 June 2025 – Extraordinary – Year end only	09:30 - 12:30
Friday 27 June 2025 – Extraordinary – Year end only	09:30 - 12:30
Thursday 24 July 2025	09:30 - 12:30
Thursday 16 October 2025	09:30 - 12:30
Thursday 12 February 2026	09:30 - 12:30

Charitable Funds Committee	
Date	Time
Thursday 12 June 2025	13:30 - 15:30
Thursday 11 September 2025 – Full Trustee Board Meeting	13:30 - 15:30
Thursday 11 December 2025	13:30 - 15:30
Thursday 12 March 2026	13:30 - 15:30

Appendix 2: Proposed Board and committee dates 2026 - 27

Board of Directors Meeting - Full Agenda	
Date	Time
Tuesday 05 May 2026 Held at Doncaster Royal Infirmary, Doncaster	09:30 - 16:30
Tuesday 07 July 2026 Held at Bassetlaw Hospital, Worksop TBC	09:30 - 16:30
Tuesday 01 September 2026	09:30 - 16:30
Tuesday 03 November 2026 Held at Montagu Hospital, TBC	09:30 - 16:30
Tuesday 05 January 2027	09:30 - 16:30
Tuesday 02 March 2027	09:30 - 16:30

Board of Directors Development Sessions (Face to face)	
Date	Time
Tuesday 21 April 2026	10:00 - 16:00
Tuesday 02 June 2026	10:00 - 16:00
Tuesday 06 October 2026	10:00 - 16:00
Tuesday 01 December 2026	10:00 - 16:00
Tuesday 02 February 2027	10:00 - 16:00

Finance and Performance Committee	
Date	Time
Thursday 30 April 2026	09:30 - 12:30
Thursday 28 May 2026	09:30 - 12:30
Tuesday 23 June 2026	09:30 - 12:30
Thursday 30 July 2026	09:30 - 12:30
Thursday 24 September 2026	09:30 - 12:30
Thursday 29 October 2026	09:30 - 12:30
Thursday 26 November 2026	09:30 - 12:30
Thursday 28 January 2027	09:30 - 12:30
Thursday 25 February 2027	09:30 - 12:30
Thursday 25 March 2027	09:30 - 12:30

Quality Committee	
Date	Time
Thursday 23 April 2026	13:00 - 16:00
Thursday 04 June 2026	13:00 - 16:00
Thursday 06 August 2026	13:00 - 16:00
Thursday 08 October 2026	13:00 - 16:00
Thursday 03 December 2026	13:00 - 16:00
Thursday 04 February 2027	13:00 - 16:00

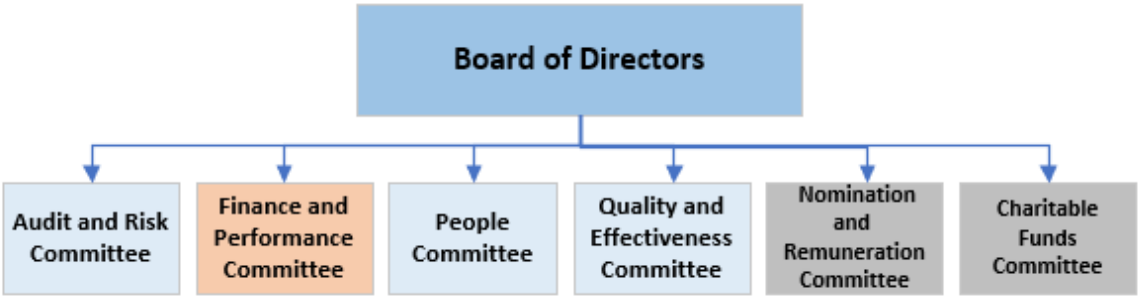
People Committee	
Date	Time
Tuesday 14 April 2026	09:30 - 12:30
Tuesday 16 June 2026	09:30 - 12:30
Tuesday 18 August 2026 – Extraordinary – only if required	09:30 - 12:30
Tuesday 20 October 2026	09:30 - 12:30
Tuesday 15 December 2026	09:30 - 12:30
Tuesday 16 February 2027	09:30 - 12:30

Audit and Risk Committee	
Date	Time
Thursday 16 April 2026	09:30 - 12:30
Thursday 18 June 2026 – Extraordinary – Year end only	09:30 - 12:30
Friday 26 June 2026 – Extraordinary – Year end only	09:30 - 12:30
Thursday 23 July 2026	09:30 - 12:30
Thursday 15 October 2026	09:30 - 12:30
Thursday 11 February 2027	09:30 - 12:30

Charitable Funds Committee	
Date	Time
Thursday 11 June 2026	13:30 - 15:30
Thursday 10 September 2026 - Full Trustee Board Meeting	13:30 - 15:30
Thursday 10 December 2026	13:30 - 15:30
Thursday 11 March 2027	13:30 - 15:30

Finance and Performance Committee

Draft Terms of Reference V1.5



1. Constitution

The Finance and Performance Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.

2.4 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.

2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.

3. Purpose

The committee is established to:

3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of all aspects of the Trusts financial and performance delivery plans, including identification of risks and mitigating actions.

3.2 Ensure there are robust processes and controls in place for the effective management of all Trust assets, including, but not limited to: finances, physical, digital and information.

3.3 Provide assurance to the Board that the Trust has in place processes and controls for effective delivery of net-zero strategic objectives

3.4 Give consideration to the wider impacts of Trust decisions-making as part of the Integrated Care System, Provider Alliances, Partners, and the wider NHS.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to give detailed consideration on the Trusts financial, net zero and performance issues in order to provide the Board of Directors with assurance and information on key issues and clear decision points in respect of:

4.1 Financial and business planning

4.1.1 All aspects of the financial arrangements of the Trust, ensuring these are being appropriately addressed including in year financial performance and productivity plans and any corrective actions required

4.1.2 All aspects of the Trusts capital program (Digital and Estates), including work with system partners, providing the Board of Directors with assurance these are fit for purpose and planned to meet future need.

4.1.3 The Trust's Procurement and Contracting plans incorporating the Board Lead for Procurement that identifies procurement activity, its strategic development, the Trust's financial and service delivery agreements and key contractual agreements.

4.1.4 That a robust process for the assessment and award of tenders is in place.

4.1.5 All aspects of the Trust's Annual Financial plan, plus any in-year financial submissions to NHS England, providing final recommendation to the Board of Directors in accordance with prescribed guidance and timescales and receive in year financial performance reporting of revenue, capital, working capital, linked to the Financial Plan with any corrective actions required

4.1.6 Provide early strategic consideration to significant business cases for new business or capital investment in order to ensure affordability and alignment with strategic aims.

4.1.7 To keep under review, consider and recommend to the Board of Directors subject to the Standing Financial Instructions, all financially related policies and enabling strategies, for example: Treasury Management Policy, Procurement, Estates and Digital etc.

4.1.8 Provide assurance to the Board of Directors that the Trust is financially viable as a foundation trust, including current and forecast compliance with financial covenants, and to oversee strong financial management to meet statutory and regulatory obligations and review of the Draft Accounts ahead of Audit and Risk Committee.

4.1.9 To consider and advise the Board of Directors on the impact of changes to the financial regime, including, but not limited to, the introduction of financial and governance arrangements in support of the Integrated Care System, and to monitor robust plans to manage the change.

4.2 Digital and Data Quality

4.2.1 To scrutinise and review all aspects of the digital and data quality arrangements for the Trust, ensuring progress is being made in line with the strategic planned milestones.

4.2.2 To scrutinise and review the Trusts digital strategic plans with key milestones on an annual basis.

4.3 Performance Management

4.3.1 Monitor and scrutinise the Trust's performance reporting and Performance Assurance Framework (annually) and support the development of appropriate performance measures, including KPI's as part of any board report.

4.3.2 To review benchmarking information to appraise whether the Trust is providing best value in corporate and service areas in relation to national access and operational performance standards.

4.3.3 To undertake post implementation review of business cases in order to receive assurance that the financial and performance benefits have been realised.

4.3.4 To scrutinise themed exception reports at either Trust or Divisional level and wherever possible consider reports against external benchmarking data and best practice evidence.

4.3.5 To review the health Inequalities strategic plans and monitor progress against these at least annually.

4.4 Estates and Net Zero

4.4.1 To review and consider the effectiveness and efficiency of the estates function via a performance report at alternate meetings, with deep-dives into specific areas of concern if and when required

4.4.2 To review an annual estates report that highlights progress made against key strategic areas that fall within the estates and facilities function.

4.4.3 To scrutinise, and recommend for approval to the Board of Directors, the net-zero Management Development Plan (Green plan).

4.4.4 All aspects of the net-zero arrangements of the Trust, ensuring these are being appropriately addressed including in year performance and delivery plans and any corrective actions required.

4.4.5 to work collaboratively at system level to support the delivery of plans to address the NHS net zero target.

4.5 Trust Health Safety and Fire

4.5.1 To receive and review reports and assurances on the arrangements for process, risk management and internal control for the Trusts Health and Safety, fire and security duties

4.5.2 To receive an annual report on the effectiveness of the Trusts Health and Safety compliance.

5. MEMBERSHIP

5.1 The membership of the Committee will comprise of executives and Non-executive directors only:

- Three Non-executive Directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
- Finance Director
- Chief Operating Officer

5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another Non-Executive Director to chair the meeting.

6. ATTENDANCE

6.1 The Chief Executive Officer and The Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.

6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.

6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an Executive Director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.

6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.

6.5 Committee Members will be required to attend a minimum of eight meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

6.6 Others who may be invited to attend the meeting include:

- Trust Secretary / Deputy Trust Secretary
- Medical Director
- Deputy Finance Director

7. FREQUENCY OF MEETING

7.1 The Committee will meet monthly and a minimum of ten times per year with additional ad hoc meetings as required.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.

7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing

protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two executive directors (one of whom may be a Deputy Director) and two Non-Executive Directors

9. REPORTING

9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

9.2 The Committee shall scrutinise and recommend to the Board of Directors the Finance and Performance sections of the Board Assurance Framework.

9.3 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

9.4 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

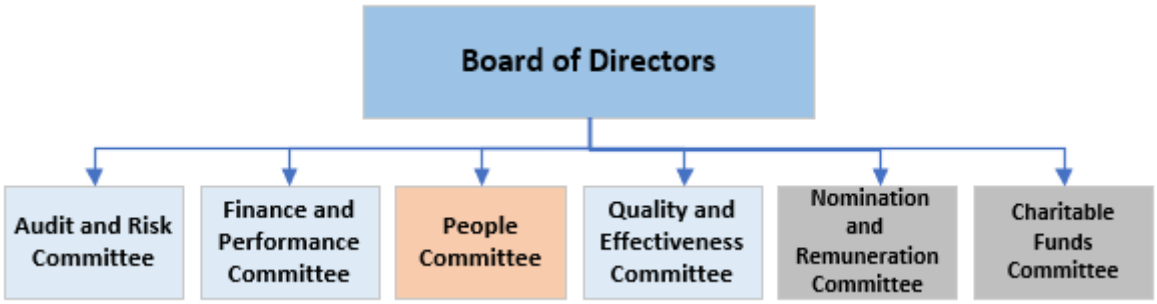
10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved …….
(Chair of the Board of Directors)

Date of approval ..……..

People Committee

Draft Terms of Reference V2.0



1. Constitution

The People Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.

2.4 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.

2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.

3. Purpose

The committee is established to:

3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of the people aspects of the Trust's People Strategy

3.2 Provide assurance to the Board of Directors that the Trust has in place a system of internal control to identify and mitigate the risks affecting delivery of the Trust's People Strategy.

3.3 Provide assurance to the Board that appropriate and effective governance mechanisms are in place for all aspects of people legislation, regulation, and best practice in order to comply with national, regional and local requirements.

3.4 Shape the culture, organisational development, learning and leadership of people within the Trust and contribute to shaping the culture of how organisations work together, across the Integrated Care System, Provider Alliances, and the wider NHS.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to ensure that there are robust processes in place for the effective management of people and these operate effectively so that action is taken to address any areas of concern.

The Committee will provide assurance to the Board of Directors on the implementation and delivery of the People Strategy.

The Committee will provide the Board of Directors with assurance, information on key issues and clear decision points, by scrutinising triangulated, analysed information in order to gain assurance on the effectiveness and delivery of:

4.1 Looking after our people

4.1.1 All health and wellbeing programmes across the Trust, via evidence biannually in line with the national framework, local priorities and input from the NED Wellbeing Guardian role.

4.1.2 The Trust's approach to positively supporting flexible working, from evidence presented annually together with deep dives and evidence of improvements and action plans in areas where required.

4.1.3 The Trust's progress and delivery of its educational commitment to colleagues, from evidence presented at each meeting together with deep dives and evidence of improvements and action plans in areas where required.

4.1.4 The Trust's performance against key people metrics at each meeting, including, but not limited to: sickness absence rates, employee turnover, statutory and essential training, and appraisals plus an annual report on Violence and Prevention standards.

4.1.5 The results of the national staff survey, plus regional or local surveys presented with links to key areas of learning, strategic priorities and actions as required.

4.1.6 The Trusts compliance to its appraisal season targets including quality impacts on colleagues via an annual report.

4.1.7 The Trust Progress against its Just Culture initiatives and the impact on employee relations process via biannual reporting.

4.1.8 To scrutinise and gain assurance that the Trust has in place systems and controls to deliver on the Trust's compliance with the requirements set out in the NHSE Safe Staffing regulations, plus nursing establishment review.

4.1.9 To scrutinise and recommend for the Board of Directors the Safe Staffing Annual review and declaration.

4.1.10 The Trust's recognition and reward program, from evidence presented annually.

4.1.11 To have oversight and report to the Board of Directors as the NED lead role on doctors disciplinary across all Trust services, via an annual report that includes trends and thematic analysis together with any lessons learned.

4.2 Belonging in #Team DBTH

4.2.1 The Trust's Equality Diversity and Inclusion approach, ensuring this is embedded within all aspects of the Trust, including colleague networks. With evidence presented via biannual reports plus deep dives of improvements and action plans in areas where required.

4.2.2 The Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)) progress presented annually together with deep dives and evidence of improvements and action plans in areas where required. Gender Pay Gap analysis to be included within the annual report.

4.2.3 The Trust's leadership and development programs, including the 'DBTH Way' and how this is applied across the Trust.

4.2.4 The Trust's approach to 'Speaking up' including progress on how this is embedded into Trust culture. Evidence presented to Committee biannually including an annual report which are both presented to the Board of Directors.

4.2.5 To review and take assurance on the Organisational Development progress made over the year via an annual report.

4.3 Growing for the future

4.3.1 The Trust's approach to workforce planning and development across the Trust and wider system from evidence presented each meeting, plus deep dives of improvements and action plans in areas where required.

4.3.2 The recruitment and attraction initiatives to attract and retain colleagues across the Trust. Assurance to be gained on the progress of recruiting, on-boarding and induction experience for all colleagues, including time to hire metrics, from evidence presented biannually.

4.3.3 The Trust's progress and delivery of its research commitment through the Research and Innovation Strategy, from evidence presented biannually together with deep dives and evidence of improvements and action plans in areas where required.

4.3.4 The Trust's career development and career pathways approach including its impact on recruitment and retention rates, placements and colleague satisfaction. Evidenced from triangulated reports.

4.3.5 The Trust's progress in meeting its anchor institution duties, in relation to widening participation, via evidence presented quarterly, together with action plans where improvements are required.

4.3.6 The compliance of Medical Appraisal rates via evidence presented annually.

4.3.7 To review and take assurance on the knowledge, Library and information service via an annual report.

4.4 New ways of Working

4.4.1 The Trust's progress against delivery to digitise its people systems.

4.4.2 The Trust's progress of its plans to attain University Teaching Hospital Status as part of the Research and Innovation Strategy from evidence presented biannually.

4.4.3 The Trust's progress against delivery of its plans to maximise its use of temporary workforce from evidence presented annually plus action plans in areas where improvements are required.

4.4.4 To gain assurance on the implementation of internal audit recommendations that relate specifically to People actions, via progress and monitoring reports to each committee on outstanding internal audit actions.

4.4.5 To gain assurance on the medical job planning process and compliance from evidence presented annually.

4.4.6 To review the medical revalidation process and compliance for the Trust from evidence presented annually.

5. MEMBERSHIP

5.1 The membership of the Committee will comprise of executives and non-executive directors only:

- Three non-executive directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
- Chief People Officer
- Chief Nurse
- Executive Medical Director

5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another non-executive director to chair the meeting.

6. ATTENDANCE

6.1 The Chief Executive Officer and the Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.

6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.

6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an executive director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.

6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.

6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

6.6 Others who may be invited to attend the meeting include:

- Trust Secretary / Deputy Trust Secretary
- Deputy Director of People & Organisational Development
- Director of Education and Research
- Head of OD, EDI and Wellbeing

7. FREQUENCY OF MEETING

7.1 The Committee will meet 5 times a year with additional ad hoc meetings as required.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.

7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two executive directors (one of whom may be a Deputy Director) and two non-executive directors

9. REPORTING

9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

9.2 The Committee shall scrutinise and recommend to the Board of Directors the relevant people sections of the Board Assurance Framework.

9.3 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

9.4 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

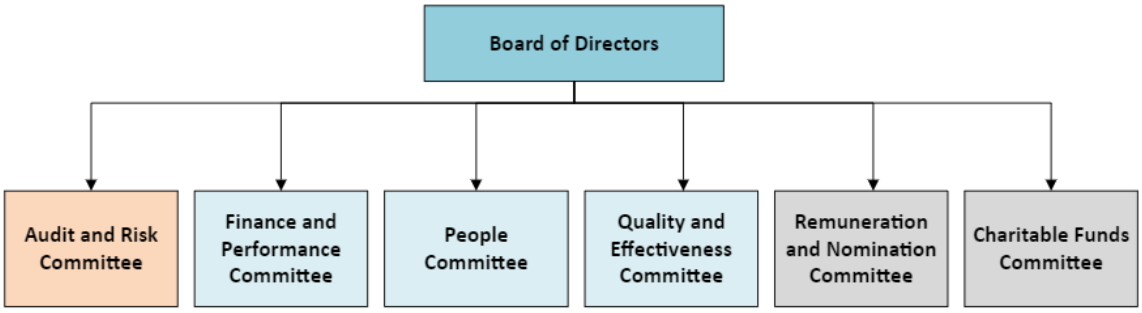
10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved …….
(Chair of the Board of Directors)

Date of approval ..……..

Audit and Risk Committee

Draft Terms of Reference V1.6



1. Constitution

The Audit and Risk Committee (the Committee) is a non-executive statutory committee and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it considers necessary in the fulfilment of these terms of reference.

2.4 In conducting its role the Committee is authorised to seek reports and assurance from executive directors and managers and will support effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.

2.5 Any committee member will refer to or receive from other committees, pieces of work or information, to fulfil its terms of reference.

3. Purpose

The committee is established to:

3.1 Provide oversight and assurance to the Board of Directors on the adequacy of the Trusts, processes, and controls for the effective management of risk to support with the delivery of the Trusts strategic objectives of People, Patients, Partnerships and Pounds.

3.2 Provide assurance to the Board of Directors that the Trust has in place an effective system of integrated governance, risk management and internal control, by means of independent and objective review of financial and corporate governance, risk management across the Trusts activities ensuring compliance with law, guidance and regulations governing the NHS.

3.3 Consider the wider impacts of Trust decision-making as part of the Integrated Care System, Provider Alliances, Partners, and the wider NHS.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to review the establishment and maintenance of governance systems, internal controls, and risk management across all activities of the Trust that enables achievement of the strategic objectives. To provide the Board of Directors with assurance, information on key issues and clear decision points in respect to each of the following:

4.1 Governance and Internal Control

4.1.1 To scrutinise and recommend to the Board of Directors the Trust's risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors.

4.1.2 To scrutinise the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in 4.1.1.

4.1.3 To scrutinise the policies and process for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification, including confirmation that all board committees have scrutinised their responsible policies.

4.1.4 To scrutinise internal controls at least annually regarding Standing Financial Instructions, the Scheme of Reservation and Delegation and Standing Orders.

4.1.5 To scrutinise the internal controls in place for monitoring compliance to Conflicts of Interest, gifts, and hospitality standards.

4.2 Internal Audit

4.2.1 To ensure there is an effective internal audit function resourced and established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board of Directors.

4.2.2 To scrutinise and approve the Internal Audit operational plan of work, ensuring it is consistent with the audit needs of the organisation as identified through a risk assessment including areas such as the Board Assurance Framework and Risk Registers.

4.2.3 To consider findings of internal audit work (and management responses) and ensure appropriate standing within the organisation and monitoring of the implementation of audit recommendations.

4.2.4 To review the effectiveness of Internal Audit annually.

4.2.5 To receive and review the Internal Audit annual report including Head of Internal Audit Opinion.

4.3 External Audit

4.3.1 To discuss and agree with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health system.

4.3.2 To discuss and agree with the External Auditors their evaluation of audit risks and assessment of the organisation as a going concern and the impact on the audit fee.

4.3.3 To review all External Audit reports, including agreement of the annual audit letter before submission to the Board of Directors and any work conducted, outside the annual audit plan, together with the appropriateness of management responses.

4.3.4 To report to the Board of Directors any identified matters and recommendations where action or improvement is required.

4.3.5 To ensure there is a clear policy for the engagement of External Auditors to supply non-audit services, considering relevant ethical guidance.

4.3.6 Ensure Trust compliance to ISA 260 requirements and delivery of any recommendations.

4.3.7 To complete an annual review of the effectiveness of External Audit.

It is the role and responsibility of the Council of Governors to appoint, or remove, the External Auditor. The Committee will therefore:

4.3.8 Develop and agree with the Council of Governors, and make recommendations to them on, the criteria for the appointment, re-appointment, and removal of the External Auditor.

4.3.9 Approve the remuneration and terms of engagement of the External Auditor.

4.4 Counter Fraud

The Committee will ensure that there is an effective counter fraud function that meets the standards for providers for bribery and corruption and provides appropriate independent assurance to the Committee, Chief Executive, and the Board of Directors:

4.4.1 To determine the specification for a counter fraud service through the procurement process to identify a provider and make recommendation to the Board of Directors for their appointment.

4.4.2 To review and approve the annual counter fraud plan, ensuring there is consistency with the potential risks and needs of the organisation.

4.4.3 To receive reports to every meeting on the work of the counter fraud service in the delivery of the annual plan.

4.4.4 To receive reports on referrals to and the outcome of investigation conducted by the counter fraud service, including assurance on the actions taken against perpetrators and additional controls recommended to avoid recurrence.

4.4.5 To undertake an annual review of the effectiveness of the counter fraud service.

4.5.6 To scrutinise the policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority.

4.5 Financial Reporting and Financial Stewardship

4.5.1 To review all internal financial controls and all internal control and risk management systems, examples may include procurement cards, single tender waivers, losses and special payments.

4.5.2 To scrutinise and review compliance with accounting policies, practices and estimation techniques.

4.5.3 To scrutinise and review unadjusted misstatements in the financial statements.

4.5.4 To scrutinise and review major judgemental areas.

4.5.5 To scrutinise and review significant adjustments (both adjusted and unadjusted misstatements & their explanations) resulting from audit scrutiny.

4.5.6 To ensure the systems for financial reporting to the Board of Directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided to the Board of Directors. Including those of significant external financial systems.

4.5.7 To receive specific Board delegation annually for agreement on the annual accounts, via the existing governance arrangements.

4.6 Management and Risk Assurance Process

4.6.1 To request, receive and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.6.2 To scrutinise and review the effectiveness of the Board Assurance Framework and compliance with the risk management framework and strategy, including an annual report on risk management.

4.7 Emergency Preparedness Resilience and Response (EPRR)

4.7.1 To receive and review reports and assurances on the statutory arrangements for process, risk management and internal control for the Trusts EPRR.

4.7.2 To receive an annual report on the effectiveness of the Trusts EPRR.

4.8 Information Governance and Cybersecurity

4.8.1 To receive and review reports and assurances on the arrangements for process, risk management and internal control for the Trusts cybersecurity and data protection arrangements.

4.8.2 Review and take assurance on the Trust's annual data security and protection toolkit process, noting when this has been submitted and any issues identified as part of the audit process.

5. MEMBERSHIP

5.1 The membership of the Committee will be four named non-executive directors, each being a Chair of the 3 other standing committees of the Board of Directors, not including the Chair of the Trust and one of whom will be the Committee Chair.

5.2 At least one of the members of the Committee will have recent and relevant financial experience.

5.3 The Board of Directors will appoint the Chair of the Committee, in their absence, they can nominate another non-executive director to chair the meeting.

6. ATTENDANCE

6.1 The Chief Executive Officer and the Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.

6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.

6.3 The Board of Directors has delegated authority to Deputy Directors to act as a nominated deputy in the absence of an Executive Director where applicable.

6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.

6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

6.6 The following roles will be regular attendees and will be recorded as being 'in attendance' and not as being 'present'.

- Internal Audit representative(s)
- External Audit representative(s)
- Counter Fraud representative(s)
- Director of Finance
- Deputy Director of Finance
- Deputy Chief Executive
- Associate Director of Strategy, Partnerships and Governance
- Trust Risk Lead

6.7 Other executive director / officers should be invited to attend, particularly when the Committee is discussing areas of risk, internal audit limited assurance reports or operation that are the responsibility of that director.

6.8 The Trust Board has delegated authority to any non-executive director of the Trust, excluding the Chair, to act as nominated deputy in the absence of any non-executive member and this attendance will count towards the quorum.

7. FREQUENCY OF MEETINGS

7.1 The Committee will meet a minimum of four times per year with additional ad hoc meetings as required.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.

7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

7.5 At least once per year, the Committee members only should meet with the external and internal auditors, to discuss matters relating to its responsibilities and issues arising from the audit. The External Auditor and Head of Internal Audit may request a private meeting if they consider that one is necessary. They will also have direct access to the Chair of the Committee as required.

8. QUORUM

A quorum shall be not less than three non-executive director members, this can include deputies as specified in point 6.8 above.

9. REPORTING

9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

9.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

9.3 The Committee will report to the Board of Directors annually on its work.

9.4 The Committee will receive effectiveness annual reports from each of the standing assurance committees.

10. REVIEW

10.1 The Committee will review its work plan at each meeting.

10.2 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved …….
(Chair of the Board of Directors)

Date of approval ..……..

Annex 1 (Aide Memoire on strategy and policy documents)

The Committee is responsible for the oversight of the following strategies:

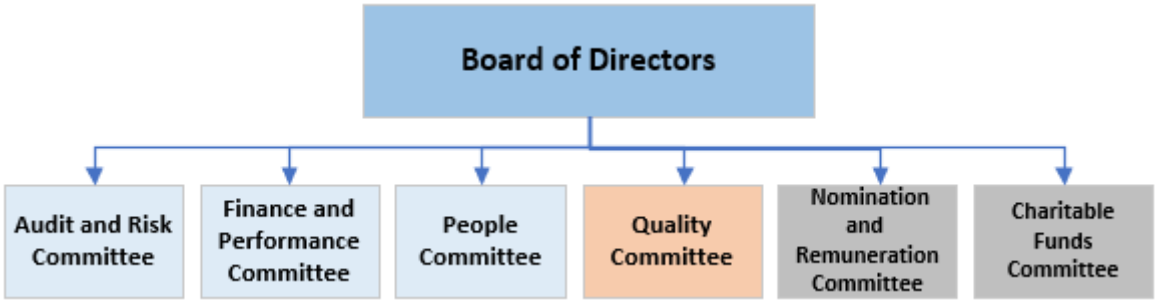
1. Risk Management Strategy (4.6.2)

The Committee is responsible for the oversight of the following policies:

1. Anti-fraud corruption and Bribery Policy (4.5.6)
2. Standards of business conduct policy (4.1.3)
3. Governance documents Standing Finance Instructions, Standing Orders, Scheme of Reservation and Delegation. (4.1.4)

Quality Committee

Draft Terms of Reference V1.5



1. Constitution

The Quality and Effectiveness Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-committee or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.

2.4 In carrying out its role the Committee is authorised to seek reports and assurance form executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.

2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.

3. Purpose

The committee is established to:

3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes, and controls to ensure that the legislative requirements within these terms of reference that ensure the safety, rights and quality of service delivery is maintained to all service users, carers, staff, and the public.

3.2 Provide direction on behalf of the Board of Directors regarding the delivery of the Trust's quality improvement priorities and strategic objectives in respect of quality and effectiveness.

3.3 Provide assurance to the Board of Directors that appropriate and effective governance systems are in place for all aspects of quality including patient

experience, health outcomes and compliance with national, regional and local requirements, where these are provided directly or commissioned by DBTH.

3.4 Give consideration to the wider impacts of Trust decision making as part of the Integrated Care System.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to set annual objectives and a forward plan that enables it to delivery its responsibilities and to review and update any strategic risks and mitigating actions in line with the Board Assurance Framework. To provide the Board of Directors with assurance, information on key issues and clear decision points in respect to each of the following:

4.1 Annual Quality Strategy, Plan and Reports

4.1.1 To scrutinise and recommend to the Board of Directors the Trust's quality priorities and strategy and gain assurance that these are being delivered in line with those plans, with any remedial actions identified where this is off-track.

4.1.2 To scrutinise the strategic content and direction of any Annual Quality Report and Plan, the Trust determines locally, engaging with the Council of Governors, and for approval by the Board of Directors.

4.1.3 To scrutinise Quality Performance Impact Assessments and Equality Impact Assessment of any Cost Improvement Plans or transformational change programme, that may impact the quality of service delivery in accordance with the Trust's QPIA Policy CORP/COMM 28.

4.1.4 To scrutinise the review of any identified Integrated Care System or national developments that may impact on the Trust in respect of service quality and patient risk.

4.1.5 To review progress on the Maternity and Neonatal Transformation programme.

4.2 Legislative and Statutory Compliance

4.2.1 To gain assurance on Mental Health Act (MHA) via an annual report, and by exception reporting when required, that demonstrate the Mental Health Act is appropriately applied and compliant with legislative requirements, plus any actions to improve compliance where identified.

4.2.2 To have oversight and report to the Board of Directors as the Non-Executive Director (NED) lead role for safeguarding and gain assurance from all evidence presented to the committee that the Trust is compliant with all its regulatory duties. Evidencing associated actions to improve compliance including Mental Capacity Act and Deprivation of Liberty.

4.3 Regulatory Assurance

4.3.1 To scrutinise and enable a discursive forum to review Care Quality Commission (CQC) compliance reports, notices or licence requirements and ensure that actions are taken to address all issues identified in CQC compliance reports.

4.3.2 To gain assurance from triangulation of information, including internal audit as appropriate, that progress on the actions identified in CQC compliance reports are embedded into clinical practice. This will be received through existing reports that will reference relevant regulatory requirements.

4.3.3 To carry out the assurance duties of the Board champion requirements, via triangulated data, receiving reports across all areas and specifically where required in respect to:

- Maternity Safety
- Hip Fracture, Falls and Dementia
- Learning from Deaths
- Children and Young People
- Resuscitation
- Safeguarding
- Palliative and End of Life Care

For the avoidance of doubt these are **not** named individual leads.

4.3.4 To scrutinise and recommend for the Board of Directors the Clinical Negligence Scheme for Trusts, (CNST) Maternity Incentive Scheme declaration and compliance against the standards.

4.4 Patient Safety, Experience and outcomes

4.4.1 To gain assurance via reports to each committee, and where necessary deep dive reports, that the Trust has in place legislatively compliant systems and controls that ensure patient incidents, complaints, duty of candour, compliments and claims are effectively monitored to ensure high quality care is delivered and to enable lessons learnt and ensure actions are progressed.

4.4.2 To review the annual clinical audit programme and recommend its approval to the Board of Directors, and monitor its delivery via clinical audit reports at each meeting.

4.4.3 To gain assurance on the implementation of internal audit recommendations that directly affect clinical standards and quality of services, via progress and monitoring reports at each committee on any outstanding internal audit actions.

4.4.4 To consider the results, issues raised and trends on the quality of the patient environment, through an annual report and where necessary exception reports, on the Patient Led Assessments of the Care Environment (PLACE).

4.4.5 To receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

4.4.6 To consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern via an annual report.

4.4.7 To gain assurance via six-monthly and exception and highlight reports, as required, that the Trust is legislatively compliant and is implementing guidance and best practice in respect of its mortality surveillance systems and learning-from-deaths processes.

4.5 Medicines Optimisation and Medical Devices

4.5.1 To gain assurance the Trust has in place processes and controls that ensure medicines are effectively managed and compliant with legislative requirements.

4.5.2 To gain assurance the Trust has in place processes and controls that ensure medical devices are effectively managed and compliant with legislative requirements.

4.6 Infection Prevention and Control

4.6.1 To gain assurance via a six-monthly and annual report that the Trust has in place Infection Prevention and Control systems and controls to ensure this is effectively managed and compliant with all legislative requirements.

4.6.2 To approve the annual Infection Prevention and Control plan.

4.6.3 To scrutinise and recommend to the Board of the Directors the Annual Infection Control Statement.

5. MEMBERSHIP

5.1 The membership of the Committee will comprise of executives and Non-executive directors only:

- Three Non-executive Directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
- Chief Nurse
- Medical Director

5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another Non-Executive Director to chair the meeting.

6. ATTENDANCE

6.1 The Chief Executive Officer and The Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.

6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.

6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an Executive Director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.

6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.

6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

6.6 Others who may be invited to attend the meeting include:

- Director of Midwifery
- Director of Allied Health Professionals

- Associate Medical Director, Clinical Safety
- Clinical Governance and Professional Standards Co-Ordinator
- Trust Secretary / Deputy Trust Secretary

7. FREQUENCY OF MEETING

7.1 The Committee will meet bi-monthly and a minimum of five times per year with additional ad hoc meetings as required.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.

7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two executive directors (one of whom may be a Deputy Director) and two Non-Executive Directors

9. REPORTING

9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

9.2 The Committee shall scrutinise and recommend to the Board of Directors the quality section of the Board Assurance Framework.

9.3 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

9.4 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

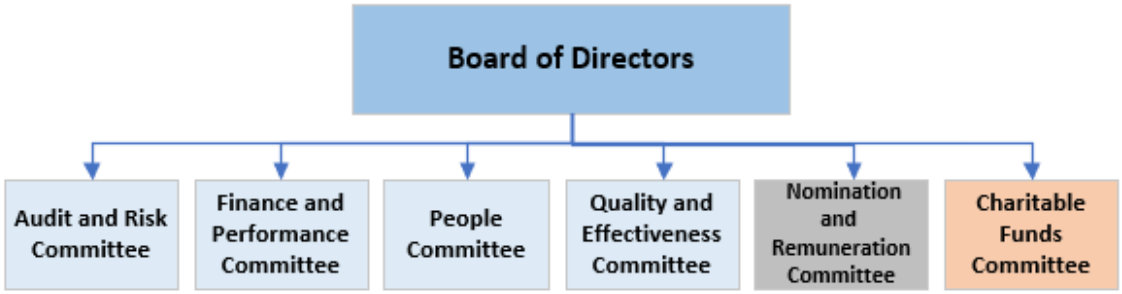
10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved …….
(Chair of the Board of Directors)

Date of approval ..……..

Charitable Funds Committee

Draft Terms of Reference V1.3



Constitution

The Charity Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.

2.4 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.

2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.

3. Purpose

The committee will oversee the management of Doncaster and Bassetlaw Teaching Hospitals Trusts Charitable Funds (Charity No.1057917), directly and via the wholly owned subsidiary Doncaster and Bassetlaw Health Services Ltd (Company number 11563750**).**

4. ROLES AND RESPONSIBILITIES

The committee is established to:

4.1 Provide assurance to the Board of Directors that the Charity has in place structures, processes, and controls for the effective increase to and utilisation of the Trusts charitable funds, to support the work of Doncaster and Bassetlaw NHS Foundation Trust.

4.2 Provide assurance to the Board of Directors that appropriate and effective governance arrangements are in place for all aspects of charity legislation, regulation, and best practice.

4.1 Expenditure, Income, and Investments

4.1.1 Authorise expenditure from the Charitable Funds, ensuring such decisions are in line with the Trusts scheme of delegation limits.

4.1.2 Develop and maintain a rolling three-year expenditure strategy for the Charitable Funds.

4.1.3 Invest the available fund monies in line with Policy and legislation, including appointing appropriate investment expertise to manage the Charities investments where appropriate.

4.1.4 Ensure the Fundraising function is managed appropriately and can demonstrate value for money and increasing income, together with robust allocation and distribution governance frameworks.

4.1.5 To oversee and implement a fund-raising strategy and policy.

4.2 Governance and Compliance

4.2.1 Ensure the committee can evidence compliance with Charity Commission standards and has all appropriate policies and procedures are in place and reviewed at least annually.

4.2.2 To develop and monitor the Funds' approach to risk including risk appetite in relation to income and expenditure decisions.

4.2.3 The committee can demonstrate it has managed the charitable funds within the terms of the Trust Deed.

4.2.4 To appoint an appropriate auditor to report on the annual accounts.

4.2.5 To approve the annual report and accounts of the Charitable Fund.

5. MEMBERSHIP

5.1 The membership of the Committee will comprise of all voting members of the board who will act as Trustees for the administration of charitable funds.

5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another Non-Executive Director to chair the meeting.

6. ATTENDANCE

6.1 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose. These may include but are not limited to:

Head of Financial Control
Managing Director of DBHS Ltd
Director of Communications and Engagement

Head of Charity

6.2 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.

6.3 Committee Members will be required to attend a minimum of 50% of meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

7. FREQUENCY OF MEETING

7.1 The Committee will meet at least twice a year with additional ad hoc meetings as required, one meeting annually shall be the full Board of Trustees Meeting.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.

7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than three members of the Committee with a minimum of one executive director and two non-executive directors.

9. REPORTING

9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

9.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

9.3 The Committee will report to the Board of Directors annually on its work.

10. REVIEW

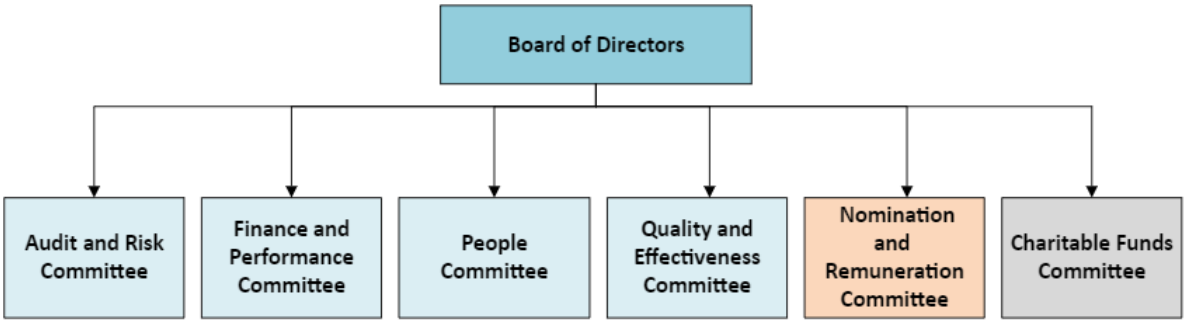
10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved …….
(Chair of the Board of Directors)

Date of approval ……..

Nominations and Remunerations Committee

Draft Terms of Reference V1.3



1. Constitution

The Nominations and Remunerations Committee (the Committee) is a standing committee, appointed by the Board of Directors ("The Board").

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.

3. Purpose

The committee is established to:

To review the structure, size, and executive composition of the Board of Directors, including nominations, succession planning, plus remuneration packages for executive directors and those not employed on Agenda for Change or medical contracts.

To approve arrangements for any redundancies, or special schemes (i.e. Mutually Agreed Resignations Scheme (MARS)). Authorise MARS payments over £80,000 or those payments where the Executive Team need further advice.

4. ROLES AND RESPONSIBILITIES

4.1 Nominations

4.1.1 Review the structure, size, and composition (including the skills, knowledge, and experience) of the Board and make recommendations to the Board about any changes.

4.1.2 Consider and make plans for succession planning for the Chief Executive and other executive directors.

4.1.3 Following appropriate recruitment processes and protocols, support the identification of candidates to fill executive director positions when they arise.

4.1.4 To Identify and nominate a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

4.1.5 Before an appointment is made evaluate the balance of skills, knowledge, and experience on the Board, and, in the light of this evaluation, support the preparation of a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the committee shall use open advertising or the services of external advisers to facilitate the search and consider candidates on merit against objective criteria. As part of this process ensure that the appointment process for the Chief Executive and executive directors meets the requirements of the Fit & Proper Person Test Framework.

4.1.6 Consider any matter relating to the continuation in office of the Chief Executive or any executive director at any time, including the suspension or termination of service of an individual as an employee of the Trust.

4.1.7 Consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

4.2 Remuneration

4.2.1 Decide and review the terms and conditions of office of the Foundation Trust's executive directors, considering national guidance and policy, including.
4.2.1(i) Salary, including and performance related pay or bonus.
4.2.1(ii) Provisions for other benefits, including pensions and cars; and
4.2.1(iii) Allowances

4.2.2 To monitor and evaluate the performance of individual executive directors.

4.2.3 To adhere to all relevant laws, regulations, and company policies, including, but not limited to, determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective.

4.2.4 To Advise upon and oversee contractual arrangements for executive directors, including, but not limited to, termination payments.

5. MEMBERSHIP

5.1 The membership of the Committee will be only non-executive directors including the Chair of the Trust.

5.2 The Board of Directors will appoint the Senior Independent Director (SID) as Chair of the Committee, in their absence, they can nominate another non-executive director to chair the meeting.

6. ATTENDANCE

6.1 Other people may attend the committee, as appropriate and with the specific invitation of the Committee Chair, however, they will be recorded as being 'in attendance' and not as being 'present'. These will include:
(i) Chief Executive or the Deputy Chief Executive in their absence.

(ii) Chief People Officer.
(iii) Trust Secretary, to provide administrative support as required.

6.2 Individuals shall not be present in the meeting when matters relating to their own terms and conditions of employment or remuneration are being discussed.

7. FREQUENCY OF MEETING

7.1 The Committee will meet at least annually.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

8. QUORUM

A quorum shall be not less than four non-executive directors including the Committee Chair or their deputy.

9. REPORTING

9.1 The minutes of all meetings of the committee shall be formally recorded by the Chief People Officer or Trust Secretary. These will be retained by the Chief People Officer and Trust Secretary for auditable purposes.

9.2 Following each Committee meeting, an update will be taken to the next confidential board meeting, an extra-ordinary confidential Board meeting can be called if the matter requires urgent attention.

9.3 The Committee will ensure that Directors' emoluments are accurately reported in the required format in the Trust's annual report.

10. REVIEW

10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved …….
(Chair of the Board of Directors)

Date of approval ……..

2411 - D7 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Day, Non-executive Director | 12:10

5 minutes

REFERENCES

Only PDFs are attached

D7 - Chair's Assurance Log - Finance and Performance Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Finance and Performance Committee Meeting	**Board Date: November 2024**
Prepared By:	Mark Day, Non-executive Director & Finance & Performance Committee Chair	
Approved By:		
Presented By:	Mark Day, Non-executive Director & Finance & Performance Committee Chair Mark Day	
Purpose	The paper summaries the **key highlights** from the Finance and Performance Committee meeting held on 29 October 2024	

Matters of Concern/Escalation Items (with Partial or No Assurance)	**Major Actions Commissioned / Work Underway**
Access Elective Recovery Plan - current forecasts indicate performance significantly behind plan. Directorate recovery plans being reviewed but initial indications show a residual shortfall and plans are not risk adjusted for winter pressures. **2024/25 Financial Performance and Forecast Outturn** - adverse forecast and slippage on CIP represents a significant risk to the financial position. **Access Standards** – figures show a deteriorating position since previous report, especially in relation to Unplanned and Emergency Care with, for example, significant numbers of patients (727) waiting in the ED for more than 12 hours and 13% of patients waiting for more than 1 hour in Ambulances before being admitted to ED. **Elective Activity Report** - concerns about day case activity and failure to reach target in Ophthalmology, Medical Ophthalmology, Trauma and Orthopaedics and Oral Surgery **EPR Update** - positive progress noted but still only partial assurance given complexities of discussions and delays introduced by requirements of other organisations involved. **BAF/Risk Register** - escalate financial risk to the next confidential Board meeting. Committee agreed to review and increase the risk for BAF 3, given partial assurances given in performance papers.	**Urgent and Emergency Care Improvement Plan** – received for information only, significant work being undertaken to redesign SDEC, frailty and ward length of stay management processes. **Getting It Right First Time Report** - work in progress. Committee welcomed the format of the new report which gives much more detail about the implementation of GIRFT recommendations and actions in the clinical directorates/divisions. **MEOC Consortium Agreement** – no paper presented, to be included in action log for presentation at next meeting. **Green Plan Delivery Progress Report** – Report presented for information – good progress noted and excellent external peer review of progress by the Trust. Work in progress **Integrated Health Care Programme – Doncaster Plan –** Report presented for information – good progress noted.

Significant or Full Assurances	Decisions Made
Capital Programme Progress Report – Full assurance	**Final Winter Plan** – Approved. Plan is aligned with NHS England plan published in September 2024. There was discussion about the risks inherent in not making allowance for unplanned challenges such as increased staff sickness or industrial action. **Terms of Reference and Workplan** – 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.

2411 - D8 CHAIR'S ASSURANCE LOG - QUALITY & EFFECTIVENESS COMMITTEE

Discussion Item | Jo Gander, Non-executive Director | 12:15

5 minutes

REFERENCES

Only PDFs are attached

D8 - Chair's Assurance Log - Quality & Performance 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: November 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 8 October 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Paediatric Audiology – **Partial Assurance** Following previous updates, significant challenges remain across the service, covering adult provision too, resulting in a limited service now being in place whilst issues are addressed. A full update to the Board of Directors in November is scheduled.	Risk ID 3209 -Patient tracking Inaccuracies a further update to be provided to December QEC to confirm completion. Restore audiology service provision including addressing the specific paediatric audiology improvements to ensure a safe and quality service is delivered. Quality & Effectiveness Committee Terms of Reference and Committee workplan
Significant or Full Assurances to Provide	**Decisions Made**
Full Assurance PSIRF Progress and Outcomes report CQC update Never Events Highlight report Mortality report inc. Mortality Data Quality Assurance Report (referred from ARC) Audit and Effectiveness Update Report	Paper to come to the next Committee re options appraisal to address areas escalated by the Audit & Risk Committee regarding the Data Quality Assurance Report

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.

2411 - D9 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

Discussion Item | Mark Bailey, Non-executive Director | 12:20

5 minutes

REFERENCES

Only PDFs are attached

D9 - Chair's Assurance Log - People Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board		
Subject:	People Committee Meeting	**Board Date:** November 2024
Prepared By:	Mark Bailey, Committee Chair & Non-Executive Director	
Approved By:	People Committee Members	
Presented By:	Mark Bailey, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 22 October 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Please see comments under **Workforce Supply & Demand** below.	**NHS England - Sexual Safety Charter** Policies, behavioural standards and training development to underpin commitment to zero-tolerance approach to unwanted, inappropriate and / or harmful sexual behaviours to our workforce. **Anti-Racism Organisation Commitment** Collaborative work at Doncaster Place and South Yorkshire ICB partners on anti-racism -focus likely to be on a charter, recruitment practices and training. **Bi-annual nursing workforce establishment review** Further data collection and analysis is underway to confirm or adjust ED workforce at DRI and to consider imminent service changes at Bassetlaw with the move into the Emergency Village development. AHP establishment review also underway to inform future planned AHP Biannual workforce reports, in line with National guidance. Data inaccuracies being worked through to ensure an accurate report to future PC. Safer Nursing Care Tool (SNCT) analysis confirms establishment levels are being met for nursing but the mix of registered to unregistered nurses falls below new national recommendations. A Trust Executive review is planned to review and consider options to progressively achieve the recommended skill mix.

Significant or Full Assurances to Provide	Decisions Made
People Strategy Full Assurance Overview of 'Year 2' plan and deliverables building from 'Year 1' which was covered in depth at June 2024 committee. High level performance measure attainment – milestones and outcomes. Recognition of indicators in supporting enabling work. **Engagement & Leadership**: Significant Assurance Trust level and local engagement on 2023 staff survey with clear actions. 2024 survey launched in September with adjustments reflecting experience to improve reach into all areas. National sexual safety at work charter and anti-racist organisation commitments. **Health & Wellbeing – Annual Report 2023-24:** Full Assurance Positive outcomes in 2023 Staff survey. National and regional recognition for innovative health initiatives. 360 Assurance independent audit – 'significant assurance' outcome. **Flexible Working – Annual Report:** Significant Assurance Growth in range and accessibility of formal and informal flexible working opportunities. Improvement noted in staff survey satisfaction level. **Education:** Significant Assurance Statutory compliance at end Sept 89.35% v. 90% target. Medical student / GMC survey improvement in 2024 with no indicators below national averages; higher regional ranking attained. Education & career promotion evidence – including 'We Care into the Future' events engaging 2,000 young people in Doncaster and Bassetlaw. **Appraisal Season 2024:** Significant Assurance Completion rate at 93.5%; exceeding 90% target for 1st time at DBTH. Post appraisal survey on quality of appraisal conversations providing assurance on linkage to performance objectives and opportunity to cover development and well-being. Compliance for medical annual appraisal at 1st April was 94.1% - noting IQPR data correction work is required. **Nursing & Midwifery Workforce review & Safe Staffing**: Significant Assurance Comprehensive report giving evidence of processes and outcomes / actions taken to monitor and ensure safe staffing against national care quality standards. Acknowledgement of much stronger positions on achieving establishment staffing levels with significant progress on agency usage and cost rates. **Workforce Supply & Demand:** Significant Assurance – grip & process /Limited Assurance on achieving / maintaining in steady state - full establishment skill levels. Update to the earlier comprehensive analysis of the workforce position by division, speciality / service and corporate area commensurate with 2024/25 business planning.	**Medical Appraisal / Revalidation** As a Designated Body for its employed doctors the Trust is required to submit an annual report for medical revalidation and appraisals and a Statement of Compliance to NHS England (NHSE). The People Committee has reviewed the 23/24 performance and assessment of compliance and is recommending signature by the Chief Executive. **Terms of Reference** The review and refresh of the People Committee terms of reference are considered appropriate for providing assurance to the Board that the Trust has structures, processes and controls for the effective delivery of the People Strategy. **Speaking Up (FTSU) – Bi-annual report:** Significant Assurance Comprehensive account of the performance against the 2024-28 Speaking Up Strategy using the delivery plan milestones for year 1 / 2. Report to be shared with DBTH Board.

Clarity on specific areas of risk and actions taken which have addressed or reduced challenged skill types. Continued work on scarce groups including potential system level approaches. Other assurance items: • **Flu vaccination** - report on lessons learned from 2023 staff flu vaccination programme and their incorporation into 2024 programme to increase uptake. • **Health & Safety** – analysis to understand and define recovery action to minimise moving & handling, slips, trips and falls and sharps incidents involving staff. Noted formation of cross discipline team working within Health & Wellbeing structure.	

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.

2411 - D10 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 12:25

5 minutes

REFERENCES

Only PDFs are attached

D10 - Chair's Assurance Log - Audit & Risk Committee September 2024.pdf

D10 - Chair's Assurance Log - Audit & Risk Committee October 2024.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Subject:	Audit & Risk Committee Meeting	**Board Date: November 2024**
Prepared By:	Kath Smart, Non-executive Director & Committee Chair	
Approved By:	ARC Members	
Presented By:	Kath Smart, Non-executive Director & Committee Chair	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 5 September 2024	

Matters of Concern (with moderate, partial, limited or no assurance)	**Work Underway / Major Actions Commissioned**
a) Limited Assurance Audit Report i. Mortality Data Quality Assurance Audit – This demonstrated there are areas for improvement in the process and 6 medium risk recommendations agreed by management covering improvement relating to the TOR & membership for the Mortality Governance Committee, oversight of the improvement plan, and establishing appropriate performance measures. The report is referred into QEC and an update on the progress with delivery of the Audit Recommendations is due back to Feb 2025 ARC. b) Key risks to escalate None	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery b) ARC requested oversight of the progress being made for Trust-wide Data Quality assurance/kitemarking to be reported back to F&P or ARC (dependent on timing) c) ARC requested that management/ TLT review where assurance sits in light of Mortuary & Pathology assurance, the Sir Jonathan Michael Report/ Pathology in light of discussions held at QEC and some cross over with other Committees (eg:Security Management). d) ARC TOR & Workplan – This has been reviewed and updated. In line with guidance and best practice, it has been agreed that Health, Safety, Fire & Security will no longer be the responsibility of ARC. As part of the due diligence during handover, ARC has asked for management to consider where these key areas report into in the Trusts management structure, and notes that future reporting will be to Finance & Performance Committee, with a significant element to People Committee. Management/ TLT were asked to review reporting lines to ensure this can be achieved. e) ARC Chair to meet with CIO to discuss CyberSecurity Assurances provided to ARC f) Post-Accounts de-brief held between Finance and EY with clear agreed actions, including the earlier production of the

	trusts Annual report for 2025 to facilitate smoother year end processes g) Risk Management – ARC has requested clear timeline of risk management training plans and rollout be brought to the committee. Progress has been made, but this action is still underway. h) Losses & Compensations – In light of repeated claims made in respect of patient property, ARC requested management to review whether a Qi / CIP project may be appropriate
Significant or Full Assurances to Provide	**Decisions Made**
a) **Cash & Treasury Management** – Significant Assurance b) **Data Security and Protection Toolkit** – Substantial Assurance Both reports presented a positive view of the areas under scrutiny and were welcomed by ARC c) **External Audit Results Report 23/24 - Annual Audit Report & finalised ISA 260 from EY** – The external audit conclusion was the same as reported in June, with a summary (see screen shot below). The only change was the finalised 8 control issues reported ARC & will be followed up on. EY to report to Council of Governors in Sept. d) **23/24 De-brief held between Finance Team and EY** – Key points have been agreed for 2024/25 process e) **Risk Management Annual Report** – This gave assurance on the progress made during 23/24, with key areas of focus for 24/25. 360 Assurance will review progress in Q4. f) **Single Tender Waivers** – Significant assurance for compliance with the Trust process g) **Losses & Compensations** – Significant Assurance for compliance with the Trust financial process. However, concern remains of the number and volume of hearing aids/dental /patient property losses which impact patient experience & trust Finances. See work commissioned. h) **Register of Interests, Corporate Hospitality & Sponsorship** – Significant Assurance was given to the process for ensuring a robust approach and the Committee acknowledged the positive steps resulting in a 81% compliance rate for declarations of interest for decision makers during Q1 i) **Health, Safety & Fire prevention** - The report demonstrated that overall system is in place and working to mitigate health & safety risks with significant assurance. The report covered detail on improvements to H&S assurances with the RoSPA	a) Standing Financial Instructions, Standing Orders, Reservation of Powers to the Board – These were reviewed and recommended for approval by the Board ; b) Requested a change of ARC date to October, so that this is ahead of the next BOD in November 24. c) ARC TOR & Workplan – The bulk was approved, with some final minor changes to be made before coming back to October ARC before being recommended to November 24 Board of Directors

accreditation, and arrangements in place to manage risk relating to Electrical Safety, Water Safety, Lifts, Ventilation, Asbestos management and Fire Safety. There are significant risks being pro-actively managed and monitored in these areas.	

Executive Summary (continued)

2023/24 Conclusions

Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its expenditure and income for the year then ended. We issued our auditor's report on 28 June 2024.
Parts of the remuneration report and staff report subject to audit	We had no matters to report. Management made a number of amendments to the remuneration report, in particular in relation to the table disclosing senior officers' remuneration and the disclosure of pay multiples
Consistency of the other information published with the financial statement	Financial information in the Annual report and published with the financial statements was consistent with the audited accounts.
Value for money (VFM)	We had no matters to report by exception on the Trust's VFM arrangements. We have included our VFM commentary in Section 03.
Consistency of the annual governance statement	We were satisfied that the annual governance statement was consistent with our understanding of the Trust.
Referrals to the Secretary of State	We made no such referrals.
Public interest report and other auditor powers	We had no reason to use our auditor powers.
Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £300,000 tolerance, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	We had no matters to report to the NAO.
Certificate	We issued our certificate as part of our opinion on 28 June 2024.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Audit & Risk Committee Meeting	**Board Date: November 2024**
Prepared By:	Kath Smart, Non-executive Director & Chair of the Audit & Risk Committee	
Approved By:	ARC Members	
Presented By:	Kath Smart, Non-executive Director & Chair of the Audit & Risk Committee	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 24 October 2024	

Matters of Concern (with moderate, partial, limited or weak assurance)	**Work Underway / Major Actions Commissioned**
a) Limited Assurance Audit Reports i. Bank and Agency Control Audit – This audit followed up on the 22/23 work, and demonstrated there are still areas for improvement in the process, with 4 medium risk recommendations agreed by management relating to refresh of & adherence to operational policies to ensure segregation of duties and appropriate control (SOPs). The report is referred into People Committee with IA following-up on closure of all actions; ii. Business Continuity Audit – This audit reviewed the Trusts business continuity plans and arrangements and highlighted 2 high, 2 medium and 1 low recommendation relating to refreshing the overarching strategy & policy, updating the business continuity plans from across the Trust (Divisions and Corporate areas); documenting testing of plans and debriefs/ lessons learnt from incidents; improvements to the EPRR Steering group and its Terms of Reference. b) Partial Assurance – was given by ARC for the Risk Management & BAF updates given to the Committee. Information provided in relation to the Risk Management activities was difficult to draw conclusion from, and the BAF showed some areas for improvement to improve compliance alongside the Trusts Risk Management Policy. ARC recommends that the Trust consider as part of its discussions in December:- i) Reviewing the Risk Management Policy to be clearer on requirements for the BAF and Risk information review at Board/ Committee level; ii) Improve the timing, process and consistency of review of the BAF & Risk Management; ARC will now review compliance with timetable (on behalf of Board) at each ARC meeting; iii) Currently ARC plans to review the BAF process at each of its ARC meetings in line with the current risk management strategy; c) Partial Assurance was given by ARC to the implementation of reviews/ visits/ inspections and accreditations Policy work. Progress is being made in this area, with more to do on	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery b) ARC TOR & Workplan – This has been reviewed and updated. In line with guidance and best practice, it has been agreed that Health, Safety, Fire & Security will no longer be the responsibility of ARC. As part of the due diligence during handover, ARC has asked for management to consider where these key areas report into in the Trusts management structure, and notes that future reporting will be to Finance & Performance Committee. Management/ TLT were asked to review reporting lines to ensure this can be achieved if revised TOR is approved by Board. c) Risk Management – ARC has requested clear timeline of risk management training plans and rollout be brought to the committee. This action is still underway. d) Losses & Compensations – In light of repeated claims made in respect of patient property, ARC requested management to review whether a Qi / CIP project may be appropriate. This action is still underway

collating and oversight of where the risks may lie following independent visits to the Trust. ARC has asked for a further update in 2025. d) Emergency Planning Core Standards Return – Following managements self-assessment of the Trusts processes against the required standards, 37/62 standards are fully compliant, 24/62 are partially compliant. This gives an overall score of 60% and equates to a "non-compliant" score in line with the assessment process. There is a full action plan which aims to increase compliance, but with dates past the end of March 2025, the Trust needs to declare non-compliant position. The EPRR return will be peer reviewed and results fed back to Audit Committee in due course. e) <u>Key risks to escalate</u> None	
Significant or Full Assurances to Provide	**Decisions Made**
a) **Payroll Audit** – Significant Assurance – This audit covered whether there is an efficient, effective and robust control environment in relation to pay expenditure. The review highlighted 1 medium risk in relation to controlling user access to the pay systems; b) **SBS** – Year End Assurance statement – Provided positive/ significant independent assurance to ARC that the financial systems have an adequate system of control c) **Security Management** - The report demonstrated that overall system is in place and working to manage security risks with significant assurance. The report covered detail on improvements to security assurances in relation to Mortuary security (following on from the Sir Jonathan Michale Report); Smoking enforcement; Security incidents; Lone Working; and Access control.	a) ARC TOR & Workplan – This was approved and is recommended for approval to November 2024 Board of Directors; b) EPRR Annual Assurance Statement – ARC reviewed the statement for EPRR which is an annual declaration, noting that peer review at ICB level is yet to take place. ARC noted the submission for recommendation to Board and asked for a consistency check between the Audit Report on Business Continuity (above a ii) before being signed off at Board.

2411 - D11 CHAIR'S ASSURANCE LOG - CHARITABLE FUNDS COMMITTEE

Discussion Item | Hazel Brand, Non-executive Director | 12:30

5 minutes

REFERENCES

Only PDFs are attached

D11 - Chair's Assurance Log - Charitable Funds Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Charitable Funds Committee Meeting	**Board Date:** 5 November 2024
Prepared By:	Hazel Brand, Committee Chair & Non-executive Director	
Approved By:	Committee Members	
Presented By:	Hazel Brand, Committee Chair & Non-executive Director	
Purpose	The paper summarises the key highlights from the Charitable Funds Committee meeting held on Thursday 19 September 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissioned**
Expenditure exceeded income by £106k in the four months to July 2024. Total overall funds are, however, £3.2m. Growing the charitable income is a key plank of the Head of Charity's action plan. **Moderate assurance** Trustees had asked that a project funded by the Charity should present at each Committee meeting. The colleague scheduled for this meeting did not attend. Trustees are, therefore, unaware of how successful the initiative had been. **Moderate assurance**	Further work commissioned: • setting up a pilot public lottery, including but not limited to colleagues from Finance, Procurement, Comms & Marketing, and Governance • developing a policy on use of the estate, including but not limited to colleagues from Governance, Estates & Facilities, Comms & Marketing • review the work plan
Significant or Full Assurances to Provide	**Decisions Made**
Colleagues planning fund-raising to be asked, as a matter of course, whether any of the 100 'dormant' funds can be used. **Significant assurance**	Approve the paper presented by Duncan Batty, Head of Charity (HoC), Doncaster & Bassetlaw Healthcare Services, specifically: • the need for investment to grow the Charity • the action plan and details of delivery of the objectives • setting up a public lottery • use of DBTH's assets and facilities, including estate, to promote the Charity and recognise projects funded by the Charity Approve the Committee Effectiveness Review. Approve the Charitable Funds Committee's Annual Report. At the March 2025 meeting, review Doncaster & Bassetlaw Hospital Services management of the Charity and its operation.

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.

2411 - D12 CHARITABLE FUNDS COMMITTEE ANNUAL REPORT 2023/2024

Discussion Item | Hazel Brand, Non-executive Director | 12:35

5 minutes

REFERENCES

Only PDFs are attached

D12 - Charitable Funds Annual Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**D12**
Report Title:	**Charitable Funds Committee Annual Report 2023/24**		
Sponsor:	Hazel Brand, Non-executive Director & Charitable Funds Committee Chair		
Author:	Angela O'Mara, Deputy Company Secretary		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

The Board is asked to receive and note the 2023/24 Charitable Funds Committee annual report, which provides an overview of the Committee's purpose, activity, membership and attendance. The report provides a summary of fundraising activities and the associated income and expenditure and highlights the focus of the Committee's work in 2024/25.

The annual report was approved by the trustees at the Charitable Funds Committee meeting of 19 September and is received for information.

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:		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:	Charitable Funds Committee		
Date:	19 September 2024		
Any outcomes /next steps	Approved by the Charitable Funds Committee and to be received and noted by the Board of Directors		
Previously circulated reports to supplement this paper:	N/A		

2411 - E STATUTORY & REGULATORY

2411 - E1 GUARDIAN OF SAFE WORKING REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 12:40

Mohammad Khan, Guardian of Safe Working
10 minutes

REFERENCES

Only PDFs are attached

E1 - Guardian of Safe Working Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**E1**
Report Title:	**Guardian of Safe Working Quarterly Report**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Mohammad I Khan, Guardian of Safe Working		
Appendices:	N/A		

Report Summary

Purpose of the report & Executive Summary

The previous report submitted to the Board in July 2024 had data included until 30 April 2024 and this report covers the period between 1 May 2024 until 6 August 2024. The reporting system changed from Allocate to HealthRota on 7 August and to simplify comparisons, all the data from that point onwards would be shared in the next report, which is likely to cover more than 3 months' period.

The number of Exception Reports (ERs) filed in this period were 32. Over these three months, the majority of Exception Reports have been by Trainees working in General Surgery (10), Ear Nose & Throat (7), Obstetrics/Gynecology (5) and in General Medicine (5). The majority of ERs were submitted in relation to additional hours worked (31), reflecting the high workload of Resident Doctors, often compounded by Rota gaps, inadequate locum provision, and unpredictable emergency care. There have been very few recent reports in relation to missed educational opportunities (1).

The cost of 'locum' cover increased over this quarter by a significant proportion. The main 2 reasons were to arrange cover for vacant shifts along with cover for on call and ward duties. The proportion of vacant shifts/ on call shifts to be covered were also compounded by sickness and junior doctors strike action leading in some specialties the requirement for stepping down of senior colleagues with much higher costs.

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

Recommendation:	The Board is requested to note the report and take assurance from the quarterly 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	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
		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:	-		

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

QUARTERLY REPORT ON SAFE WORKING HOURS:

DOCTORS AND DENTISTS IN TRAINING, DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Author: Mohammad I Khan, Guardian of Safe Working

Report date: 5 November 2024

Executive Summary

The number of Exception Reports (ERs) remains low and there were 32 ERs filed between 1 May 2024 and 6 August 2024.

From August 2023, an increase in training posts and a decrease in Rota gaps was associated with a decrease in locum costs. More recently, Rota gaps have again increased compounded by higher proportion of less than full time (LTFT) doctors employed as compared to before. As a rough comparison, the Rota gaps due to LTFT doctors were 4 times higher in June 2024 as compared to the start of year in 2024.

Over the past 3 months, the majority of Exception Reports have been by Trainees working in General Surgery, Ear Nose & Throat (ENT), Obstetrics/Gynecology and in General Medicine. The Paediatrics Department had previously encouraged Trainees to report and has participated in a successful regional Exception Reporting drive with changes made to the work schedule. It was quite encouraging to see that there was only one ER from Paediatrics as compared to much higher numbers in the previous quarter. Other specialties can learn from this and implement similar ER drives within their own departments in order to increase awareness and support for reporting.

In this quarter almost all ERs were submitted in relation to additional hours worked, reflecting the high workload of Resident Doctors, often compounded by Rota gaps and inadequate locum provision.

The Board of Directors can be assured that the vast majority of Trainee doctors are able to work safely. Resident Doctors have been able to access educational opportunities as envisaged in the 2016 contract in this quarter, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics. Departments have been requested to identify where this remains a challenge and to support Resident Doctors to maximise their training opportunities.

Introduction

This report sets out the information from the Guardian of Safe Working (GOSW) about the 2016 Terms and Conditions for Resident Doctors to assure the Board of the safe working of resident doctors. This report is for the period 1 May 2024 to 6 August 2024, although data from other months is used for comparison. The Board should receive a quarterly report from the Guardian as per the 2016 contract, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade
- Details of fines levied against departments with safety issues
- Data on rota gaps, vacancies and locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

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

Table 1. Number of exception reports by month, May 2024 to July 2024.

Month	Complete	Pending	Unresolved	Total
May 2024	11	0	0	11
June 2024	5	0	0	5
July 2024	12	0	0	12
Grand Total	**28**	**0**	**0**	**28**

There is seasonal variation in Exception Reporting (ER) with the highest number of monthly reports usually occurring during the winter months and in months of rotation like August. The latter coincides with Foundation Year 1 (FY1) Doctors commencing work and is likely due to a combination of awareness of exception reporting following Trust induction and adjusting to their new roles. There was a special 30 min presentation on ER reporting and its importance in August 2024 during the FY1 doctors' induction delivered by the Guardian of Safe Working.

There was a special drive to action the open ERs on Allocate software by the end of August as the reporting software was being changed to HealthRota on 7 August 2024. All open ERs on Allocate have been actioned and resolved with no outstanding ERs on the previously used Allocate software.

Table 2. Number of exception reports by specialty, May 2024 to July 2024.

Specialty	2024-05	2024-06	2024-07	Grand Total
Gastroenterology				0
General medicine	3	1		4
General surgery	3		5	8
Geriatric medicine				0
Renal Medicine				0
Accident and emergency				0
Obstetrics and gynaecology	3		2	5
Paediatrics				0
Otolaryngology (ENT)	2	1	4	7
Respiratory Medicine			1	1
Trauma & Orthopaedic Surgery				0
Vascular Surgery				0
Ophthalmology				0
Urology		3		3
Grand Total	**11**	**5**	**12**	**28**

Over the past 3 months, the majority of ERs have been submitted by Trainees working in General surgery (29%), ENT (25%), General Medicine (14%) and in Obstetrics/Gynaecology (18%).

Table 3: Number of exception reports by doctors' grade, May 2024 to July 2024.

FY1/2	CT1/2	ST1-3	ST4-8	Total
17	4	2	5	28

The vast majority of ERs were filed by Foundation year doctors indicating the pressure the doctors early in their careers are faced with especially in the major busy specialities.

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

Table 4. Reason for submission of Exception Report, 1 May 2024 to 6 August 2024.

Additional Hours Worked	88%
Change in pattern of work	3%
Service Support	0%
Educational opportunities	3%
Breaks	6%
Total	100%

Over the past Quarter, almost all (88%) of ERs were submitted in relation to additional hours worked, reflecting the high workload of Resident Doctors and emergency care requiring doctors to stay late in order to ensure patient safety. There was only one report made in relation to missed educational opportunities, which is reassuring to see for this quarter.

Table 5: Outcomes of Exception Reports (ER), 1 May 2024 to 6 August 2024

Exception Reports with TOIL granted	24%
Exception Reports with overpayment	56%
Exception Reports leading to work schedule reviews	0
Exception Reports with organisational changes	5%
Exception Reports with no changes/actions	15%

There were two ERs reporting missed breaks along with additional hours worked. One ER mentioned not being able to have a break until 6 hours into the shift. Both these ERs were flagged as immediate safety concern (ISC) by the reporting doctor and were dealt with appropriately in a timely manner.

As discussed at the July Board meeting, there were two ERs in the previous quarter which were flagged as ISC and both of these have been dealt with, actioned and closed. One was in Paediatrics where a senior trainee submitted a report due to lack of senior support, heavy workload and insufficient staffing leading to then feeling unsafe on a shift. This led to a detailed discussion with the educational supervisor acknowledging a very busy shift with a few sick children and consequent developing resuscitation scenarios. There was breakdown of communication within the team and further discussions involved the on call consultant as well. Steps were taken to ensure a senior nurse is present at ward round and better handover with improvement

of communication within the teams and improved senior support on shifts. The trainee was granted time off in lieu (TOIL) as they overstayed that night to finish pending jobs.

The second ISC was filed by a trainee in Obstetrics/Gynaecology. It was to do with a shift becoming understaffed when the second doctor was pulled away for a clinic leaving the on call doctor to carry two bleeps. This has happened at times and work needs to be done by the speciality to have alternate plans for such scenarios to minimise the risk of over burdening the resident doctors. This was discussed and assurances were made with the Trainee being granted TOIL.

b) Work schedule reviews

There have been no work schedule reviews this quarter.

c) Locum bookings

Locum and bank usage.
The cost of 'locum' cover has increased as compared to the first quarter of 2024. This coincides with a significant increase in vacant shifts as well as sickness and strike actions.

Emergency Medicine has the biggest usage of locum but other busy specialities like General Medicine, Orthopaedics and Obstetrics/Gynaecology are also among the specialities contributing to the locum cost.

The majority of locum cover since April 2024 was to provide staffing for rota vacancies. The number of locum shifts covering rota vacancies has increased steadily over the months. The main reasons for locum shifts were vacant shifts (53%), on call/Ward Cover (22%), sickness (5%), LTFT rota gaps (4%) and extra cover (4%).
The resident medical workforce have now resolved the national pay dispute and the gaps due to strike actions and the associated costs should not be an ongoing concern.

d) Vacancies

Rota vacancies have increased with some fluctuations in the last few months. Of the current Rota vacancies in July 2024, 9% of the Medical Specialty posts and 16% of Urgent and Emergency Care posts were unfilled compared with 60% of posts in Trauma and Orthopedics, 11% in General Surgery, 20% in Obstetrics/Gynecology, and 11% in Paediatrics.

In previous years, monthly Rota vacancies have varied between 30.9 WTE and 41.6 WTE (in 2022) and between 19.2 WTE to 31.4 WTE (in 2021). The monthly Rota vacancies in Jan 2024 were 46 WTE, which has changed slightly to 49.9 WTE in July 2024.

Table 6. Trainee vacancies by specialty May 2024 to July 2024.

	VACANCIES (WTE)	Posts	May	June	July
Medicine	**Specialty Medicine**	**65**	**5.5**	**5.5**	**5.5**
	FY1	**15**	1	1	1
	FY2	**2**	0.6	0.6	0.6
	CT/ST GPST 1-3	**25**	2.9	2.9	2.9
	ST3+	**23**	1	1	1
	Elderly Medicine	**23**	**2.7**	**3.3**	**3.3**
	FY1	**3**	0	0	0
	FY2 (No FY2 placements)	**1**	0	0	0
	CT/ST GPST 1-3	**15**	1.7	2.3	2.3
	ST3+	**4**	1	1	1
	Renal	**7**	**0.2**	**0.2**	**0.2**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2	**6**	0	0	0
	CT/ST GPST 1-3 (No CT/GPST placements)	**0**	0	0	0
	ST3+	**1**	0.2	0.2	0.2
U&EC	**Urgent & Emergency Care**	**40**	**6.5**	**6.5**	**6.5**
	FY1	**5**	0	0	0
	FY2	**5**	1.2	1.2	1.2
	CT/ST GPST 1-3	**28**	5.3	5.3	5.3
	ST3+	**2**	0	0	0
Women's & Children's	**Obstetrics & Gynaecology**	**26**	**5.4**	**5.4**	**5.4**
	FY1	**2**	0	0	0
	FY2	**1**	0	0	0
	CT/ST GPST 1-3	**12**	3.8	3.8	3.8
	ST3+	**11**	1.6	1.6	1.6
	Paediatrics	**32**	**4**	**3.8**	**3.8**
	FY1	**3**	0	0	0
	FY2	**1**	1	1	1
	CT/ST GPST 1-3	**20**	2.6	2.6	2.6
	ST3+	**8**	0.4	0.2	0.2
	GU Medicine	**2**	**0.4**	**0.4**	**0.4**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2	**1**	0	0	0
	CT/ST GPST 1-3	**1**	0.4	0.4	0.4
	ST3+ (No ST3+ placements)	**0**	0	0	0
Surgery & Cancer	**ENT**	**8**	**1.2**	**1.2**	**1.2**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2	**2**	0	0	0
	CT/ST GPST 1-3	**3**	0.2	0.2	0.2
	ST3+	**3**	1	1	1

	General Surgery	**18**	**2**	**2**	**2**
	FY1	**10**	0	0	0
	FY2	**1**	0	0	0
	CT/ST GPST 1-3	**5**	2	2	2
	ST3+	**2**	0	0	0
	Ophthalmology	**9**	**0**	**1**	**2**
	ST3+	**1**	0	0	0
	Urology	**5**	**7.4**	**7.4**	**7.4**
	FY1	**1**	0	0	0
	FY2	**2**	0.2	0.2	0.2
	CT/ST GPST 1-3 (No CT/GPST placements)	**0**	0	0	0
	ST3+	**2**	0	0	0
	Trauma & Orthopaedics	**6**	**3.6**	**3.6**	**3.6**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2	**1**	0	0	0
	CT/ST GPST 1-3	**5**	2.4	2.4	2.4
	ST3+	**4**	1.2	1.2	1.2
	Vascular	**8**	**5.2**	**5.2**	**5.2**
	FY1	**2**	0	0	0
	FY2 (No FY2 placements)	**0**	0	0	0
	CT/ST GPST 1-3	**2**	1.2	1.2	1.2
	ST3+	**4**	4	4	4
Clinical Specialties	**Anaesthetics**	**15**	**1.2**	**1.2**	**1.2**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2 (No FY2 placements)	**0**	0	0	0
	CT/ST GPST 1-3	**11**	1.2	1.2	1.2
	ST3+	**4**	0	0	0
	Radiology (POSTS DIS-ETABLISHED Oct 19-Oct 21)				
	ICT	**12**	**1.4**	**1.4**	**2.2**
	FY1 (No FY1 placements)	**0**	0	0	0
	FY2	**6**	0.4	0.4	1.2
	CT/ST GPST 1-3	**4**	1	1	1
	ST3+	**2**	0	0	0
	Total	**308**	**46.7**	**48.1**	**49.9**

e) **Fines**

No fines have been levied this quarter.

Qualitative information

The most recent Resident Doctor Forum meeting took place on 5 September 2024. The following points were discussed:

1. Implementation of HealthRota and its associated challenges

2. Challenges in Annual Leave requests in some specialities; leave requests in hours vs days
3. Encouragement to have Resident Doctors mess rep for DRI as well as BDGH

Summary

Ongoing exception reports highlight high workloads for Resident Doctors, especially in major busy Specialities despite significant improvements. High workload and understaffing are the usual causes for Resident Doctors being unable to undertake educational opportunities.

Engagement

The national annual Guardians Conference took place on 12 October 2024. The first half of the meeting was about neuro-divergent doctors, the challenges they face and the support that can be provided. The option of self-rostering and its use with success in certain areas of medicine was discussed. There was also focus on improving working lives of Resident Doctors by providing support in training, induction, avoiding payroll errors, reforming mandatory training and having a digital staff passport. The talk on train, retain and reform as part of the NHS workforce training and education plan was also shared.

The local quarterly Resident Doctors' Forum (RDF) took place in September 2024, with the next one planned for November 2024 with a special focus on Just Culture. The group has been renamed as Resident Doctors Forum (RDF), following the national change in terminology as part of the pay award discussions, and is open to all Trainee Doctors with the aim of improving engagement.

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

- Induction with new doctors especially FY1s and additional teaching sessions to reinforce the importance of Exception Reporting and addressing any underlying barriers to submitting ERs with both Trainees and Educational Supervisors.

- Specialty-specific training sessions regarding exception reporting aimed at Supervising Consultant colleagues has also been planned. Since the introduction of the new software system HealthRota for exception reporting, there have been some challenges both involving the software itself as well as getting engagement from the senior teams to register and get used to the new system. An awareness session with training has been planned in the Trust Medical Committee (TMC) for senior colleagues and is hoped to iron out some of the anxieties.

- Quarterly GOSW reports are submitted to the JLNC and TMC with regular involvement and discussion. Some Trainees have expressed concern about the lack of support they receive from senior colleagues to exception report; some have stated that they are discouraged from reporting. This has led to the dissemination of information about "when to Exception Report" to senior medical colleagues and promoting a positive culture of reporting within the Trust. This will be repeated as necessary to ensure Trainees are aware that they are encouraged to exception report and will be provided the necessary support needed.

- There is ongoing work collaboratively with the Freedom to Speak Up Guardian and Trust SuppoRTT Champions. Engagement sessions have already occurred and further sessions are planned to take place during Resident Doctor Forums.

Recommendation

The Board of Directors can be assured that a clear majority of Trainee doctors are able to work safely. General Medicine has been less of a concern since August 2023 with regards high workloads for Resident Doctors and there has been a more recent spread of ERs across different specialties. The number of training posts has increased and the proportion of training posts that have been appointed has increased significantly since August 2023. Other departments should implement an Exception Reporting drive similar to that successfully undertaken by the Paediatrics Department. The goal of which was to highlight the importance of reporting and to demonstrate senior colleague support with reporting. This helps to address any concerns Resident Doctors may have in relation to a negative reporting culture within the Trust. This has also helped in spreading awareness of exception reporting in other specialities and the potential of positive impact it can lead to for various teams.

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

2411 - E2 MATERNITY & NEONATAL UPDATE

Decision Item | Karen Jessop, Chief Nurse & Lois Mellor, Director of Midwifery | 12:50

10 minutes

REFERENCES

Only PDFs are attached

- E2 - Maternity & Neonatal Update.pdf
- E2 - Appendix 1 - ATAIN Dasboard.pdf
- E2 - Appendix 2 - Transitional Care Action Plan Progress.pdf
- E2 - Appendix 3 - Quality Metrics.pdf
- E2 - Appendix 3 - Quality Metrics.xlsm
- E2 - Appendix 4 - Saving Babies Lives Care Bundle.pdf
- E2 - Glossary of Terms - Maternity.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**E2**
Report Title:	**Maternity & Neonatal Update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse - Paediatrics		
Appendices:	1. Q2 ATAIN Report 2. Transitional Care action plan 3. Quality Metrics 4. Saving Babies Lives Care Bundle		

Report Summary

Purpose of the report & Executive Summary

The following paper 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

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:- • That Trust Board have been sighted on the number of MNSI / ENS cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place. • Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce have not been met and approved the progress update against previously approved action plan

	• Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal nursing workforce are not met and approved the progress update against previously approved action plan • Reviewed and approved Q2 ATAIN • Reviewed and approved the transitional care progress update against previously approved action 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		**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	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

Aug / September 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

There were 3 stillbirths in August and 1 in September.

2.2 Neonatal Deaths

There were no neonatal deaths in August or September.

2.3 Perinatal Mortality Review Tool (PMRT) 1.8.2024 to 30.9.2024

Date	Type of Death	Antenatal / Intrapartum / Neonatal	Information
June	Stillbirth	Antenatal	Booked at another trust In report writing stage
July	Stillbirth	Antenatal	Report published
Aug	Stillbirth	Antenatal	Report published
Aug	Stillbirth	Antenatal	Report published
Sept	Stillbirth	Antenatal	Planned for review in Nov

2.4 Learning from PMRT reviews

Issues
None identified, all care grade A and B.

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	29
Referrals / cases rejected	8
Total investigations to date	21
Total investigations completed	19
Current active cases	2
Exception reporting	0

There were cases referred to MNSI in August (1) and September (1) 2024, both have been accepted by MNSI and they are in contact with the families. Verbal duty of candour and duty of candour letter 1 has been given to the family. The service remains in contact with the families and updates on progress on a regular basis.

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 are two PSIIs in progress;

- One related to a number of common injuries during birth, there were no immediate themes identified. A detailed thematic analysis is nearly completed, no further similar injuries have occurred.
- One related to care provided when a pregnant woman attended the emergency department, a number of providers are involved and the LMNS is involved in the review.

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

The service is making steady progress on the single delivery plan, the baby friendly initiative assessment is due in October 2024. Work is continuing to recruit women for the assessors to speak to about their knowledge related to infant feeding for the assessment.

There is a continued focus on improving the culture and relationships in the maternity service. A number of sessions are being planned in the next few months with support from the Nursing and Midwifery Council, the General medical council and the Royal College of Midwives.

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

All lead obstetric roles have been advertised, and are currently being recruited to, to support delivery of the plan.

5. Training Compliance for all staff groups

Training figures as at August 2024 and September 2024 are detailed below:-

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

August 2024

Staff Group	K2 / CA Compliance Aug 24	Study Day Compliance Aug 24
90% of Obstetric Consultants & SAS Drs	**94.1%**	**94.1%**
90% of all other obstetric doctors contributing to the obstetric rota	**93.3%**	**93.3%**
90% of midwives including bank & agency staff	**93.3%**	**87.5%**

September 2024

Staff Group	K2 / CA Compliance Sept 24	Study Day Compliance Sept 24
90% of Obstetric Consultants & SAS Drs	**94.4%**	**94.4%**
90% of all other obstetric doctors contributing to the obstetric rota	**57.1%**	**50%**
90% of midwives including bank & agency staff	**99.5%**	**91.9%**

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)**.**

The new cohort of doctors commenced in August and all the new starters have been allocated a date for their training to achieve > 90% before final submission.

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

Table 3 & 4 - PROMPT figures

August 2024

Staff Group	Prompt Compliance Aug 24
90% of Obstetric Consultants & SAS Drs	**100%**
90% of all other obstetric doctors contributing to the obstetric rota	**57.8%**
90% of midwives including bank & agency	**85.2%**
90% of maternity support workers and health care assistants	**84%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**93.3%**
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%**

The new cohort of doctors commenced in August and all the new starters have been allocated a date for their training to achieve > 90% before final submission.

Sept 2024

Staff Group	Prompt Compliance Sept 24
90% of Obstetric Consultants & SAS Drs	**83.3 %**
90% of all other obstetric doctors contributing to the obstetric rota	**27.2%**
90% of midwives including bank & agency	**90.6%**
90% of maternity support workers and health care assistants	**87.5 %**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**93.3%**
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	**68.1 %**

Table 5 & 6 - NLS figures

August 2024

Staff Group	NLS Compliance Aug 24
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**100%**
90% of neonatal junior doctors (who attend any births)	**97%**
90% of neonatal nurses (Band 5 and above who attend any births)	**92%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**60%**
90% of midwives including bank & agency	**93.3%**

September 2024

Staff Group	NLS Compliance Sept 24
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**94%**
90% of neonatal junior doctors (who attend any births)	**93%**
90% of neonatal nurses (Band 5 and above who attend any births)	**95%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of midwives including bank & agency	**91.8%**

6. Safety Champion meetings

A meeting was held on 26th September 2024, where the board safety champion and non-executive director meets with the perinatal quadrumvirate leadership team.

6.1 Positive Points recognised

The neonatal unit visit was very positive, and nursing staff feel very supported in their roles.

6.2 Concerns raised by the visit and staff

No concerns were raised by staff on M1/M2 but there was a recognition that the ward manager post is currently vacant, the new manager commences in post in October. M1 has recently opened after refurbishment, and currently due to staffing M2 is temporarily closed, once the new qualified midwives commence in October 2024, and settle in the plan is to reopen M2 in December / January 2025.

6.3 Concerns raised by service users

Since the last board report the maternity and neonatal voices partnerships chairs have stepped down. This has been escalated to the local maternity and neonatal system, and the integrated care board. A meeting is planned to develop an interim solution until further recruitment is possible. The funding for the MNVP remain in place, and an ICB representative was expected to attend the meeting but another urgent meeting to attend. The service continues to strive to ensure that service user's voice is heard by working closely with changing lives.

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 perinatal quad and board safety champion are working closely together for continued and sustained improvements.

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

Nothing identified for the Trust Board.

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.

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.

Ongoing quarterly review meetings with the LMNS continue. Following these meetings the LMNS has confirmed that it is assured that all best endeavours and significant progress is being made in line with the locally agreed improvement trajectories.

Please see the attached Appendix 4 Board report for details.

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

Work 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. There is a planned assurance visit from the LMNS in October 2024, where the current evidence will be assessed.

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

August - 4
2 were perinatal mortality cases

September - 14
Mostly baby admissions to NNU, and jaundiced babies requiring phototherapy

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. The next report will be presented at board in January 2025.

Midwifery staffing

Midwifery staffing remains stable, and currently the service has 202.41 WTE contracted midwives against 225.04 WTE recommended. There are 18 newly qualified midwives commencing on 7th October 2024, with a further 6 commencing in November / December 2025.

All rotas are planned to have a supernumerary coordinator on every shift for August and September 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 87% recruited with 82% 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 79% 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 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 supported for year 1 and 2 of the proposal. Recruitment has commenced with plans to hold an open day in November
Below is a summary of the 4 year plan and current progress;

Year	Investment	Progress Update
2023/2024	Increase clinical roles to 25% uplift at SCBU and NNU	Business case approved - recruitment in progress
2024/2025	Quality roles on SCBU and coordinator at night NNU	Business case approved - recruitment in progress
2025/2026	24 hr coordinator for SCBU at night	We need to review the activity and acuity as this is a significant investment for a unit which has low activity. As part of this we need to understand the impact of transitional care on cot days.
2026/2027	AHP at recommendations	Not progressed as we review year 3 as described above

10.2 Obstetric Staffing

A new consultant obstetrician has been recruited, and will be commencing in the service soon.

Ongoing monthly monitoring of compliance of short-term locums and engagement of long term locums is continuing. In August/ September 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 August and September 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.

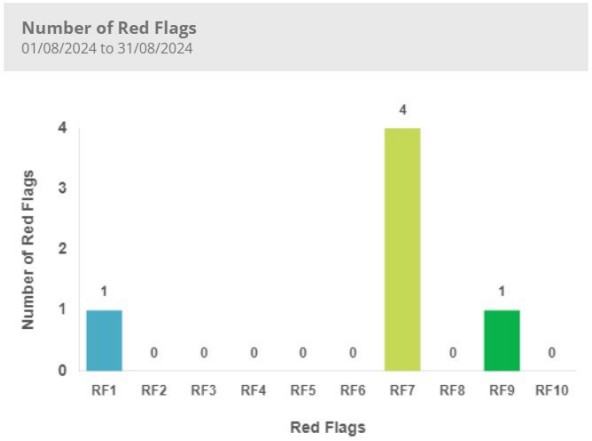
10.4 Anaesthetic Workforce

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 August and September have been recorded below:

Table 7 & 8 - DRI



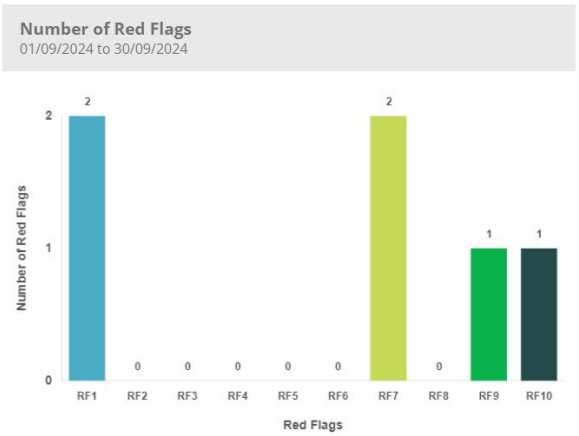
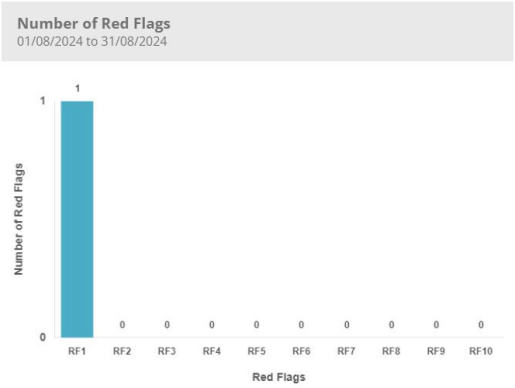
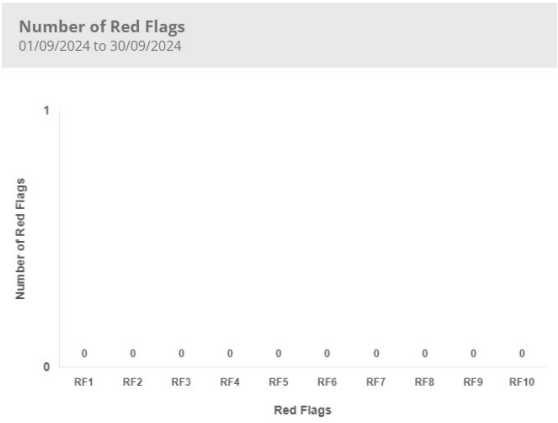


Table 9 & 10 - BDGH





Key

RF1 - Delayed or cancelled time critical activity
RF2 - Missed or delayed care
RF3 - Missed medication during an admission to hospital and midwife led care
RF4 - Delay in providing pain relief
RF5 - Delay between presentation and triage
RF6 - Full clinical examination not carried out when presenting in labour
RF7 - Delay between admission for induction and beginning the process
RF8 - Delayed recognition of and action on abnormal vital signs
RF9 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour
RF10 - Coordinator unable to maintain supernumerary status providing 1:1 care

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

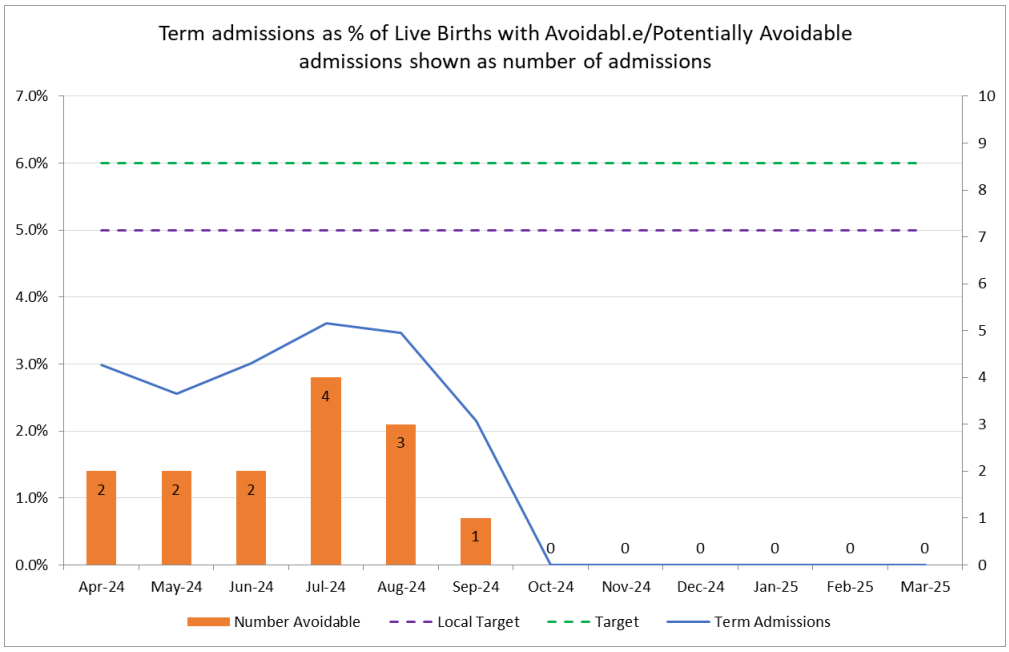
The service has an annual plan that has been developed in conjunction with the MNVP, and this work is ongoing. The MNVP does not have a chair at present and the LMNS are supporting DBTH to ensure that service user's voice is included. There is a meeting planned in October with the LMNS and ICB to organise an interim plan until a MNVP chair is appointed.

12. Avoidable Admission into the Neonatal unit (ATAIN)

12.1 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.

Attached is the Q2 ATAIN report (Appendix 1).

12.2 DBTH transitional care

The transitional care project progress has been shared at the Board safety Champion meeting, and governance meetings. The neonatal and maternity services are working together to improve the provision of transitional care. The opening of ward M2 will assist in creating a transitional care area, and this is plan in early 2025.

At November 2023 board meeting the transitional care action plan was approved. This was reviewed and updated in light of year 6 requirements and progress made from year 5.
The new action plan for a move towards a transitional care pathway based on the BAPM framework for babies from 34+0 was approved at the July board meeting and agreed that progress against the plan would be provided before the year 6 submission deadline. Attached is a progress update for review and approval and it is requested that approval be formally recorded in the minutes which is included in Appendix 2.

13. 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.

14. 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 the health inequalities meeting (no-one gets left behind) chaired by the planned care Matron welcome signs and information boards for neonates have been put outside the unit.

15. Perinatal Metrics

The maternity dashboard has been included in Appendix 3.

Metrics with significant deterioration:

- PPH > 1500mls
- Neonatal death rate

There has been a review of PPH's and a recent change to guidance about stopping aspirin in pregnancy earlier has been implemented. This has been potentially identified as contributing

to the increase in rates of PPH, the plan is to observe the rates over the next few months post the change in practice.

The number of neonatal death is very small, and the service is considering if the SPC charts are the most appropriate format for identifying trends. Each neonatal death is reviewed using the perinatal mortality review tool, and this is peer reviewed for learning opportunities.

Metrics with no significant change are:

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

Metrics with a significant improvement:

- HIE rate
- Stillbirth

Analysis and learning is currently in progress.

16. 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:

And formally record that:

- Neonatal Medical Workforce action plan progress update
- Neonatal nursing workforce action plan progress update
- Q2 ATAIN report
- Transitional care progress update against previously approved action plan

And formally record that:

- That the BAPM standards for neonatal medical workforce are not met and approve the attached progress update against previously approved action plan
- That the BAPM standards for neonatal nursing workforce are not met and approve the attached progress update against previously approved action 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.

Transitional Care Pathway Actions

Unit/Trust: Doncaster & Bassetlaw

Actions from Transitional Care Pathway/policy audits

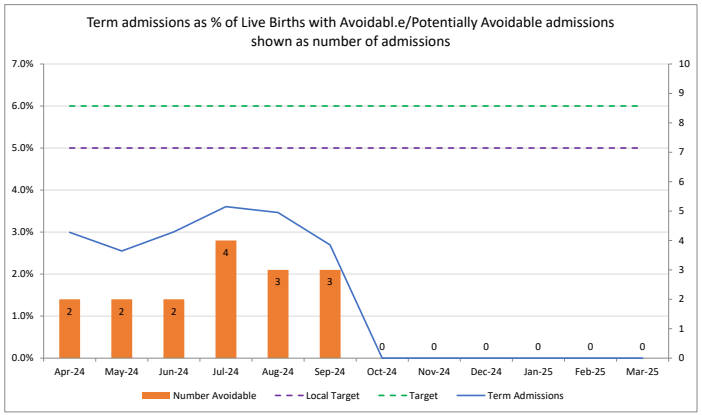
Month	Action	Responsible person	Deadline	Progress Made	Rag Rating	Trust Sign off: Group	Date	LMNS Sign off Group	Date
Apr-24	Currenlty TC babies admited to NNU/SACBU as TC service not fully implemented in DBTH. Qi project registered - to	Alex Merriman/Danielle Bhanvra	Nov-25	SEPT: Qi registrered, presented to BSC. Space identified on both sites		Divisional Governance	18.10.24		

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

SYB ATAIN - QI Dashboard V5.0

Unit/Trust: Doncaster & Bassetlaw **Completed by:** Alex Merriman

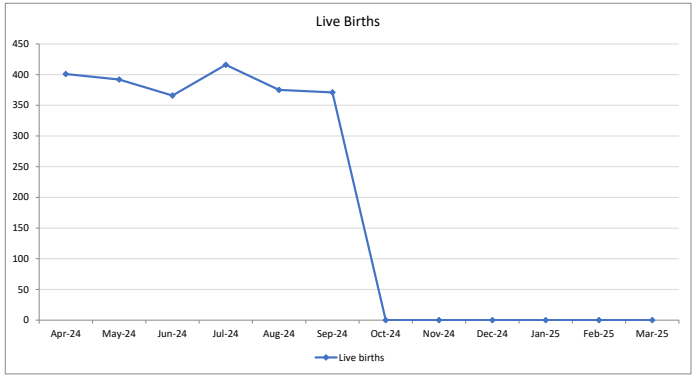
Month	Live Births All Gestations	All Inborn Admissions (excl transfers)	Inborn TERM admissions (37/40)	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions	Case Reviews MDT	Case Reviews Other
Apr-24	401	39	12	3.0%	5.0%	6.0%	2	16.7%	12	
May-24	392	25	10	2.6%	5.0%	6.0%	2	20.0%	10	
Jun-24	366	27	11	3.0%	5.0%	6.0%	2	18.2%	11	
Jul-24	416	29	15	3.6%	5.0%	6.0%	4	26.7%	15	
Aug-24	375	33	13	3.5%	5.0%	6.0%	3	23.1%	13	
Sep-24	371	32	10	2.7%	5.0%	6.0%	3	30.0%	10	
Oct-24				0.0%	5.0%	6.0%	0	0.0%		
Nov-24				0.0%	5.0%	6.0%	0	0.0%		
Dec-24				0.0%	5.0%	6.0%	0	0.0%		
Jan-25				0.0%	5.0%	6.0%	0	0.0%		
Feb-25				0.0%	5.0%	6.0%	0	0.0%		
Mar-25				0.0%	5.0%	6.0%	0	0.0%		



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

Enter each case only ONCE

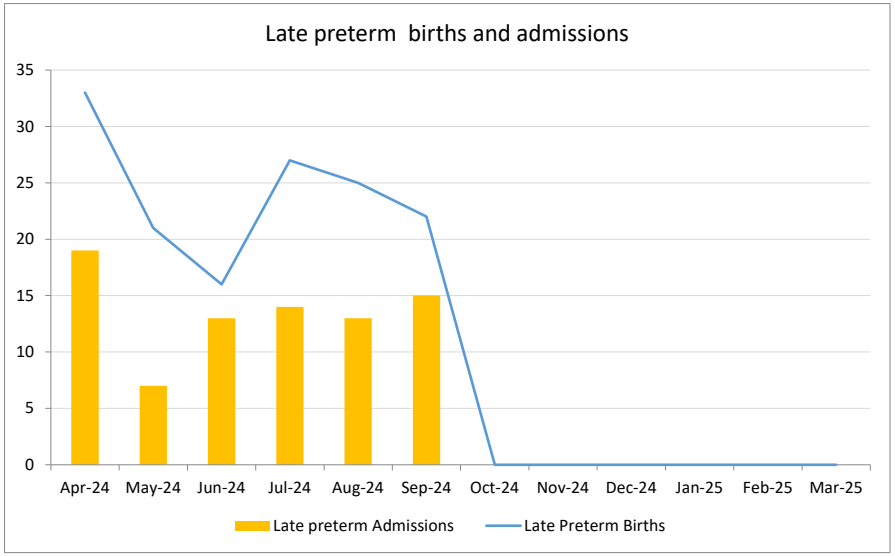
Primary reason	Secondary reason/detail	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Admitted to the NNU but would have met TC admission criteria	Apr - Antiobiotics, May - jaundice,	1	1		1	1	1							5
Admitted or remained on NNU for NG feeding	May - Hypoglyceamia. Aug; cleft lip		1			1								2
Management of a respiratory problem					1									1
Hypothermia/temperature management														0
Hypoglycaemia/management of blood glucose		1		1										2
Antibiotics														0
Requires period of observation														0
Observation following resuscitation														0
Suspected sepsis														0
Jaundice after 24h					1									1
Seizures where concerns with clinical care														0
Diagnosed NAS				1										1
Other: Social Reasons														0
Other: Congenital anomaly manageable on PNW														0
Other: Other	Fall				1									1
Other: Other	HIE					1								1
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Other: Other														0
Total		**2**	**2**	**2**	**4**	**3**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**14**



SYB ATAIN - Late Preterm Admissions

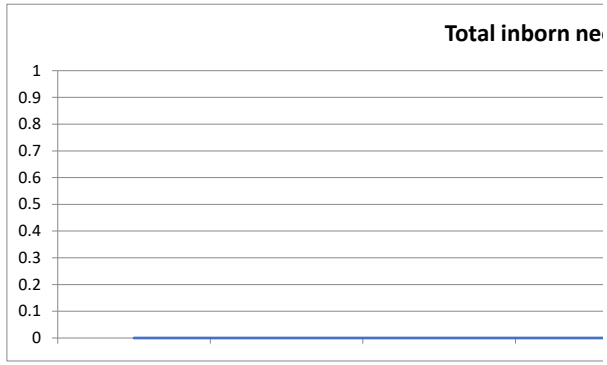
Unit/Trust: Doncaster & Bassetlaw

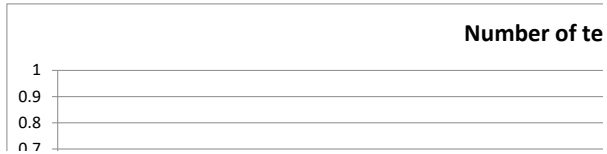
Month	Births 34 to 36+6 weeks Gestation	Admissions 34-36.6w gestation
Apr-24	33	19
May-24	21	7
Jun-24	16	13
Jul-24	27	14
Aug-24	25	13
Sep-24	22	15
Oct-24		
Nov-24		
Dec-24		
Jan-25		
Feb-25		
Mar-25		

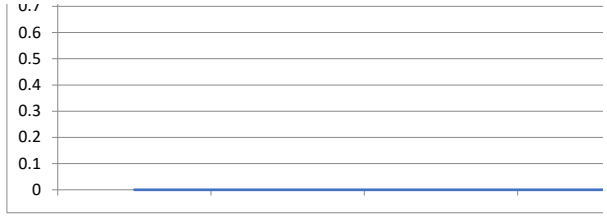


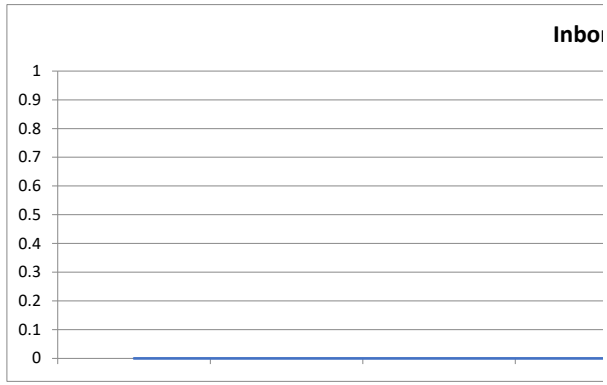
Actions from TC pathway for late pre-term babies (34 weeks to 36+6 weeks gestation)

Month	Action	Responsible person	Deadline	Progress Made	Rag Rating	Trust Sign off: Group	Date	LMNS Sign off Group	Date
Apr-24	Currenlty TC babies admited to NNU/SCBU as TC service not fully implemented in DBTH. Qi project registered - to								


Total inborn ne
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0


Number of te
1
0.9
0.8


0.7
0.6
0.5
0.4
0.3
0.2
0.1
0


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

ATAIN Actions

Unit/Trust: Doncaster & Bassetlaw

Actions from ATAIN reviews for babies >37 weeks gestation

Month	Action	Responsible person	Deadline	Progress Made	Rag Rating	Trust Sign off: Group	Date	LMNS Sign off Group	Date
Apr-24	Review antenatal information provide and amend leaflet/information. Ensure information available in a variety	A Merriman	Sep-24	MAY UPDATE: Local steriod leafelt being drafted. Currently using		Divisional Governance	18.10.24		
Oct-23	Quality Improvement project to implement Transitional Care	A Merriman/D Bhanvra	Apr-24	13/10/23 Draft guidelines cascaded for comments. MAY UPDATE: Qi		Divisional Governance	18.10.24		
Jun-24	work with SG midwives and SS team to ensure robust plans in place for babies in the antenatal period. If we had	R Turner/Safeguarding/C Biltcliffe/D Pollard	Sep-24	JUNE UPDATE: Email sent to SG Midwives to ask fro input re use of		Divisional Governance	18.10.24		
Aug-24	Ward manager and Infant feeding team to work together to ensure all stfaf aware of current guidnace and policy	R Turner/C Barber/L Sinfield	Nov-24	AUG: IFT info4rmed of action. Currently prioritising BFI		Divisional Governance	18.10.24		
Sep-24	Any case where CTG interpretatin found ot be a potenail inpacting factor pon admission is ot be sent to FM lead	E Swinburne/A Merriman	Jan-25	SEPT: New action this month.		Divisional Governance	18.10.24		
Oct-23	Datix to be completed when neonates are admitted with low temperature to identify underlying cause. Undertake QI	C Emmerson	Jul-23	Oct 23 Undertake data quality check against admissions and datix					
Mar-24	NAS Obs - high score on ward resolving quickly on admsission to NNU. Michelle Clark and A Merriman to work	M Clark/A Merriman	Jul-24	MARCH - education materilas shared by M Clarke. AM, LJ & KOS					

Year 6 CNST Action Plan - Transitional Care Progress Update

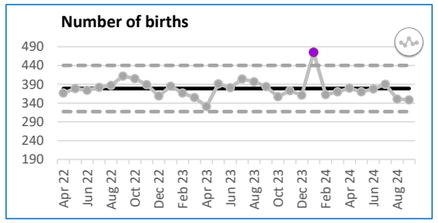
Action No	Action	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Completed	Progress Rag Rating	Comments/Evidence
1	Estates to support TC	Identify TC areas at both Doncaster and Bassetlaw Site	LJ/KO'S/ AM (CE)	Sep-24	Yes	Green	Areas identifed at both sites
2	Staffing model	Review current staffing model	DB/SF/AM (CE)	Sep-24	Yes	Green	To extend TC to full BAPM standards. TC requires additional staffing model at Doncaster and to be merged into SCBU at Basetlaw.Staffing model agreed
3	Band 3/4 training /badgernet	Develop training package for band 3 MSW and TNA. Liaise with ODN	AM (CE)	Mar-25	No	Red	ODN have an training package. Need new midwives in post then B3's then can start training
4	Meet with MNVP	Collaborate with MNVP on TC care/guidelines	LJ/KO'S/ AM (CE)	Mar-25	No	Red	Recuiting new MNVP chair.To plan initial engagement meeting when in post
5	TC guidleine to include full BAPM standards including NGT feeding is not being supported on TC reviewed at a later date	Once staffing model agreed and implement to review TC guidleine and include additional BAPM standards	DB /SF	Mar-25	No	Red	To implement full model with training to enable guideline to be fully implememted

Maternity overview

Trust Total

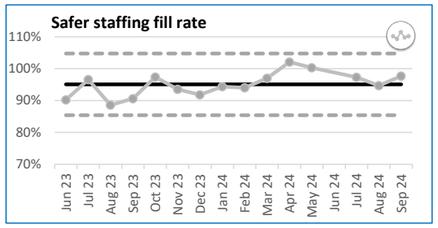
Latest month 01/09/24
Number of births **349**

No significant change



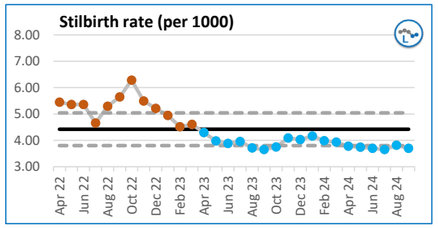
Latest month 01/09/24
Safer staffing fill rate **98%**

No significant change



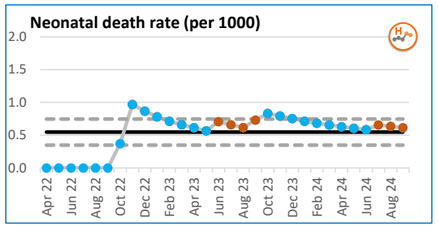
Latest month 01/09/24
Still birth rate/1000 **3.7**

Significant Improvement



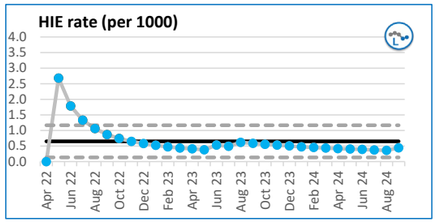
Latest month 01/09/24
Neonatal Death rate/1000 **0.6**

Significant deterioration



Latest month 01/09/24
HIE rate/1000 **0.4**

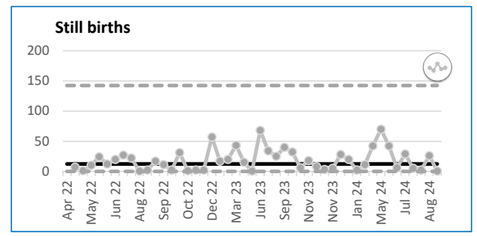
Significant Improvement



Date of last stillbirth 29/08/24

Average days between stillbirths **12.3**

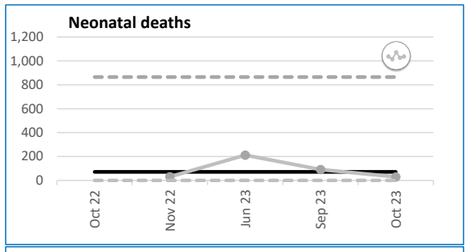
No significant change



Date of last neonatal death 01/10/23

Average days between deaths **71.6**

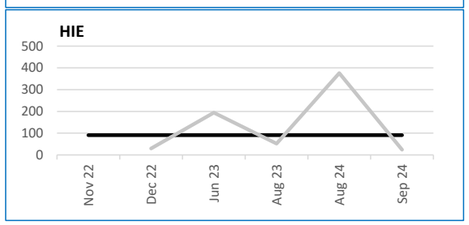
No significant change



Date of last HIE 11/09/24

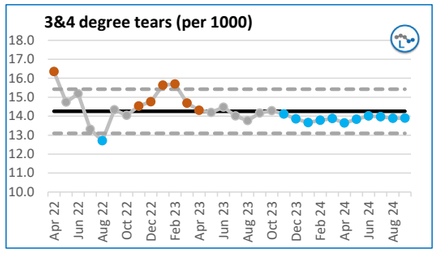
Average days between HIE **90.8**

No significant change



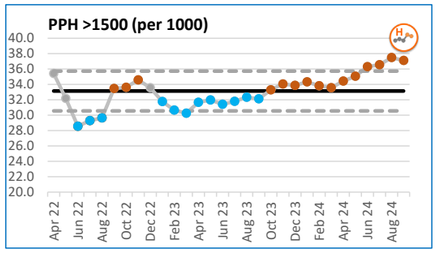
Latest month 01/09/24
3&4 degree tears (per 1000) **13.9**

Significant Improvement



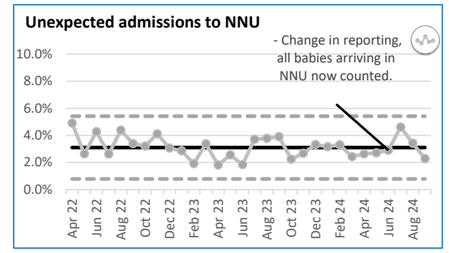
Latest month 01/09/24
PPH >1500 (per 1000) **37.1**

Significant deterioration



Latest month 01/09/24
Unexpected admissions to NNU **0.0**

No significant change



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

Implementation Report

Trust	**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
Date of Report	**19-Jun-24**
ICB Accountable Officer	**Cathy Winfield, Executive Chief Nurse**
Trust Accountable Officer	
LMNS Peer Assessor Names	**LMNS PMO Team - Programme Director, Obstetric Clinical Lead, Neonatal Clinical Lead,**

Background

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

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

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

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

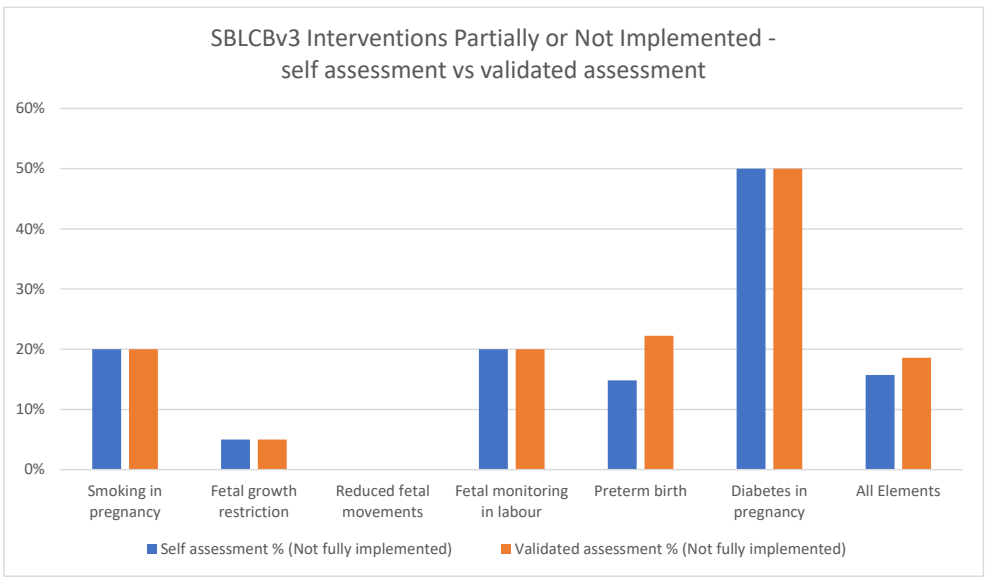
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

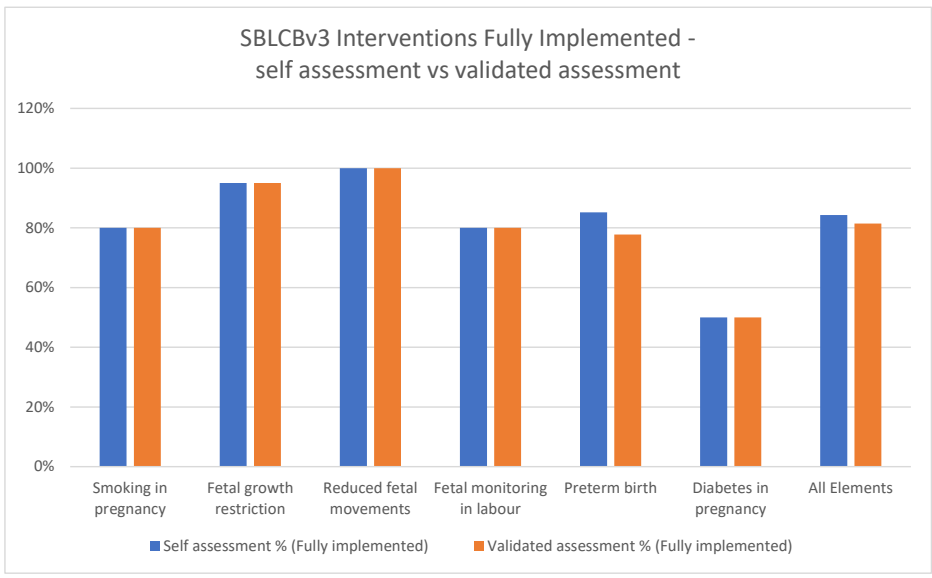
Implementation Grading

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

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	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	85%	Partially implemented	78%	CNST Met
Element 6	Diabetes	Partially implemented	50%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	84%	Partially implemented	81%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24 - discussed. Previously fully implemented but the Highlight Report shows a gradual decline over the quarter to below target for
1.4	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
1.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24 - discussed: % of women referred who set a quit date (1c) is 11.4% target > 30%. ABL is 13% and RDaSH are 9.8%. Target achieved for 1e (quit at 4 weeks) but to note ABL are low at 29%
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24 - discussed at meeting. Ongoing audit evidence required to demonstrate ongoing implementation.
1.8	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Sept 24 - remains partially implemented. Note progress in training compliance (now 66%) but <target trajectory. Rolling programme during 24/25 as per CCF - and data captured via ESR.
1.9	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - remains partially implemented. Note progress in training compliance (now 66%) but <target trajectory. Rolling programme during 24/25 as per CCF - and data captured via ESR.
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.

Element 2

INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24 - fully implemented during 23/24. Note reviewiing women booked during the quarter - so there were 9 women who had not yet reached this gestation. Discussion regarding cohort audited and
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.11	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Sept 24 - discussed. Trajectory difficult to predict as not a study day - matrons chasing teams to complete training and plan to be trained by end Q4.
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.

INTERVENTIONS

Element 3	3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
	3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
Element 4	**INTERVENTIONS**				
	4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
	4.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - to discuss. Note progress (71%) but <% target so remains partially implemented. Trajectory to implement amends to K2 was August 24 as a mandatory field - so improvement anticipated beyond
	4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
	4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
	4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
Element 5	**INTERVENTIONS**				
	5.1	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Sept 24 discussed: Obstetric JD / job p[lan rrequired. JD for maternal medicine midwife not preterm - new JD created to
	5.2	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Sept 24 - partial - PTB rate >national ambition. Local actions fully implemented and note improvement in PTB rate.
	5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring.
	5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. .
	5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. .
	5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
	5.16	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - discussed. Audit plan included as evidence. Results included in tool and <target trajectory so partially implemented? (Previously fully implemented) Plan to create huddle and improve
	5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.20	Fully implemented	fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept - 24: discussed. Fully implemented during 23/24. Continue with quarterly monitoring of implementation. To review birth interval data and confirm.
	5.21	Partially implemented	Partially implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24 - to discuss. Was previously fully implemented - Trust have moved this to refelct reducing performance. Note much better alignment to ODN data. Action plan in place.
	5.22	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - discussed. Note significant variation in local vs ODN data - plan to address? <90% target trajectory so remains partially implemented.
	5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24 - not progress (and data alignment) now fully implemented. Continue with quarterly monitoring.
	5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
	5.25	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - discussed. Compliance has varied and more recent data
	5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.

5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.

Element 6

INTERVENTIONS				
6.1	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Sept 24 - discussed. Ongoing discussions regarding separate clinics. Registered as a QI project and risk register. Trust Board sighted and working across divisions. Women are receiving care but is not
6.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Sept 24 - 100% of women offered CGM (fully implemented) Staff training element - information not received. Internal escalations.
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
6.4	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - discussed. Was previously fully implemented. Evidence uploaded and 20% indicated. Note that HbA1c is being taken either
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24.

Glossary of terms / Definitions for use with maternity papers

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

Lois Mellor
Director of Midwifery
Updated 24.6.24

2411 - E3 LEARNING FROM DEATHS

Discussion Item | Dr Nick Mallaband, Acting Executive Medical Director | 13:00

10 minutes

REFERENCES

Only PDFs are attached

E3 - Learning from Deaths Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**E3**
Report Title:	Learning from Deaths Update		
Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Mandy Dalton, Interim Learning from Deaths Manager		
Appendices:			

Report Summary

1. Purpose of Report and Executive Summary

This paper sets out to update the Trust's position with regards the Learning from Deaths (LFD) Framework.

Key points:

- A team of 25 senior clinicians and nurses have received training in undertaking Structured Judgement Reviews (SJRs)
- By the end of Q1 3.5% of in hospital deaths have been reviewed.
- A trajectory for SJRs to be completed in each quarter was agreed at the Mortality Governance meeting in September 2024.
- The Q1 Learning from Deaths report has been received by the Mortality Governance Group and a reporting schedule agreed for the remaining year.
- The first SJR team meeting was held in September providing further supervision to the reviewers and undertaking 2nd review on cases as necessary.
- Clarification has been sought in terms of the role of the Non-Executive Director in light of the Learning from Deaths framework and the NHS England's guidance (PAR994) of December 2021.
- SJRs continue to be undertaken when deaths are directly due to sepsis or pneumonia.
- Meetings have been held with AQUA (the suppliers of the SJR plus application). The first training workshop is in October 2024.
- The transition over to SJR plus will occur throughout Quarter 3.

2. Learning from Deaths (LFD) – July 2024

2.1 Background and Context:

The Learning from Deaths framework (DoH March 2015) set out 7 workstreams:

1. Delivering a new LFD Framework
2. Improving how Trusts engage with Bereaved families
3. Improving LFD of service users with learning disabilities or serious mental health illness
4. Improving the recording of information about patient death reviews

5. Improving the quality and consistency of investigations into patient deaths
6. Supporting Trust Boards to implement the new requirements
7. Improve how CQC assess all the above.

The LFD framework was published in July 2017. This emphasised that Trusts must collect and publish, via a quarterly report the following:

- Number of deaths
- Number of deaths subject to case review using SJR
- Number of deaths investigated under PSIRF
- Number of deaths investigated and considered more likely than not to be due to problems in care
- Themes and issues identified from reviews and investigations, including examples of good practice
- Actions taken in response and an assessment of the impact of the actions

The Trust employed a LFD lead and a quarterly LFD report was published from April 2017. SJR training was delivered by the Yorkshire and Humber Improvement Academy and a multidisciplinary team met monthly to extract themes for learning and quality improvement work was identified and actioned. What then followed was the national directive to set up an independent Medical Examiner (ME) team, (a system that will be statute from 9th September 2024), whilst this work was ongoing the LFD work slipped and along came the pandemic.

The ME team grew and became well established, but due to a variety of reasons the Learning from Deaths process suffered, with clinical teams assuming that the ME team had replaced the LFD work. The ME team are an independent body, funded by the National Medical Examiner's office with very specific good practice guidelines and rules to follow.

SJRs continue to be requested by the ME team based on the LFD guidance, however until recently returns of these had been extremely poor and there was no robust process in place for reviews and opportunities to learn from deaths to inform the Trust's quality improvement work.

2.2 Current Position

- A team of 25 senior clinicians and nurses have received training in undertaking structured judgement mortality reviews by the part-time Interim LFD Project Lead (who led this work back in early 2017). This is supported by the Yorkshire and Humber Improvement Academy.
- The reviewers are allocating protected time within their schedules to allow them to undertake this work.
- We have redeployed and trained a senior clinical member of staff to undertake reviews and thus increase our numbers in the short term.
- A sample of deaths due to sepsis and pneumonia have been reviewed since April 2024.
- A number of deaths due to peritonitis will be reviewed as these have triggered an alert via the Hospital Standardised Mortality Ratio (HSMR) data.
- The information department have developed a Mortality Dashboard identifying themes and trends of data which inform the Trust's HSMR and Summary Hospital-level Mortality Indicator (SHMI) numbers.
- It has been identified that Mortality and Morbidity activity is ongoing in several specialties but this work needs to be shared and captured through the Trust's governance work.

- SJR plus, an IT application to be used for capturing SJR data and producing dashboards for information sharing from the bed to the Board has been purchased. Training on its use has commenced.
- The LFD reports have recommenced with effect from 1 April 2024.

2.3 Q1 Structured Judgement Reviews

17 reviews have been requested via the ME team. This is 3% of the quarterly deaths and to date, 5 of these have been returned. We are aiming for 25 SJRs per month (15% of all in hospital deaths). A trajectory will be set in the Q1 LFD report.

In addition:

- 13 deaths due to sepsis have been reviewed and some initial themes are emerging.
- Senior review is good
- Recognition of deterioration is good
- Blood culture sampling is poor
- Delivery of antibiotics within 1 hour is poor.
- 7 deaths due to peritonitis have been identified from the Hospital Episode Statistics (HES) data which feeds into HSMR and SHMI performance. These deaths occurred between January 2023 and January 2024 and resulted in the Trust being an outlier for peritonitis deaths. Just 2 of these patients died as a result of peritonitis according to their Medical Cause of Death Certificates. Early findings of 5 of the cases demonstrate that the rules applied to the clinical coding of various conditions appear to be an issue.
- An action plan to improve clinical coding and depth of coding is in place and work underway.

2.4 Summary and Conclusion

- A permanent LFD Manager will continue to drive this work forward and ensure that the Trust is compliant with the LFD Framework. This person must have the skills to utilise the SJR plus app and use it to its full potential. The current interim arrangement will continue until April 2025 and a period of overlap would be beneficial by way of clinical supervision.
- Produce a quarterly LFD report, which recommenced from Quarter 1 2024/25. The schedule for presenting the Quarter 1 LFD report is as follows:
    - Mortality Governance Committee – September 2024
    - Effective Committee – November 2024
    - Quality and Effectiveness Committee – December 2024
    - Board of Directors – January 2025
- Collaborative working with the Patient Safety Incident Response Framework (PSIRF) leads to be established
- Communication with His Majesty's Coroners (HMC) to ensure they are aware that SJRs have no place in coronial investigations
- The Mortality Governance Policy to be updated to reflect the above.
- Monthly/bi-monthly Mortality Review Meeting established (first one held in September). This meeting ensures reviewers receive peer support and advice and will also pick up on the cases that require a 2nd review due to the 1st level review identifying any poor care.

Recommendation:	The Board of Directors are asked to: • Note the current position paper and update on the recommendations. • Take assurance from the ongoing mortality work and progress to date.			
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
		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:	National Guidance on Learning from Deaths, National Quality Board, March 2017.		
Resources:			

Assurance Route	
Previously considered by:	Quality & Effectiveness Committee
Date:	8 October 2024

BREAK 13:10 - 13-20

2411 - E4 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE - COMPLIANCE AGAINST THE NATIONAL CORE STANDARDS

Discussion Item | Denise Smith, Chief Operating Officer | 13:20

5 minutes

REFERENCES

Only PDFs are attached

- E4 - Emergency Preparedness Resilience & Response Annual Assurance.pdf
- E4 - Appendix A Core Standards Self Assessment.pdf
- E4 - Appendix B Deep Dive Self Assessment.pdf
- E4 - Appendix C Statement of Compliance 2024-25.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**E4**
Report Title:	**Emergency Preparedness Resilience and Response (EPRR) annual assurance process 2024/25**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:	Appendix A Core Standards Self-Assessment Appendix B Deep Dive Self-Assessment Appendix C Accountable Emergency Officer signed statement of compliance		

Report Summary

This report sets out the:

- Emergency preparedness, resilience and response (EPRR) annual assurance process for 2024/25
- Trust self-assessment against the EPRR Core Standards
- Accountable Emergency Officer signed statement of compliance

The Trust final self-assessment and Accountable Emergency Officer statement of compliance has been submitted. This showed a final self-assessment of 'fully compliant' in 34 of the 62 core standards and 'partially compliant' in 28 of the core standards. This gives 55% compliance and overall assessment of non-compliant.

Recommendation:	The Trust Board of Directors 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

		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:	• Civil Contingency Act 2004 • Health and Social Care Act 2012		
Resources:	No additional impact		
Assurance Route			
Previously considered by:	Audit and Risk Committee (October 2024)		
Date:	24 October 2024		
Any outcomes / next steps	Following consideration at the Audit and Risk Committee, the Trust self-assessment has been revised and three of the standards shown as 'fully compliant' have been amended to 'partially compliant'. The overall assessment of 'non-compliant' remains the same. **November 2024:** Formal review meetings will be held between the ICB and the Trust to review the submission **December 2024**: the final ratings for South Yorkshire will be shared with the NEY Regional Health Resilience Partnership (RHRP). The Trust Board will receive the finalised position and Statement of Compliance.		
Previously circulated reports to supplement this paper:	None		

1. Introduction

This report sets out the

- Emergency preparedness, resilience and response (EPRR) annual assurance process for 2024/25
- Trust self-assessment against the EPRR Core Standards

2. Background

The Trust has a responsibility for developing and monitoring compliance with the mandatory obligations within the Civil Contingencies Act (2004), and ensuring compliance with the National Guidance set out in the NHS England Emergency Planning Resilience and Response (EPRR) Framework (2015).

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process.

3. Final outcome of the annual assurance process for 2023/24

The Trust final self-assessment and Accountable Emergency Officer statement of compliance was submitted on 21 November 2023. This showed a final self-assessment of fully compliant in 19 of the 62 core standards and partially compliant in 43 of the 62 core standards, giving 31% compliance and overall assessment of non-compliant.

4. Annual assurance process for 2024 / 25

The Trust is asked to undertake a self-assessment against the individual core standards and rate the compliance for each. The compliance level for each standard is defined as follows:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

In addition, there is an annual deep dive, for 2024/25, this focuses on cyber security and IT related incidents. The compliance ratings against individual deep dive questions do not contribute to the overall organisational EPRR assurance rating.

The NHS South Yorkshire ICB timetable for the EPRR core standards assurance for 2024/25 is set out below:

- **30 September**: Organisations to submit to the numbers of the specific Core Standards where they expect to move to full compliance, requiring an evidence review.
- **31 October**: Self-assessment and submission of evidence
- **Early November:** Formal review meetings will be held between the ICB and each provider's AEO and EPRR teams to review their submission.
- **19 November:** Check & Challenge LHRP
- **Late November:** ICB meets with NHS England NEY team to review the South Yorkshire submissions.
- **2 December**: the final ratings for South Yorkshire will be shared with the NEY Regional Health Resilience Partnership (RHRP). Boards should then sign off the finalised organisational positions at the earliest opportunity following this date and share the paper(s) with the ICB.

5. Organisational assurance rating

The overall organisation assurance rating is based on the percentage of core standards the organisation assesses itself as being 'fully compliant' with, the criteria for each overall rating is as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against **89% - 99%** of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against **77% - 88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

6. Trust self-assessment

The Trust has completed the core standards and deep dive self-assessments; these are attached at Appendices A and B for information.

The core standards self-assessment shows the Trust as fully compliant in 34 of the 62 core standards and partially compliant in 28 of the 62 core standards; this gives 55% compliance and overall assessment of non-compliant. This is an improvement from 31% in 2023/24, although the Trust remains non-compliant overall.

7. Summary and next steps

The Trust self-assessments, evidence and statement of compliance (Appendix C) have been submitted to the ICB. During November 2024, a formal review meeting take place between the Trust and the ICB to review submission. In December 2024 the final ratings for South Yorkshire will be shared with the NEY Regional Health Resilience Partnership (RHRP). The Trust Board will then receive the final outcome for 2024/25.

8. Recommendations

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

Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Fully compliant	N/A	N/A	N/A
EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant	N/A	N/A	N/A
EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Partially compliant	The Accountable Emergency Officer will provide an EPRR Report to the Trust's Board of Directors (Public meeting) on an annual basis.	Chief Operating Officer	30 September 2025
EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant	N/A	N/A	N/A
EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Fully compliant	N/A	N/A	N/A
Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Fully compliant	N/A	N/A	N/A

Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Fully compliant	N/A	N/A	N/A
Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant	N/A	N/A	N/A
Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Partially compliant	Work with the ICB to determine processes for collaborative planning, to consider: - formal consultation routes; - records of consultation.	Chief Operating Officer	30 September 2025
Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Review and update the Trust's Major Incident Policy.	Chief Operating Officer	30 September 2025
Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Fully compliant	N/A	N/A	N/A
Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Partially compliant	Review and revise the Trust plans to respond to an infectious diseases outbreak	Chief Operating Officer	30 September 2025

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New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Review and revise the Trust plans to respond to a new and emerging pandemic	Chief Operating Officer	30 September 2025
Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Partially compliant	Review and revise the Trust plans to support an incident requiring countermeasures or mass countermeasure deployment	Chief Operating Officer	30 September 2025
Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Partially compliant	Review and revise the Trust plans to respond to incidents with mass casualties	Chief Operating Officer	30 September 2025
Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Update the Trust's Evacuation and Shelter Plan	Chief Operating Officer	30 September 2025
Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Review and revise the Trust plans to control access and egress in the event of an incident	Chief Operating Officer	30 September 2025

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Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	N/A	N/A	N/A
Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Review multi agency arrangements for excess deaths and mass fatalities to understand Trust role in the event of an incident	Chief Operating Officer	30 September 2025
On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners • Process explicitly described within the EPRR policy or statement of intent	Partially compliant	Develop and publish an On-Call Policy and handbook	Chief Operating Officer	30 September 2025
Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Partially compliant	Develop and deliver Trust training plan for on call staff	Chief Operating Officer	30 September 2025
EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Partially compliant	Undertake TNA for all staff involved in EPRR and ensure all relevant staff are fully trained	Chief Operating Officer	30 September 2025
EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Partially compliant	Develop and delivery annual exercising programme to test incident response arrangements	Chief Operating Officer	30 September 2025

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Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Partially compliant	Incorporate EPRR training records into staff corporate training records	Chief People Officer	30 September 2025
Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Partially compliant	Incorporate EPRR awareness into staff induction programmes	Chief Operating Officer	30 September 2025
Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Fully compliant	N/A	N/A	N/A
Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Fully compliant	N/A	N/A	N/A
Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Partially compliant	Review and revise the Trust's Business Continuity Strategy and Policy.	Chief Operating Officer	30 September 2025
Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Partially compliant	Ensure all relevant staff are aware of the need to maintain personal records and decision logs (to the required standard) and store appropriately. Ensure arrangements are in place to provide 24 hour access to trained loggists	Chief Operating Officer	30 September 2025
Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Fully compliant	N/A	N/A	N/A
Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant	N/A	N/A	N/A
Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant	N/A	N/A	N/A

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Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Fully compliant	N/A	N/A	N/A
Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Fully compliant	N/A	N/A	N/A
Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Fully compliant	N/A	N/A	N/A
Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Fully compliant	N/A	N/A	N/A
LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Fully compliant	N/A	N/A	N/A
LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Fully compliant	N/A	N/A	N/A

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Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Partially compliant	Work with the ICB to ensure that the Trust applies, and supports all Mutual Aid arrangements as appropriate.	Chief Operating Officer	30 September 2025
Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Partially compliant	Work with the ICB to ensure that the Trust applies, and supports all arrangements for Information Sharing as appropriate.	Chief Operating Officer	30 September 2025
BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Partially compliant	Review and update the Trust's Business Continuity Policy.	Chief Operating Officer	30 September 2025
Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Partially compliant	Review and update the Trust's Business Continuity Policy.	Chief Operating Officer	30 September 2025
Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Partially compliant	Refresh Business Continuity Processes in light of the updated guidance.	Chief Operating Officer	30 September 2025

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Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Partially compliant	Ensure business continuity plans are in place for the management of incidents	Chief Operating Officer	30 September 2025
Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Partially compliant	Undertake exercises to test BCPs - locally and Trust wide.	Chief Operating Officer	30 September 2025
Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Fully compliant	N/A	N/A	N/A
BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Partially compliant	Include KPIs and Business Continuity update in the Annual EPRR report to the Audit Committee and Board.	Chief Operating Officer	30 September 2025
BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Fully compliant	N/A	N/A	N/A

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BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Partially compliant	Include the maintenance and continual improvement of BC in annual EPRR report to the Audit Committee and Board.	Chief Operating Officer	30 September 2025
Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Fully compliant	N/A	N/A	N/A
Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Fully compliant	N/A	N/A	N/A
Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Fully compliant	N/A	N/A	N/A
Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Fully compliant	N/A	N/A	N/A

Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Fully compliant	N/A	N/A	N/A
Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Fully compliant	N/A	N/A	N/A
Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Fully compliant	N/A	N/A	N/A

Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Fully compliant	N/A	N/A	N/A
Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Fully compliant	N/A	N/A	N/A
Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Fully compliant	N/A	N/A	N/A
Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Fully compliant	N/A	N/A	N/A

Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Partially compliant	Ensure staff have access to and are trained in the use of appropriate PPE Ensure arrangements are in place to maintain stock levels of PRPS and FFP3 (or equivalent)	Chief Operating Officer	30 September 2025
Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Fully compliant	N/A	N/A	N/A

Ref	Domain	Standard	Deep Dive question	Supporting evidence- including examples of evidence	Self assessment RAG Red (not compliant) = Not evidenced in EPRR arrangements. Amber (partially compliant) = Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale
Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)								
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	Fully compliant	N/A	N/A	N/A
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'	Fully compliant	N/A	N/A	N/A
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	Fully compliant	N/A	N/A	N/A
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	Fully compliant	N/A	N/A	N/A

DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	Partially compliant	Exercise in a box to be reviewed and a decision made which is to be done and when. Business continuity exercises with divisions to take place by end of Apr 25	DL	30/04/2025
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	Partially compliant	SOPs are in place but do need implementing fully within the organisation.	JR / DL	31/01/2025
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	Partially compliant	TNA to be reviewed/refreshed	JB	31/01/2025
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package	Fully compliant	N/A	N/A	N/A
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	Partially compliant	DR datasheet to be finalised. Support to be given to divisions for cmpletion of BC plans.	JB	31/01/2025
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	Partially compliant	Actions per CS spreadsheet	JR / JB	31/03/2025
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Partially compliant		JB	31/01/2025

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-25

STATEMENT OF COMPLIANCE

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's Accountable Emergency Officer (AEO) pending submission to the Board / governing body together with the core standards and deep dive self-assessment.

Signed by the organisation's Accountable Emergency Officer

Date signed: 30 October 2024

2411 - E5 BOARD OF DIRECTORS REGISTER OF INTERESTS & FIT & PROPER PERSON TEST

Discussion Item

Rebecca Allen, Associate Director Strategy, Partnerships & Governance

5 minutes

REFERENCES

Only PDFs are attached

E5 - Board of Directors Register of Interest & Fit & Proper PersonTest.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	November 2024	**Agenda Reference:**	**E5**
Report Title:	**Board of Directors Register of Interest & Fit & Proper Person Test**		
Sponsor:	Suzy Brain England, Chair of the Trust Board		
Author:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance		
Appendices:			

Report Summary

Purpose of the report
This report provides the Board of Directors with information to demonstrate compliance with the new NHSE Fit and Proper Person Test (FPPT) framework.

Background analysis
The Fit and Proper Person Test is a regulation to ensure that NHS providers meet their obligations to only employ and retain board members who can comply to the requirements under the new NHSE FPPT regulations.

The recommendations from the Kark review have strengthened the testing and include:

- checks for disqualification as a Trustee from the Charity Commission Register,
- checks for disqualification as a company director from the disqualified director register
- Insolvency or bankruptcy order
- Upheld disciplinary findings
- Check on employment tribunal history, and
- Check on social media.
- Check all professional qualifications listed (Medical / clinical and accountancy professions)
- Each Board member is required to sign and return a self-attestation template that they are fit and proper).

For any Board member who leaves after the 30 September 2023, we are required to retain an exit reference on file, held on ESR until the age of 75 years, and to be supplied on request.

In order to confidently and quickly check social media and employment tribunal records, the Trust commissioned a professional service to carry out all checks. These are underpinned by algorithms which 'deep dive' into all on-line content as part of their searches.

The FPPT Board register is maintained by the Trust Secretary, with the supporting evidence files of the checks carried out to validate the self-attestation readily available for inspection as required by the CQC. All Declarations of Interest are held within the MES Declare system on line and can be viewed by members of the Public Doncaster & Bassetlaw NHS Trust .

Recommendation:	The Board is asked to note and take assurance that the appropriate checks have been completed in year and checked by the Trust Chair.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information~~

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
		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 **YES**		
Legal/ Regulation:	The Well led framework and the NHS Code of Governance requires the Trust to maintain and have available for the public, a register of interest and to annually assess all directors via the Fit and Proper Persons Test		
Resources:	NHS England » NHS England Fit and Proper Person Test Framework for board members		

Assurance Route	
Previously considered by:	N/A
Date:	N/A
Any outcomes/next steps	The annual return will be sent to the Regional Director NHSE
Previously circulated reports to supplement this paper:	N/A

2411 - E6 USE OF TRUST SEAL

Information Item

Rebecca Allen, Associate Director Strategy, Partnerships & Governance

5 minutes

REFERENCES

Only PDFs are attached

E6 - Use of Trust Seal.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	5 November 2024	**Agenda Reference:**	**E6**
Report Title:	**Use of the Trust Seal**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen Associate Director Strategy, Partnerships and Governance		
Appendices:			

Report Summary

Purpose of the report
This report provides the Board of Directors with details of any significant transactions requiring the use of the Trust seal.

Summary of Key Points
The Trust seal has been used, in line with the obligations set out in the Standing Financial Instructions four times since the Board of Directors last received a report on its use in respect of the following transactions:

Licence to occupy part of Montagu Hospital – Agreement with Aurora Wellbeing Centre
Date seal applied: 8 August 2024
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Aurora Well Being Centre
Signatories: Richard Parker, Chief Executive & Jonathan Sargeant, Chief Finance Officer

Licence to occupy part of Doncaster Royal Infirmary – Agreement with Aurora Wellbeing Centre
Date seal applied: 8 August 2024
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Aurora Well Being Centre
Signatories: Richard Parker, Chief Executive & Jonathan Sargeant, Chief Finance Officer

Lease – Agreement for substation at Montague Hospital Site
Date seal applied: 10 September 2024
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Northern Power Grid
Signatories: Richard Parker, Chief Executive & Jonathan Sargeant, Chief Finance Officer

Deed for variation to Lease agreement (above) for substation at Montagu Hospital Site
Date seal applied: 2 October 2024
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Northern Power Grid
Signatories: Richard Parker, Chief Executive & Jonathan Sargeant, Chief Finance Officer

Recommendation:	The Board is asked to **note** the report on the use of the Trust seal

Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information~~
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
	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 and the NHS Code of Governance requires the Trust to maintain and have available for the public, a register of interest and to annually assess all directors via the Fit and Proper Persons Test		
Resources:	NHS England » NHS England Fit and Proper Person Test Framework for board members		

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

2411 - F INFORMATION

2411 - F1 BOARD OF DIRECTORS WORK PLAN

Information Item | Rebecca Allen, Director of Strategy, Partnerships & Governance | 13:35

to follow

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	Frailty Services			
STRATEGY, PLANNING & PARTNERSHIPS										
Winter Plan	Chief Operating Officer	Annual	Nov-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	TBC - March 25							
~~Corporate Objectives - Quarterly Outcomes~~ Delivery Update 2024/25 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	Mar-25							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	Mar-25							
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	Every Meeting	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 July 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.*

2411 - G CLOSING ITEMS

2411 - G1 MINUTES OF THE MEETING HELD ON 3 SEPTEMBER 2024

Decision Item | Suzy Brain England OBE, Chair of the Board | 13:35

5 minutes

REFERENCES

Only PDFs are attached

G1 -Draft Public Board of Directors Minutes - 3 September 2024.pdf

DRAFT

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 3 September 2024 at 09:30 via MS Teams

Present:
Mark Bailey - Non-executive Director (from agenda item D3)
Suzy Brain England OBE - Chair of the Board (Chair)
Hazel Brand - Non-executive Director
Mark Day - Non-executive Director
Karen Jessop - Chief Nurse
Dr Emyr Jones - Non-executive Director
Zoe Lintin - Chief People Officer
Dr Nick Mallaband - Acting Executive Medical Director
Lucy Nickson - Non-executive Director
Richard Parker OBE - Chief Executive
Jon Sargeant - Chief Financial Officer
Kath Smart - Non-executive Director
Denise Smith - Chief Operating Officer

In attendance:
Ken Agwuh - Director of Infection, Prevention & Control (agenda item E4)
Rebecca Allen - Associate Director of Strategy, Partnerships & Governance
Danielle Bhanvra - Head of Midwifery (agenda item E1)
Mim Boyack – Infection Control Lead Nurse (agenda item E4)
Simon Brown - Deputy Chief Nurse (agenda item D5)
Sam Debbage – Director of Education & Research (agenda item D4)
Jane Fearnside – Head of Research (agenda item D4)
Angela O'Mara - Deputy Company Secretary (minutes)
Denise Phillip - Head of Safeguarding (agenda item E3)
Emma Shaheen - Director of Communications & Engagement
Julie Wragg - Person Centred Care Practitioner (agenda B1)

Public in attendance:
Rob Allen - Public Governor
Duncan Batty - Head of DBTH Charity
Mark Bright - Public Governor
Laura Brookshaw - 360 Assurance
Abbey Harris - Maternity and Neonatal Independent Senior Advocate (agenda item E1)
Gina Holmes - Staff Side Chair
Lynne Logan - Public Governor
Dave Northwood - Public Governor
Gavin Portier - Staff Governor
Chinwe Russell - Board Development Delegate
Khai Mohammad Shadhan - Board Development Delegate
Clive Smith - Public Governor

Apologies: Jo Gander - Non-executive Director
Zara Jones - Deputy Chief Executive
Lois Mellor - Director of Midwifery

P24/09/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and observers, the above apologies for absence were noted. No conflicts of interests were declared.

P24/09/A2 **Actions from Previous Meetings**

Action 3 - Integrated Quality & Performance Report - updated version provided @ agenda item D1 – action to be closed.
Action 4 - L2P Medical Appraisal System - action not yet due.
Action 5 - Refresh of Board Assurance Framework (BAF) – updated BAF @ agenda item D6 – action to be closed.
Action 6 - Board Assurance Framework 3 (Operational Performance) - updated BAF @ agenda item D6 – action to be closed.
Action 7 – Progress Report – Strategic Priority Success Measures – included @ agenda item C2 – action to be closed
Action 8 – Immediate Safety Concerns Exception Reports – action not yet due.

P24/09/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. Partnership work continued to be a key priority, with a good level of engagement across South Yorkshire & Bassetlaw Acute Federation.

Since the last Board meeting, the annual NHS Providers' Governor Focus Conference had taken place, as a facilitator at the event, the Chair of the Board shared her appreciation of governor engagement and contribution.

Expressions of interest were currently being sought for the role of Lead and Deputy Lead Governor.

The Trust's pre-recorded Annual Members Meeting would be broadcast at 6pm on 26 September 2024, and questions were invited from governors and members of the public.

The Board:

- ***Noted the Chair's Report***

P24/09/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's attention was drawn to the improved Care Quality Commission's 2023 inpatient survey results, which were above the national average and work to build upon this achievement would continue. More recently, a Friends and Family Test, specifically

related to the Mexborough Elective Orthopaedic Centre demonstrated outstanding satisfaction results, which the Chief Executive confirmed was a testimony to colleagues' efforts in establishing the facility. Partner Trusts continued to work collaboratively to ensure utilisation was maximised.

The Trust's challenging financial position was noted, with NHS South Yorkshire recently named as one of nine integrated care systems subject to review by NHS England as part of the Investigation & Intervention Programme. The paper highlighted the current and projected deficit and the planned actions and areas of focus to ensure a balanced approach considering the three core pillars of safety, quality and finance. The importance of strong financial management was recognised, drawing upon the Trust's expertise and historical efforts of overcoming such challenges.

Non-executive Director, Kath Smart acknowledged the internal communications regarding the financial position and enquired of colleagues' feedback, the Director of Communication & Engagement confirmed this had been limited but further views were expected in the post-Board Team Brief and a number of cost saving suggestions had been received in response to the request for ideas.

In response to a question from Non-executive Director, Hazel Brand, the Chief Executive confirmed that where a member of the public became unwell in an on-site catering facility provided by an external supplier, they had a responsibility as part of health and safety regulations to have a designated first aider. In addition, Trust colleagues were encouraged to be aware of visitors and check on individuals where concerns arose regarding their welfare.

Non-executive Director, Kath Smart highlighted a successful summer event, featuring speakers, music and dance in celebration of the cultural diversity of the Trust and the contribution of international colleagues.

The Associate Director of Strategy, Partnerships & Governance shared with the Board colleague feedback welcoming the compassionate approach taken by the Trust, and in particular the Chief Executive and Chief People Officer, in respect of the care demonstrated to colleagues who may have been affected by the recent rioting.

The Board:

- ***Noted the Chief Executive's Report***

P24/09/B1 **<u>Wendy's Story (Enclosure B1)</u>**

The Chief Nurse introduced Julie Wragg, Person Centred Care Practitioner, to share the experience of Wendy, a patient living with dementia, the subsequent learning and change in practice associated with her care.

Wendy began to show symptoms of dementia at the age of 35 and was originally misdiagnosed with depression, it was not until five years later that she received a diagnosis.

In early 2022, following a fall at home, Wendy was brought to the hospital's Emergency Department by ambulance, and subsequently raised her concerns with the Trust Patient Advice & Liaison Service regarding the experience and care she had received during this visit.

Arrangements were made for Julie to meet with Wendy, who was keen to share her experience of living well with dementia. With the support of a personal assistant, Wendy lives independently, is Vice Chair of Doncaster Dementia Collaborative and plays an active role in improving services for people with dementia in the Doncaster community. and whilst there were positives to report, Wendy's belief was her experience was directly linked to her dementia diagnosis and she was keen to focus on aspects of learning associated with this.

Whilst Wendy received an apology from the Trust for the care received, there was no offer of a solution, or improvements to ensure others did not receive the same treatment.

Training had subsequently been implemented to improve the quality of complaint responses, the complaint policy had been reviewed and reporting and analysis of learning improved.

There was an increased focus on person centred care, including mobility and a relaunch of John's Campaign to ensure the carer of a patient with dementia had extended access rights.

Colleagues had undertaken dementia interpreter training and attended the dementia tour bus which simulates how it feels to live with dementia.

The Chair of the Board thanked Julie for sharing Wendy's story and the powerful impact of hearing the very personal experience was recognised by the Chief People Officer.

The Chief Nurse recognised the ongoing work to embed revisions to the response to complaints, with all complaint letters reviewed by the Chief Nurse ahead of Chief Executive sign off.

Non-executive Director, Emyr Jones and the Acting Executive Medical Director recognised the challenges of accessing medical records between general practice and the Emergency Department due to a lack of integration.

Non-executive Director, Kath Smart acknowledged the importance of communication, with many patients not able to communicate, the role of the carer was crucial and the relaunch of John's Campaign and the Visitors Charter recognised this.

The Chair of the Board shared her thanks with Wendy for sharing her story and encouraging the learning.

The Board:

- ***Note and take assurance from Wendy's Story***

P24/09/C1 **<u>Winter Plan Briefing 2024/25 (Enclosure C1)</u>**

The paper shared the Trust's approach to 2024/25 winter planning and a forecast of demand. In the absence of national guidance, the focus was on delivery of the high impact priority interventions in NHSE's Urgent & Emergency Care Recovery Plan. It was predicted that demand would peak in December 2024 for Bassetlaw and February 2025 for Doncaster.

Where elements of the plan were reliant on partnership working, Non-executive Director, Emyr Jones enquired what options could be explored if support was not available in the community. The Chief Operating Officer confirmed her intention to:

- engage in conversation with partners regarding the use of the Better Care Fund to support care outside of the hospital
- correspond with Place to identify the levels of patients requiring community care, to determine a variance to expected costs
- discuss "step up" virtual ward provision

Work to understand why conveyance and referral rates to hospital were higher in South Yorkshire was the subject of an Integrated Care Board's programme of work.

The need for a robust partnership approach was reinforced and where the lack of community provision impacted upon costs, the option to recover would be explored.

In response to a question from Non-executive Director, Kath Smart with regards to escalation plans where demand exceeded capacity, the Chief Operating Officer advised speciality teams would assist with assessment in the Emergency Department, the safe discharge of patients would be expedited and the use of virtual wards encouraged. A daily escalation call with partners would take place to review delayed discharges.

Non-executive Director, Hazel Brand enquired what plans were in place to maximise the uptake of the influenza vaccine by colleagues, the take up rate locally and nationally had reduced last year and learning had been established. Occupational Health and peer vaccinators would support this year's campaign, which would be extensively promoted across the Trust. The Chair of the Board encouraged colleagues to take up the vaccine for their own and patients protection.

The Chief Executive recognised the reduced level of interest in influenza and covid vaccinations and stressed the importance from an individual, community, and public service perspective. The planned opening of the Bassetlaw Emergency Village and Mexborough Elective Orthopaedic Centre (MEOC) would also support the winter plan, with the advantage that MEOC was not impacted by winter and emergency pressures.

In response to a question by Non-executive Director, Lucy Nickson, the Chief Operating Officer confirmed that the detailed planning had been led by divisional colleagues, with check and challenge by operational and finance colleagues. The final winter plan would be received by the Finance & Performance Committee before presentation to the Board of Directors.

The Chief Financial Officer confirmed that the forecast allowed for additional costs during the winter months. Historically, the Chief Executive acknowledged there may have been

reserves, however, until national guidance was received plans were on the assumption that no additional funding would be made available.

The Board:

- ***Noted the Winter Plan Briefing 2024/25***

P24/09/C2 **Strategic Priorities – Delivery Update (Enclosure C2)**

The report provided a mid-year update on progress against the key success measures identified to support delivery of the Trust's strategic priorities and the refresh of the Trust's strategy. Delivery of the operational and financial plan and progress towards becoming a digitally enabled organisation were reported to be off track and the supporting narrative was provided in the accompanying delivery update slide deck.

Non-executive Director, Kath Smart questioned the on track rating assigned to the success measure relating to clinically effective and efficient services, in view of the limited assurance audit reports in respect of mortality data quality assurance and the ongoing work related to Getting It Right First Time, as the impact was yet to be realised. The Chief Executive confirmed the assessment was reflective of the progress of plans, rather than delivery of the improvement at this stage in the year. Challenge in respect of the change was both appropriate and welcomed and as a member of the Finance and Performance Committee, Kath Smart confirmed the detailed scrutiny as part of these meetings and the open and transparent reporting and efforts were acknowledged. In terms of elective activity narrative and a forecast position within the Integrated Quality & Performance it was agreed this would be subject to further debate as part of the Making Data Count Board Workshop.

The Board:

- ***Noted and took assurance from the Strategic Priorities – Delivery Update***

P24/09/D1 **Integrated Quality & Performance Report (Enclosure D1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to access, quality, and workforce standards for July 2024. The format continued to be iteratively developed and included an executive summary, key performance indicators, assurance reports and a summary of future developments of the IQPR.

The Executive Directors summarised their respective key performance indicators.

Non-executive Director, Emyr Jones welcomed the inclusion of the statistical process control charts, to see the trend and impact of interventions. More detailed analysis was to be presented to the Quality & Effectiveness Committee relating to sepsis and mortality.

In response to a question from Non-executive Director, Kath Smart regarding a dip in Emergency Department performance from March 2024 and how previously identified good practice could be taken forward. The Chief Operating Officer acknowledged the

importance of moving the patient out of the department within one hour of the inpatient bed becoming available. Whilst there was a heightened sense of awareness in respect of emergency care flow there was a need to embed practice as business as usual.

Kath Smart noted the inclusion of mixed sex accommodation breaches and enquired of the learning to avoid such breaches and where this would be reported to from a governance perspective. In addition to the Clinical Site Team and divisional colleagues reporting was expected via the Performance Review Meeting and to the Caring Committee.

Where a risk ID was provided as part of the IQPR assurance report, Kath Smart stressed the need for the performance and risk to be aligned, where a risk was sat on a divisional risk register it would be helpful if this was included.

Non-executive Director, Hazel Brand enquired of the Chief Operating Officer's level of confidence that productivity in outpatients and theatres could be increased, whilst good levels of improvement had been seen in on the day theatre cancellations, there was further work required to deliver the core, elective and theatre improvement plans

The Board:

- ***Noted and took assurance from the Integrated Quality & Performance Board***

P24/09/D2 **Financial Position & Financial Plan Update (Enclosure D2)**

The Chief Financial Officer reported a month four deficit of £2.5m, £400k adverse to plan and a year to date deficit of £16m, £2.5m adverse to plan. The Trust's year to date position was mainly driven by elective recovery fund underperformance against a plan of £3.3m and a pay overspend of £1.7m, partly offset by an underspend on independent sector work of £1.2m and a one-off benefit of £1m.

The cash balance at month four was £14m.

The total year to date capital spend, excluding donated assets and charitable funds, was £5.4m, against a plan of £5.1m, with a charitable funds capital spend of £2.45m related to the da Vinci® and stroke rehabilitation robots.

In month, the Trust had delivered £1m of savings against a plan of £1.3m, £3.1m of savings had been delivered year to date, against a plan of £3.1m.

A reforecast had taken place at the end of month two, at the request of the Finance & Performance Committee and a number of actions had been identified, including temporary staffing controls, non-pay costs linked to clinical supplies, services and high costs drugs and a revision to the elective recovery plan to ensure the Elective Recovery Fund target was met.

Providers across the system were working collaboratively on cost improvement programmes and sharing best practice. NHS South Yorkshire were subject to NHSE review as part of the Investigation & Intervention Programme and Chief Financial Officers and Chief Executives were working closely with the Integrated Care Board.

Non-executive Director, Lucy Nickson acknowledged the assurance provided, in challenging circumstances.

The Chair of the Board confirmed her request at the Acute Federation Board for more sustainable solutions from the Integrated Care Board.

The Board:

- *The Board noted the financial position and financial plan update*

P24/09/D3 **Healthcare Support Worker Band 2/3 Project (Enclosure D3)**

The paper highlighted the impact and decision making arising from the national review and revision to Band 2 and 3 Healthcare Assistant profiles. In response to the review and in the absence of national guidance, at its meeting of 3 July 2024 the Board of Directors determined an appropriate implementation date for colleagues who had operated at a higher band than they had been remunerated for. This date being the first occasion the matter had been raised with the Trust. Subsequently as local trusts finalised their own positions it became apparent that the Trust's agreed date of 1 June 2022 was not aligned with South Yorkshire & Bassetlaw Acute Federation partners. In view of the inequity the decision was revisited at a meeting of Board members on 14 August 2024 and agreement reached to revise the effective date to 1 August 2021.

In response to an observation by Non-executive Director, Hazel Brand the impact of a lack of national guidance on decision making was acknowledged. Whilst the original date aligned to the Trust's pay banding policy, subsequent partner decisions resulted in an inequitable position and the benefit of transparency of approach from system partners was recognised.

The Board:

- ***Noted the Healthcare Support Worker Band 2/3 Project Update***

P24/09/D4 **Research & Innovation Bi-annual Report Enclosure D4)**

The Chair of the Board welcomed the Director of Education & Research and Head of Research to the meeting to provide an update on research and innovation activity within the Trust. Key achievements included the ongoing work towards University Teaching Hospital status, the delivery of year zero of the Research and Innovation Strategy, Place based research and innovation activity and future growth opportunities related to clinical academics and industry partnerships.

An update was provided on the Born and Bred in Doncaster (BaBi-D) programme of work, including the impact on colleagues and the community.

Non-executive Director, Emyr Jones recognised the ambitious activity in what were challenging times, both operationally and financially. The benefit of research and innovation on the quality of care, service provision and improvements was recognised.

In response to a question from Non-executive Director, Mark Bailey regarding establishing research interest at recruitment and building in capacity to conduct research. It was confirmed that this would feature as part of the business planning process for consultants and other professional colleagues. The Acting Executive Medical Director was working with the Associate Director of Research and Innovation to look at research activity withing job plans, to ensure this was of benefit to the Trust.

The Board:

- ***Noted and took assurance from the Research & Innovation Bi-annual Report***

P24/09/D5 **Patient Experience Annual Report (Enclosure D5)**

The Deputy Chief Nurse shared the key highlights from the annual report, which provided an insight into patient experience during 2023/24, using data and evidence from a range of sources.

In response to a question from Non-executive Director, Hazel Brand with regards to the reference to relative ward rounds, the Deputy Chief Nurse confirmed these involved colleagues keeping relatives informed with regards to the patient's care, which had positively impacted upon the level of complaints received.

Non-executive Director, Mark Bailey enquired how colleagues were engaged and informed, with each division represented at the Patient Experience & Engagement Committee there was an opportunity to contribute and provide feedback on areas of learning, along with positive stories and compliments received through internal meetings and forums.

The Board:

- ***Noted and took assurance from the Patient Experience Annual Report***

P24/09/D6 **Board Assurance Framework & Trust Risk Register (Enclosure D6)**

The Board received the updated Board Assurance Framework (BAF) which had been reviewed by the respective Board Committees. A Board workshop would take place in December 2024, when the BAF would be considered alongside the Trust's strategic priorities.

Discussions during the meeting had been the focus of the current strategic risks and mitigating actions.

With regards to risk ID 1807 relating to critical lift failure, Non-executive Director Hazel Brand enquired of the current working order at Bassetlaw Hospital. The Chief Executive confirmed that due to the routing of pedestrian traffic to accommodate the development of the Bassetlaw Emergency Village there had been an increase in usage of previously underutilised lifts which had resulted in the need for repairs. All work had been carried out and all lifts were in working order. Estates and Facilities colleagues had supported with contingency measures during the repairs and any views shared regarding the need for transportation across site during this time was confirmed to be speculation.

Non-executive Director, Kath Smart welcomed the alignment of strategic risks to the four strategic priorities; patients, people, partnership, and pounds and encouraged a more balanced approach to Committee oversight. Where there was an element of overlap between Board Committees, the Associate Director of Strategy, Partnerships & Governance confirmed this would be considered at the Board workshop, along with the articulation of risks.

In respect of risk 1, to deliver safe, exceptional, patient centred care, the current score remained at 16, the recent changes to the operational clinical governance structure would be reviewed as practice became embedded.

Non-executive Director, Kath Smart sought clarity on the plans to support an improvement in the time to recruit, related to risk 2. The Chief People Officer confirmed this had been discussed extensively at the Board's People Committee and improvement was currently limited by the Trust's current mixed model of central and devolved recruitment. The recruitment team were currently working closely with colleagues to share best practice.

The report highlighted that risk 4, related to estates risk, remained an extreme risk with a rating of 20, however, there was significant assurance on the mitigating actions in place to maintain the critical infrastructure.

With regards to risk 5, regarding efficiency and spending public money wisely, this was currently reviewed at the Board's Finance & Performance Committee, there had been significant work to address the Trust's deficit position and the current overspend, which was subject to internal and external scrutiny and the Board had been kept updated on current issues and had taken assurance from the mitigating actions.

The Board:

- ***Noted and took assurance from the Board Assurance Framework & Trust Risk Register***

P24/09/D7 **Chair's Assurance Log – Quality & Effectiveness Committee (Enclosure D7)**

In the absence of the Chair of the Quality & Effectiveness Committee, Non-executive Director, Emyr Jones provided an overview of the four quadrants of the assurance log, positive assurance, areas of major works, areas of focus and decisions made.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P24/09/D8 **Chair's Assurance Log – Charitable Funds Committee (Enclosure D8)**

The Chair of the Charitable Funds Committee, Non-executive Director, Hazel Brand provided an overview of the four quadrants of the Chair's assurance log, positive assurance, areas of major works, areas of focus and decisions made.

The Chair of the Finance & Performance Committee provided a verbal update from July's Committee meeting. The adverse forecast and slippage on the Cost Improvement Programmes had been brought to the attention of the Board of Directors, the tight financial position, whilst not uncommon across the NHS, was subject to additional scrutiny across NHS South Yorkshire and members of the Board had met in August to discuss the Trust's financial recovery and NHSE's Investigation and Intervention Programme.

P24/09/D9 **Trust Governance Re-evaluation & Recommendations (Enclosure D9)**

The report summarised the evaluation of the Trust's corporate governance arrangements, arising from the internal audit of the Board and its Committees and the evaluation of the effectiveness of the Council of Governors through internal and external assessments; the findings of which had been progressed by the Associate Director of Strategy, Partnerships & Governance since their appointment.

The Board were asked to consider and vote on the following recommendations related to Board and Board Committee arrangements:

- To reinstate face-to-face Board meetings at least 3 times a year (to include Doncaster Royal Infirmary, Bassetlaw and Montagu Hospitals)
- To ensure all committee and board cover sheets were completed in full, a review of the template would be completed in year to support this
- To review risk management processes collectively with the Board Assurance Framework (BAF), including the frequency of its review
- To procure an external well-led review for 2025/26
- To review the Terms of Reference of all Board Committees

The following thoughts were offered by Board Members:

- An opportunity to benefit from face to face interactions, inside and outside of the meeting, supportive of team dynamics and working as a unitary Board
- The importance of achieving a balanced approach between virtual and face to face meetings post Covid, which was mirrored in partner organisations
- Supports inclusivity for those not digitally enabled, allows members of the public the opportunity to attend a Board meeting at a hospital site close to their home
- A need to consider the time currently devoted to Board development sessions
- The frequency and cycle of receipt of the BAF to be considered as a priority
- Supportive of an external well-led review in 2025/26 and keen to understand the 2024/25 internal well-led review. The Associate Director of Strategy, Partnership & Governance confirmed the internal review would take the form of a self-assessment and along with wider discussions would inform the specification of the external review
- The impact of face to face meetings on time commitment, associated travel costs and the environment
- Committee members were actively encouraged to engage in the workplan and terms of reference conversations

The Board were asked to consider and vote on the following recommendations related to the Council of Governors' effectiveness review/surveys:

- 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

The following thoughts were offered:

- Governor observation of Board Committees was not recommended as best practice by NHS Providers' Governwell Team and was referenced within the corporate governance internal audit report
- Governors were keen to engage face to face to develop relationships
- Restricted face to face engagement opportunities restricted the ability for the Board of Directors to develop working relationships with the Council of Governors
- Wider opportunities existed for governors to meet outside of formal Council of Governors meetings, such as training and developments sessions and informal gatherings.
- The use of NHS mail for Governors would be progressed to support freedom of communication
- Parking challenges for governors attending on-site meetings, which was acknowledged as a wider issue, an alternative provision was currently available and further options would be considered

One member of the Board abstained from voting on a return to face to face meetings, all remaining members voted in favour of this recommendation and all remaining recommendations received the unanimous support of the Board.

Arrangements to progress the recommendations would be considered outside of the meeting.

The Board:

- ***Approved the recommendations from the Trust Governance Re-evaluation***

P24/09/E1 **Maternity & Neonatal Update (Enclosure E1)**

The report provided an overview of the progress made against the single delivery plan, maternity self-assessment tool and the requirements of the Clinical Negligence Scheme for Trusts (CNST). The review and learning from patient safety events, perinatal mortality reviews and patient safety investigations.

Midwifery staffing remained stable and newly qualified midwives were expected to commence in post in early October.

The number of term admissions was reducing and remained below the national ambition.

Work continued towards achievement of Year 6 CNST standards and all safety actions were currently on track for submission in March 2025. Safety action eight, relating to training compliance, remained the most challenged and an action plan, closely managed by the Education Team, Ward Managers and Matrons was in place.

The Head of Midwifery confirmed Safety Champion meetings, which included the Chief Nurse as Board Safety Champion, Non-executive Director Maternity Champions and the perinatal quadrumvirate leadership team had taken place in June and July 2024.

Progress against the maternity and neonatal cultural improvement plan (SCORE Survey) was reported at the Safety Champion meeting and monitored at the Maternity and Neonatal Safety Quality Committee, with any identified support considered for implementation.

Progress was reported against the action plan to achieve the British Association of Perinatal Medicine (BAPM) national standards for the neonatal workforce. The requirements of the Year 6 BAPM standards for neonatal medical workforce requirements were not met and the Board was asked to consider and approve the action plan to address this.

The Chair of the Board acknowledged the change in requirements and associated increased costs, which were not funded nationally. The Chief Executive acknowledged the increased cost to meet the standard and service requirement and recognised the funding position, which was similar to that of Birthrate Plus®; which may be the subject of future national discussions.

The Board:

- ***noted and took assurance from the Maternity & Neonatal Update***
- ***reviewed and approved the Q1 Avoiding Term Admissions into Neonatal Units & Perinatal Mortality Report***
- ***noted that the BAPM national standards for the neonatal nursing workforce had not been met and approved the progress made against the action plan to address achievement of the BAPM standards***
- ***noted that the BAPM national standards for the neonatal medical workforce had not been met and approved the action plan to address achievement of the BAPM standards***
- ***noted the Board Safety Champion meetings with the perinatal leadership team***
- ***noted the progress against the maternity and neonatal cultural improvement plan (SCORE survey)***

P24/09/E1 **Maternity & Neonatal Independent Senior Advocate (Enclosure E1)**

The Chair welcomed the Maternity and Neonatal Independent Senior Advocate (MNISA) to the meeting to provide an update on the MNISA pilot service for South Yorkshire, which had been introduced in response to an immediate and essential action from the Ockenden Review.

A summary of the referrals into the service was provided since its inception in January 2024 and emerging themes and associated learning was reported. Communication and the impact on families, especially additional needs, were identified as a key theme.

The Chief Nurse and Non-executive Safety Champions acknowledged the positive engagement with the Trust and welcomed the MNISA's contribution and feedback.

In response to a question from Non-executive Director, Lucy Nickson, the MNISA confirmed that learning from other organisations had been shared with the Trust and providers were encouraged to continue to work collaboratively.

The Board:

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

P24/09/E2 **The NHS Premises Assurance Model (Enclosure E2)**

The NHS Premises Assurance Model provides assurance on regulatory and statutory matters related to the Trust's estate and related services in accordance with the NHS Constitution *"To be cared for in a clean, safe, secure and suitable environment".*

It reports how the organisation manages its infrastructure, providing assurance that systems and processes were in place to mitigate the risks associated with non-compliant infrastructure and major systems as documented in the Trust risk register.

The evidence within the return aligned with the significant assurance finding of the estates planned preventative maintenance internal audit report.

In response to a question from Non-executive Director, Hazel Brand, it was confirmed that following approval by Board the submission was part of a national return to NHS England.

Non-executive Director, Kath Smart acknowledged the outcome which seemed a fair outcome given the challenged estate. In respect of plans for compliance with NHS Standards of Healthcare Cleanliness (2021) in 2024/25, the Chief Financial Officer confirmed that they were within the rolling programme but were not necessarily funded.

The Chair of the Board took the opportunity to share a question from Clive Smith, Public Governor "given that the operational risk of fire to the estate was rated at 20, the same score as of October 2023, could the non-executive directors give assurance that actions

to reduce the risk were being addressed in a serious, thorough, and timely manner"? It was acknowledged that the fire improvement works related largely to the East Ward Block and were associated with a proposal to renovate and reconfigure. The Board's Finance & Performance Committee had oversight of this programme of work and the Chair confirmed the Committee was assured by management actions. In addition to the significant assurance received from the internal audit report relating to the planned preventative maintenance of the estate, the Chair of the Audit & Risk Committee also confirmed receipt of a bi-annual health and safety report, which included fire safety and a jointly agreed action plan with South Yorkshire Fire & Rescue Service (SYFRS). The Chief Executive reflected on fire improvement work previously completed in accordance with an enforcement notice, which had been fulfilled to the satisfaction of SYFRS. In addition, the Trust commissioned an external authorised person for fire safety, which provided external expert assurance.

The Board:

- ***Approved the NHS Premises Assurance Model submission***

P24/09/E3 **Safeguarding Annual Report (Enclosure E3)**

The Chair of the Board welcomed the Head of Safeguarding to the meeting, to present the 2023/24 Safeguarding Annual Report. An overview of the key achievements and impact of the safeguarding team was shared, with 2024/25 priorities articulated, underpinned by a work plan.

The Chief People Officer shared her appreciation of the focus on training and the positive impact on the Trust's overall statutory and essential training position.

In response to a question from Non-executive Director, Kath Smart with regards to Section 42 enquires from the Local Authority, the Head of Safeguarding confirmed plans to develop a bespoke training package to support timely returns. No concerns had been received from the Local Authority, however, there was an opportunity to strengthen internal processes.

Non-executive Director, Emyr Jones enquired of the impact of operating across two systems, which the Head of Safeguarding acknowledged impacted upon meeting attendances with two Local Authorities, two Integrated Care Boards and one Safeguarding Service.

The Board:

- ***Noted and took assurance from the Safeguarding Annual Report***

P24/09/E4 **Infection, Prevention & Control Annual Report (Enclosure E4)**

The Chair of the Board welcomed the Director of Infection, Prevention & Control and the Infection Control Lead Nurse to the meeting. The extensive annual report provided assurance of the Trust's compliance with the Health and Social Care Act 2008 - Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections.

The Board:

- ***Noted and took assurance from Infection, Prevention & Control Annual Report***

P24/09/F1 **Board of Directors Workplan (Enclosure F1)**

The Board received the Board of Directors workplan, the Associate Director of Strategy, Partnerships & Governance suggested any feedback be emailed to her post meeting.

The Board:

- ***noted the Board of Directors Workplan***

P24/09/F2 **Appointment of Internal & External Auditors (Enclosure F2)**

The Board:

- ***noted the Appointment of the Internal & External Auditors***

P24/09/G1 **Minutes of the meeting held on 2 July 2024 (Enclosure G1)**

The Board:

- ***Approved the minutes of the meeting held on 2 July 2024***

P24/09/G2 **Pre-submitted Governor Questions regarding the business of the meeting (verbal)**

The question received from the Council of Governors was incorporated within agenda item E2 (The NHS Premises Assurance Model).

P24/09/G3 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

P24/09/G4 **Date and time of next meeting (Verbal)**

Date: Tuesday 5 November 2024
Time: 9:30
Venue: MS Teams

P24/09/G5 **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.***

P24/09/H **Close of meeting (Verbal)**

The meeting closed at 13.51

2411 - G2 PRE-SUBMITTED GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 13:20

10 minutes

2411 - G3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 13:30

10 minutes

2411 - G4 DATE AND TIME OF THE NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 13:40

Date: Tuesday 7 January 2025
Time: 09:30
Venue: MS Teams

2411 - G5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Suzy Brain England OBE, Chair of the Board | 13:40

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.