Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

4 March 2025

09:30 GMT Europe/London

Virtual -TEAMS

Join the meeting now

AGENDA

2503 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 4 March 2025 v5.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 4 March 2025 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.*			5
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	**PATIENTS**			**09:55**
B1	Audiology Service Update *Zara Jones, Deputy Chief Executive*	*Assurance*		10
B2	Maternity & Neonatal Update *Karen Jessop, Chief Nurse* *Danielle Bhanvra, Deputy Director of Midwifery*	*Assurance*		10
B3	Learning from Deaths Report *Nick Mallaband, Acting Executive Medical Director*	*Assurance*		10
B4	Addressing Health Inequalities *Zara Jones, Deputy Chief Executive*	*Assurance*		10

C	**PEOPLE**			**10:35**
C1	Guardian of Safe Working Annual Report *Zoe Lintin, Chief People Officer* *Mohammad Khan, Guardian of Safe Working*	*Assurance*		10
D	**PARTNERSHIP**			**10:45**
D1	Doncaster & Bassetlaw Healthcare Services Update *Sam Wilde, Chief Financial Officer*	*Assurance*		5
D2	Trust Strategy Update Report *Zara Jones, Deputy Chief Executive*	*Assurance*		10
BREAK 11:00- 11:10				
E	**POUNDS**			**11:10**
E1	Financial Position Update *Sam Wilde, Chief Financial Officer*	*Note*		10
F	**ASSURANCE & GOVERNANCE**			**11:20**
F1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
F2	Board Assurance Framework including Trust Risk Register *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Assurance*		20
F3	Delivery Update 2024/25 Strategic Priorities Success Measures *Zara Jones, Deputy Chief Executive*	*Assurance*		10
F4	Chair's Assurance Log – Finance & Performance Committee *Kath Smart, Non-executive Director*	*Assurance*		5
F5	Chair's Assurance Log – Quality Committee *Jo Gander, Non-executive Director*	*Assurance*		5
F6	Chair's Assurance Log – People Committee *Lucy Nickson, Non-executive Director*	*Assurance*		5
F7	Chair's Assurance Log – Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*		5

G	**INFORMATION**			**12:30**
G1	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-
H	**CLOSING ITEMS**			**12:30**
H1	Minutes of the meeting held on 7 January 2025 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
H2	Pre-submitted Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
H3	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
H4	**Date and time of next meeting:** **Date:** Tuesday 6 May 2025 **Time:** 9:30 **Venue:** Boardroom, Doncaster Royal Infirmary	*Information*		
H5	**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*		
G	**MEETING CLOSE**			**12:55**

***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

2503 - 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 (1.2.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 1 February 2025)

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

Sam Wilde, Chief Financial Officer
Director - Doncaster and Bassetlaw Healthcare Services Ltd
Member of NHS Benchmarking Network and Co-Chair of the Network's Steering Group, which oversees its operation

Zoe Lintin, Chief People Officer
Trustee on the Board of The Diocese of Sheffield Academies 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 1 February 2025)

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 1 February 2025)

2503 - 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 - 7 January 2025.pdf

Action notes prepared by: Angela O'Mara
Updated: 7 January 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	7 January 2025

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P24/11/D5**	**Strategic Risk 2 – Board Assurance Framework** To consider the risk and mitigating actions in place related to sickness absence.	**ZL**	**January 2025**	**Update 16/12/2024 –** BAF updated to include sickness absence and reviewed by the People Committee on 17/12/2024. **Action to be closed**
2.	**P24/11/E4**	**Emergency Preparedness, Resilience & Response Compliance against the National Core Standards** To report the Trust's compliance following completion of the ICB's assessment.	**DS**	**January 2025**	**Update 23/12/2024** - no change to the previously declared level of compliance (31%) following review by the ICB. **Action to be closed.**
3.	**P25/01/C3**	**Audiology Service Update** The Deputy Chief Executive agreed to provide a further update to the next meeting of the Board.	**ZJ**	**March 2025**	Included on the agenda @ B1.

2503 - A3 CHAIR'S REPORT

Information Item | Suzy Brain England OBE, Chair of the Board | 09:35

10 minutes

REFERENCES

Only PDFs are attached

A3 - Chair's Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**A3**
Report Title:	**Chair's Report**		
Sponsor:	Suzy Brain England OBE, Chair of the Board		
Author:	Katie Michel, PA to the Chief Executive and Chair		
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 January 2025, 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
	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
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:			
Resources:	N/A		
Assurance Route			
Previously considered by:	N/A		
Date:			
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

Regional Workshop – NHS England

Following on from the national event with Provider and Integrated Care Board leaders in November 2024 I attended a North East and Yorkshire regional event in late January 2025 to further develop leaders' thinking and test how identified system challenges could be addressed.

The purpose of the workshop was to:

- Provide more information on the development of the oversight and assessment, improvement and strategic commissioning frameworks.
- Seek and discuss feedback on the approach to implementing these frameworks and the broader NHS operating model, and how they will support delivery of a neighbourhood health service.
- Understand key outstanding issues to be resolved, that advisory groups of chairs and chief executives can address as work progresses.

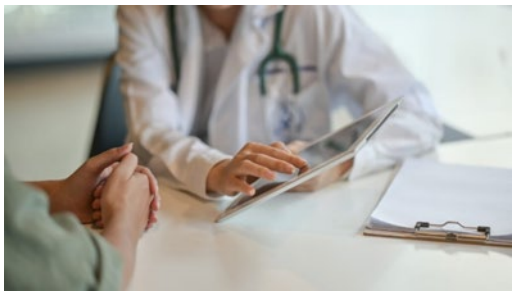
Webinars

During the last two months I have attended a range of webinars and roundtables hosted by NHS England, NHS Confederation and Doncaster Chamber. They have included hot topics of interest, including annual planning, manager regulation, NHS policy and political developments and the City of Doncaster Council's 2025/26 budget and service provision roundtable with public sector partners, facilitated by Dan Fell, Chief Executive of Doncaster Chamber.

NHS 10 Year Plan Workshop

As part of the government's plans to build a health service fit for the future, the national "Change NHS" consultation was launched to help shape the new 10 year health plan. In order to seek input from executive, non-executive and governor colleagues Rob Mason, Head of Quality Improvement & Innovation facilitated the workshop, utilising the national "Workshop in a Box" resources to support discussion and feedback to the national team. Delegates were asked to consider the three proposed shifts of: moving care from hospitals to the community, embracing digital transformation, and moving from treatment to prevention. The impact of the proposed shifts were considered, digital and prevention priorities were identified and the benefits and potential challenges of virtual wards, community diagnostic centres and ambulance triage assessed.

Colleague Engagement



As part of the ongoing programme of ward and departmental visits across the Trust's sites, I joined Chief Nurse, Karen Jessop on a recent visit to the Emergency Department at Doncaster Royal Infirmary. Having the opportunity to meet and receive feedback from those involved in service delivery provides a valuable insight from both a patient and colleague perspective and supports a more holistic view.

Board Development Delegate Programme

The Trust continues to provide opportunities to aspirant leaders as part of its Board Development Delegate Programme. Providing learning, mentorship and hands on experience of observing the Board and its assurance Committees in order to develop an understanding of the role and responsibilities of executive and non-executive directors in a large and complex organisation. The application process has recently closed for the next cohort, with activities planned between April and November 2025 but you can find out more about the programme here for future interest.

Board Development Session

Last month's Board development session opened with a focused discussion on Health Inequalities, we were joined by Dr Kelly MacKenzie, Consultant in Public Health and Richard Woodhouse, Project Lead who shared an update on the ongoing work to support delivery of the Trust's Tackling Health Inequalities strategy. In addition to the ongoing training and education, identified areas of focus included elective care, urgent and emergency care and maternity and children and young people patient pathways. Consideration was given to the impact on decision making and reporting through the Trust's governance structure.

Further priority discussions included the ongoing development of the Trust's strategy, underpinned by the Trust's strategic priorities; Patient, People Partnership and Pounds and incorporating the following ambitions:

- To be digitally enabled (analogue to digital)
- To tackle Health Inequalities
- To provide the best possible care environment, including moving care from the hospital to the community
- To be a leading centre for research and education

As part of the iterative development of the Board Assurance Framework the Associate Director of Strategy, Partnerships & Governance shared the revised template and recapped the function and practical use of the tool. Board members reviewed the current risks to delivery of its strategic objectives, and considered amendments or additions, including inclusion of digital and cyber security related risks. The updated frameworks would be shared with the Board Committees, where time allowed, before presentation at the Board of Directors meeting in March 2025.

Governor Engagement

In the first week of February, the Trust's quarterly Council of Governors' meeting took place; in addition to the usual updates from myself, the Chief Executive and Board Committee Chairs, the Council considered and agreed the approach to 2025's governor elections and the Trust's engagement and communication strategy for members.

In advance of a number of non-executive directors' terms of office drawing to a close in Q1/2 2025/26, the Board of Directors had considered the required skills, experience and diversity of a fit for the future Board of Directors. In accordance with its statutory duties, the Council of Governors' Nominations and Remuneration Committee considered this assessment, proposed recruitment options and a review of non-executive director remuneration. The recommendations from which were presented to the Council of Governors for approval.

As part of the annual business planning cycle, governors were briefed on the national planning guidance, including the impact of NHS England's Elective Reform Plan and the Trust's internal processes and timeline to ensure effective engagement and confirm and challenge opportunities ahead of the national deadlines for submission. I facilitated the session, which was led by Clare Ainsley, Head of Planning and Service Development and supported by the wider team. Trust Board and non-executive colleagues joined the briefing which provided a valuable insight into the extensive trust-wide work to deliver local and national strategic priorities. To close, there was an excellent interactive session where a range of reflections and suggestions were captured from those in attendance.

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, Nottingham and Nottinghamshire ICS Non-executive Directors, South Yorkshire Trust Chairs, and planned and chaired the South Yorkshire & Bassetlaw Acute Federation Board.

Non-executive Director (NED) Champion Roles & Activity

In her role as non-executive Maternity and Neonatal Safety Champion, Jo Gander has participated in the Maternity Safety Champion visit of 23 January 2025 and the Local Maternity and Neonatal System (LMNS) assurance visit in late February. Jo has chaired the urology consultant interview panel and visited Radiology with Chief Financial Officer, Sam Wilde.

As Deputy Chair of the Board, Kath Smart chaired a consultant interview panel, presented to NHS Cadets on leadership within the NHS, met with multiple stakeholders and visited the Critical Care Unit at Doncaster Royal Infirmary with Chief Nurse, Karen Jessop.

In his capacity as clinical Non-Executive Director, Dr Emyr Jones gave a presentation on medical leadership to new consultant colleagues, attended the Maternity & Neonatal Quality and Safety Champion visit and joined the Chief Operating Officer, Denise Smith on an engagement visit with Specialist Nurses.

As the non-executive Freedom to Speak Up Champion, Hazel Brand attended the Freedom to Speak Up Forum as well as a regular catch up with Zoe Lintin, Chief People Officer and Paula Hill, Lead Freedom to Speak Up Guardian. Hazel represented the Trust at a number of Nottingham and Nottinghamshire Integrated Care System and Bassetlaw Place meetings.

2503 - A4 CHIEF EXECUTIVE'S REPORT

Information Item | Richard Parker OBE, Chief Executive | 09:45

10 minutes

REFERENCES

Only PDFs are attached

A4 - Chief Executive's Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**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
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	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:			

This report present updates categorised under our four strategic priorities.

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

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

Visitors Charter

Last year, we were pleased to have launched the Visitors' Charter at Doncaster and Bassetlaw Teaching Hospitals (DBTH), now implemented and utilised across the Trust.

This charter reinforces our commitment to supporting a positive patient experience by using an **open and flexible visiting policy** which recognises the vital role of loved ones and carers in providing the highest standards of patient care.

The Charter is advertised in ward areas and on internal and external websites so both colleagues and visitors have clear expectations,

Stroke trial update

As part of the stroke trail 70 stroke patients have been investigated as part of a pioneering genetic testing pilot at DBTH. So far 20% of patients were found to have a genetic difference that makes a common stroke prevention drug, Clopidogrel, less effective

By identifying this variation early, doctors have been able to offer alternative treatments, cutting their risk of another stroke by 50%.

As one of just four NHS sites in England selected for this national trial, DBTH is helping to lead the way in using genetic testing to determine whether Clopidogrel, a commonly prescribed stroke prevention drug, is the most effective option for each patient.

Sensory room to transform care for children with additional needs

Children with cerebral palsy, autism and visual impairments will be amongst those to benefit from the opening of a brand-new sensory room at Doncaster Royal Infirmary (DRI).

The room made possible through £14,245 of funding from Doncaster and Bassetlaw Teaching Hospitals Charity is situated within the Children's Outpatients Department (OPD). It includes a kaleido projector, fibre optic curtain and a colourful bubbling water tube.

Amongst the long list of benefits to patients are developing communication to encourage vocalisation, improving balance and spatial orientation and for children with visual impairments, strengthening their eyes.

People - *We are supportive, positive, and welcoming*

Race Equality Week

As part of Race Equality Week 2025 (3-7 February) organisations in Doncaster, including DBTH, highlighted the commitment we have made to working together to take action to support our anti-racism journey. At DBTH this builds on the commitment we made last year, alongside other South Yorkshire NHS partners, to work towards the anti-racism framework developed by NHS organisations in the Northwest and we continue to work with colleagues to develop the DBTH programme.

To progress this work in Doncaster three key areas have been identified as priorities for this year. They are:

1. Commit to a Doncaster-wide anti-racism message
2. To use anti-racist and inclusive recruitment practices
3. Develop and provide anti-racist training for our workforce

Recruiting to the Board Development Delegate Programme

DBTH is seeking aspiring leaders from diverse backgrounds who are considering their next steps towards a board-level, executive, or equivalent position to join the next cohort of its Board Development Delegate Programme.

The initiative provides hands-on experience, knowledge, and insight into the responsibilities of executive and non-executive directors within a complex organisation. Upon completion, delegates will be supported in progressing into senior roles across the public, private, and voluntary sectors, including school and college governor positions.

This voluntary developmental role runs alongside an individual's current job, providing structured learning, mentorship, and networking opportunities. Candidates should be working towards a director-level role within two years of completing the programme. Applications are encouraged from individuals of all backgrounds.

National Living Wage (NLW) update

As announced in the Autumn Budget 2024, the NLW will increase to £12.21 per hour. At the time, concerns were raised with the government about how this would affect Agenda for Change (AfC) pay rates, particularly for bands 1, 2 and 3. In response, the government has confirmed measures to ensure compliance with the new NLW while maintaining pay band differentials.

From 1 April 2025:

- Colleagues in AfC band 1 (closed) and band 2 will receive an advance on the 2025/26 pay award, increasing their hourly rate to £12.36.
- The entry point for band 3 will also receive a temporary increase of 28p per hour, raising it to £12.59.

Information has been provided and communicated to colleagues.

Excellence in wound care

Congratulations to DBTH's Skin Integrity Team who were recognised in three categories at this year's *Journal of Wound Care Awards*, which took place in February.

The awards celebrate excellence in wound care, recognising innovation, collaboration, and outstanding contributions to improving patient outcomes. The team were presented with a bronze award in 'pressure care'

and a gold award for 'collaboration' across the Nottingham and Nottinghamshire ICB. Michelle Deether from the team also received a silver award in the 'new talent' category.

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

The Yorkshire and Humber Care Record launched 24 February

Week commencing 24 February DBTH introduced the Yorkshire and Humber Care Record (YHCR), a new system that will help improve how we access and share patient information across the region.

The YHCR is part of the national Connecting Care Records programme and advances the Yorkshire and Humber Care Record. This means that, for the first time, hospitals, GPs, mental health services, and social care providers will have access to a single, joined-up record for the 1.4 million people in our region.

What this means for patient care

- **Better, safer, and more coordinated services** – with the latest patient information available when and where it is needed.
- **Less duplication** – reducing the need for patients to repeat their medical and social care history.
- **Fewer unnecessary tests and delays** – improving efficiency across the system.
- **More personalised care** – professionals will have a full picture of a patient's history, ensuring better decision-making.

Community and employee liver health checks in Love your Liver Month

DBTH partnered with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to take the Love Your Liver Roadshow to Doncaster and Mexborough last month, providing free liver health checks and raising awareness as part of Love Your Liver Month.

The primary care bus delivered liver health checks directly to the using a Fibroscanner, a quick and painless test that provides instant results. This state-of-the-art equipment was generously donated to DBTH by the Doncaster Cancer Detection Trust. Alongside the checks, healthcare professionals were available to offer advice on alcohol, diet, and lifestyle choices to help improve and maintain liver health.

The roadshow saw 111 members of the public attend, with 16 referred for further investigation and 94 DBTH colleagues with 8 referred for further investigations.

Aging Well – Engagement opportunity

NHS Nottingham and Nottinghamshire are carrying out an engagement exercise with older adults and carers to find out about how they receive healthcare and what matters to them.

Across the system, our aim is to be responsive to our ageing population and proactively focus on ageing well and enabling citizens to live healthier for longer.

You can get involved by completing the online form on the following link: https://notts.icb.nhs.uk/get-involved/current-and-previous-engagement-consultations/ or by emailing us at nnicb-nn.engagement@nhs.net

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

Financial position update

Later in the agenda, the Chief Finance Officer will provide an update on the financial position and its impact on the end of the 2024/25 year.

This marks a continuation of the improvements which have been made since the Trust highlighted the significant financial challenges to colleagues in August 2024; following a weaker-than-expected first-quarter performance.

The progress reflects the hard work of colleagues who have implemented cost improvements, reduced waste, and enhanced efficiencies—all while maintaining a clear focus on patient safety and care.

Imaging Suite completed at Montagu CDC

The new state-of-the-art imaging suite at Montagu Hospital will open in March and is set to enhance diagnostic services for patients across South Yorkshire and Bassetlaw.

As part of the Montagu Community Diagnostic Centre (CDC), the new facility will increase appointment availability and offer patients greater choice in a calm and accessible setting.

Last month, colleagues at DBTH took part in a handover ceremony, officially marking the building's transfer to the Trust. This milestone signifies the successful completion of construction, and the facility now enters the commissioning phase to ensure it is fully operational before welcoming its first patients at the end of March 2025.

The £16.4 million project was completed exactly one year after construction began in February 2024, representing a significant investment in modern diagnostic services.

2503 - B PATIENTS

2503 - B1 AUDIOLOGY SERVICE UPDATE

Discussion Item | Zara Jones, Deputy Chief Executive | 09:55

10 minutes

REFERENCES

Only PDFs are attached

B1 - Audiology Service Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**B1**
Report Title:	**Audiology Service Update**		
Sponsor:	Zara Jones, Deputy Chief Executive Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Claire Jones, Audiology Recovery Programme Lead		
Appendices:	N/A		

Report Summary

The Board of Directors received a report in January 2025 setting out the position regarding our audiology service following the limiting of service activity from September 2024.

The reasons for this included specific challenges relating to the paediatric service, linked to a national NHS England established programme, alongside more local issues across the entire service associated with IT, physical estate, equipment and compliance with expected standards following some clinical observations.

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.

A commitment was made to provide regular updates to the Board of Directors, our patients, partners and stakeholders on progress.

The Trust continues to make progress against the wider work stream areas including estates, IT and clinical workforce training and development. These areas are key to being able to run a safe and effective service in the future.

This paper provides a brief update on the position regarding the work streams that underpin the Audiology Recovery Programme in place across the audiology service within the Trust. A further detailed update with regards to the paediatric audiology recall position is also provided.

Additional actions to support patient safety and to ensure appointments continue to be offered to patients include outsourcing of adult diagnostic activity to the independent sector, mutual aid transfers to other NHS providers for adult and paediatric appointments, investment in estate refurbishment and new equipment and continuation of repair clinics on-site where this can be provided.

The Trust is sincerely sorry for the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically.

Updates will continue to be provided to the Board of Directors as our recovery work continues.

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**	**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
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	X	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal/ Regulation:			
Resources:	Resources associated with the quality improvements and recovery actions stated.		

Assurance Route	
Previously considered by:	Executive Team, Trust Leadership Team, Quality Committee, Finance and Performance Committee
Date:	Various dates in 2025
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:	Board of Directors report [January 2025]

Context

As previously reported to the Board of Directors in the January 2025 board report, the audiology service across DBTH has offered a limited provision to our patients since September 2024, as it undertakes a process of necessary and complex improvement. Whilst elements of the service have been made available to patients [basic repairs & urgent referrals] we have not been able to offer the levels or standard of service that we would wish for our community and stakeholders.

This board paper serves to update on the activities and decisions taken across the audiology service since the last update to the Board of Directors in January 2025.

1.0 The Audiology recovery programme

To enable the audiology service to recommence in its entirety, there are a number of key interdependencies at play. It is imperative that each interdependency has its own focus and identified work stream, to enable all the individual strands of the service to align, so that we can enable patients and families to have access to a safe and effective audiology service.

It is important to note that whilst the service is working through the improvement and redesign work, patients are still being seen and the number of patients being seen is increasing week on week as staff are being certified as competent.

The table below shows the numbers of adults that have been allocated and seen in the last three months.

Outsourcing activity	**Number of patients referred**	**Number of patients booked**
Scrivens	382	298
Mutual Aid across The South Yorkshire and Bassetlaw Acute Federation	78	48
Stepping up of Internal activity in DBTH	**Number of patients seen**	**Date**
Hearing aid fittings	24	w/c 17.02.25
Hearing aid fittings	28	w/c 24.2.25
Diagnostic clinics	18	w/c 24.02.25
Diagnostic clinics	45	w/c 03.03.25

The audiology recovery programme consists of six key workstreams, see below. Each work stream has both an operational lead and an executive lead and progress in each of the work streams are reported into the bi-weekly audiology recovery group meeting, chaired by Deputy Chief Executive with the Medical Director in attendance. The progress from this group is reported into the bi-weekly Audiology Integrated Care Board [ICB] meeting, chaired by the ICB Deputy Director of Nursing.

Central to the progress and delivery of the audiology recovery programme is the experience and voice of our patients. Communication across all of the workstreams will be shared with our patient groups as the programme evolves and improvements across the patient pathways are delivered.

The six workstreams in place within the audiology recovery programme are as follows:

1.1 Harm reviews – *To robustly assess all current waiters at the Trust to ensure no unforeseen harm has occurred and put in place effective governance to mitigate any ongoing risks. To conclude the review of harm on the paediatric recall list following case note review and the further assessment of children at Sheffield Children's Hospital.*

As reported to the January 2025 Board of Directors, as part of the Paediatric audiology independent review process one hundred and thirty one children were recommended for recall and prioritised into categories of urgency.

Forty children were identified as the highest priority, P1, and Duty of Candour Part one was completed for all. These children were referred to Sheffield Children's Hospital [SCHFT] for assessment. Clinical assessments have been sent back to DBTH for Subject Matter Expert [SME] review and the allocation of harm level for the children.

The levels of harm has to be determined and agreed with two SMEs and then presented to the ICB panel for agreement before the final harm grading can be confirmed.

To date twenty five cases have been reviewed by the SMEs and levels of harm allocated. The outcomes to date are; five children with moderate harm, five with low harm and fifteen children with no harm. Five children still have their level of harm yet to be determined, and three of these children are awaiting further testing and assessment.

Duty of Candour part two has been commenced in all twenty five cases and followed up in writing.

The themes of harm identified are delays to treatment, inappropriate or incorrect treatment or testing not completed to the national expected standards as determined by the British Association of Audiologists. All the themes have an improvement plan that is covered in the overarching audiology action plan.

We are unable to state at this time whether the harm sustained will be long term or short term. Further audiology assessment has taken place with one of the moderate harm children and this has indicated that the speech delays are not due to hearing issues, the SME has indicated that in this case the level of harm may be downgraded to low harm or no harm, DBTH are awaiting confirmation of this.

Fourteen children were graded as priority 2 [P2] and appointments were scheduled at SCHFT for the beginning of February. In this cohort there was an issue with the children not being brought to their appointments. In these cases we have followed the Trust Was not Brought policy and appointments for these children have been rescheduled for March 2025. Of the two patients who did attend the original appointment, they have been reviewed and we are awaiting the SME harm review feedback.

Seventy seven children were graded as priority 3 [P3]. Of this cohort sixteen are NICU babies to be seen at SCHFT, and sixty one were graded as well babies to be seen at DBTH.

Of the children seen at SCHFT, eleven have been seen and we are awaiting the SME harm review feedback. Three children were not brought to their appointments and in these cases we are following the Trust Was not Brought policy.

Sixty one children have been appointed to DBTH for screening, these clinics are taking place in the month of February, with additional capacity being built in to March for any children who were not brought.

1.2 Mutual aid and patient activity – *To work with system partners to access mutual aid capacity to help reduce risk in high priority referrals and long waiters. To increase the number of DBTH audiology clinics available in line with the verified competency of the staff.*

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.

1.3 Clinical workforce – *To ensure that the clinical team have the right levels of support in place to function effectively and that each individual meets the competency requirements for their role and is working in line with current audiology standards.*

The DBTH audiologists have in place a training schedule that involves them working in external audiology departments in Nottingham University NHS Trust and King's Mill Hospital that forms part of the wider Sherwood Forest Hospitals Trust, to undertake supervised assessments of patients in order to determine their competency. This will ensure that practice meets the national British Association of Audiology requirements. This process started in January 2025 and is hoped to conclude in the next few months.

1.4 Digital - *To ensure the Trust has appropriate underpinning digital systems to support the audiology teams in delivering an effective service and to ensure that the audiology staff are suitably trained to use digital systems appropriately.*

Work has been happening in the last few weeks to embed the new AuditBase audiology electronic patient record system. This system replaces the RioMed system that is being contractually stood down with the final exit strategy being finalised week commencing 10th February 2025. The Trust patient administration system, CAMIS continues to be responsible for the full administration of all audiology patients with the patient level clinical detail being supported by AuditBase.

1.5 Infrastructure and Estates – *To ensure that the audiology service has the right physical facilities and supporting equipment in place to enable the delivery of high quality care for patients.*

Estates work commenced at the start of February 2025 on the three paediatric audiology rooms in the DRI paediatric outpatients department to modernise and incorporate the acceptable standard of soundproofing and the required observation spaces. This will enable paediatric assessments to be carried out safely and effectively. The works in this area should be completed by the 7th April 2025.

Sound treating has been applied to the audiology rooms at Sandringham Road and calibration of these rooms is expected to take place on the 5th March 2025.

Further remedial work at BDGH is expected to take place in April 2025 with an agreed handover of mid-May 2025. Improvements to the two DBTH ENT outpatient audiology booths commence on the 14th April 2025 with an agreed handover of mid-May 2025.

1.6 Data - *To have a reliable and consistent data set that correlate to current clinical activity and accurately identifies numbers of patients requiring mutual aid. Additionally, to have a Patient Tracking List [PTL] that is*

accurate for all activity for when the service has recommenced in its entirety and to be able to complete capacity and demand modelling to meet DMO1 going forward and quantify current waiting times.

Work is underway to develop a reliable PTL in conjunction with the NHSE Intensive Support Team who are providing regular check and challenge meetings to provide assurance of the DBTH model. This will enable a clear overview of the capacity in the audiology service and the demand placed upon it. The PTL will also allow for the modelling of capacity solutions and the impact that they may have on the waiting list. For example, further outsourcing to private providers, outsourcing via the mutual aid route and possible insourcing solutions.

2.0 Audiology Recovery Programme – Governance

To ensure that the audiology recovery programme has visibility at all levels of the organisation, a programme of governance has been established. This will provide oversight of both the delivery and risks associated with the programme of work. [See Figure 1].

There are a number of risks that have been identified in relation to the six underpinning audiology recovery workstreams. It will be important that these risks are reviewed and regraded accordingly as progress is made with the delivery of the recovery programme, ensuring that any changes are communicated and ratified at the appropriate level of the organisation.

The Trust is sincerely sorry for the low and moderate harm now confirmed for some of our patients, as detailed above and for the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically.

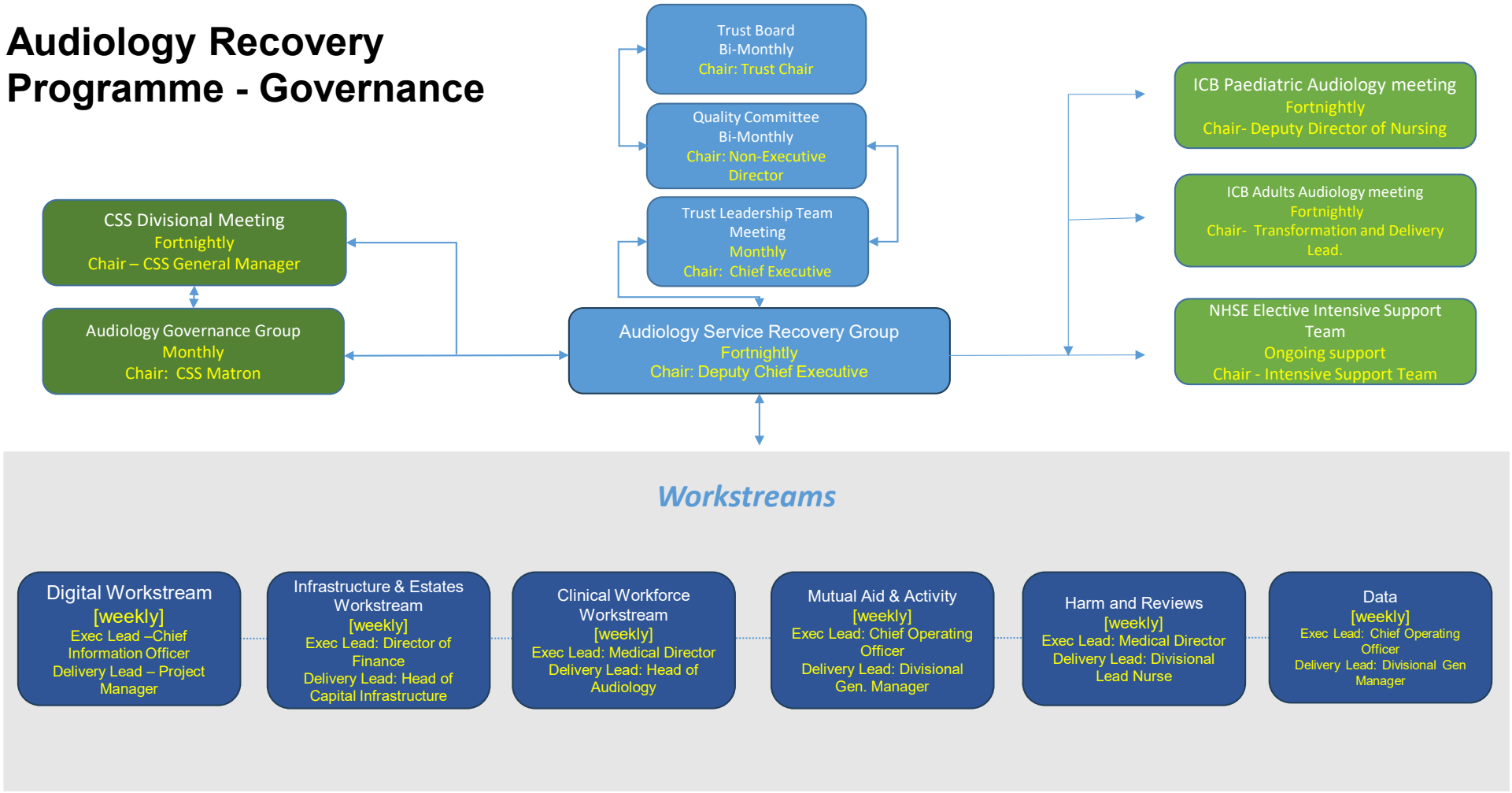


Figure 1. Audiology Recovery Programme Governance and workstreams.

2503 - B2 MATERNITY & NEONATAL UPDATE

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

Deputy Director of Midwifery
10 minutes

REFERENCES

Only PDFs are attached

- B2 - Materntity & Neonatal Update.pdf
- B2 - Appendix 1 - PMRT Q3 Report.pdf
- B2 - Appendix 2 - ATAIN dashboard and action plan.pdf
- B2 - Appendix 3 - Maternity Dashboard.pdf
- B2 - Appendix 4 - SBL.pdf
- B2 - Glossary of Terms - Maternity.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**B2**
Report Title:	**Maternity & Neonatal safety report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Sam Fawkes, Deputy Divisional Nurse, Paediatrics Danielle Bhanvra, Deputy Director of Midwifery		
Appendices:	Appendix 1 - Q3 Perinatal Mortality Review Tool (PMRT) Appendix 2 - Q3 Avoiding Term Admissions Into Neonatal units (ATAIN) dashboard Appendix 3 - Trust Quality Metrics Appendix 4 – Saving Babies Lives (SBL) Care Bundle v3 Q2		

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

The service submitted compliance with 9/10 standards for CNST Year 6, with a view this will be upgraded to full compliance following submission and review by the Maternity Incentive Scheme.

To note: patient level detail of the PMRT reviews have been removed from this report.

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. • Reviewed and approved Q3 PMRT report (Appendix 1) • Reviewed and approved Q2 SBL (Appendix 4) • Reviewed and approved Q3 ATAIN (Appendix 2)

	• Board Safety Champions are meeting with the perinatal leadership team bi monthly and any support required of the Trust Board has been identified and is being implemented. • Progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support being considered and implemented.			
Action Required:	**Approval**	Review and discussion	**Take assurance**	Information only
Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	*We are supportive, positive, and welcoming.*	***We work together to enhance our services with clear goals for our communities.***	*We are efficient and spend public money wisely.*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes /~~No/ NA~~		**Yes /~~No/ NA~~**	

Implications			
Relationship to Board assurance framework:	**x**	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	X	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
		BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal/ Regulation:	CQC - Regulation 12 Potential high impact *Clinical Negligence Scheme for trusts - High impact*		
Resources:			
Assurance Route			

Previously considered by:		The Maternity and Neonatal Safety Quality Committee Divisional Governance Meetings
Date:	Monthly	
Any outcomes/next steps	Support to continue improvements in maternity & neonatal service, and achieve year 7 CNST standards going forward	
Previously circulated reports to supplement this paper:		

Bi Monthly Board Report

December 2024 / January 2025

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 2 stillbirths in December and 0 in January reportable to MBRRACE.

2.2 Neonatal Deaths

There was 1 neonatal deaths in December and 0 in January.

2.3 Perinatal Mortality Review Tool (PMRT) 1.12.2024 to 31.01.2025

Date	Type of Death	Antenatal / Intrapartum / Neonatal	Information
Sept	Stillbirth	Antenatal	Report published
Oct	Stillbirth	Antenatal	Report published
Oct	Stillbirth	Antenatal	Report published
Oct	Neonatal death		Report published
Nov	Stillbirth	Antenatal	Being investigated further
Jan	Neonatal death		March meeting for discussion
Jan	Stillbirth	Antenatal	March meeting for discussion

2.4 Learning from PMRT reviews

Issues
Further discussions to take place in March 2025 meeting about timing of birth for diabetic women.

Learning
Q3 PMRT report is attached in Appendix 1.

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

3.1 Investigation Progress Update

Table 1 MNSI cases

Cases to date	
Total referrals	29
Referrals / cases rejected	8
Total investigations to date	21
Total investigations completed	19
Current active cases	2
Exception reporting	0

There were no cases referred to MNSI in December 2024 and January 2025.

3.2 Reports Received since last report

None.

3.3 Current investigations

Two cases being investigated, one of which does not meet the criteria for MNSI investigation but the family have requested this to be progressed.

M1-037943 - is in draft the writing process
MI- 038535 - the family meeting has been completed and staff interviews are in progress

3.4 Coroner Reg 28 made directly to the Trust

None.

3.5 Maternity Patent Safety Incident Investigations (PSII)

There is one PSII in progress;

- 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. The report is in final draft and is with the family.

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

The service is making continued progress on the single delivery plan. A baby friendly initiative assessment was undertaken in October 2024 which resulted in the Trust achieving reaccreditation.

There is a continued focus on improving the culture and relationships in the maternity service. A number of sessions have commenced and will continue over the next few months one is jointly facilitated by 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 roles have now been recruited to with the exception of the deputy clinical director.

5. Training Compliance for all staff groups

Training figures as at December 2024 and January 2025 are detailed below:-

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

December 2024

Staff Group	K2 / CA Compliance Dec 24	Study Day Compliance Dec 24
90% of Obstetric Consultants & SAS Drs	**94.44%**	**94.44%**
90% of all other obstetric doctors contributing to the obstetric rota	**94.44%**	**88.88%**
90% of midwives including bank & agency staff	**94.91%**	**90.90%**

January 2025

Staff Group	K2 / CA Compliance Jan 25	Study Day Compliance Jan 25
90% of Obstetric Consultants & SAS Drs	**94.44%**	**94.44%**
90% of all other obstetric doctors contributing to the obstetric rota	**100%**	**94.44%**
90% of midwives including bank & agency staff	**93.46%**	**91.33%**

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

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

Table 3 & 4 - PROMPT figures

December 2024

Staff Group	Prompt Compliance Dec 24
90% of Obstetric Consultants & SAS Drs	**100%**
90% of all other obstetric doctors contributing to the obstetric rota	**94.29%**
90% of midwives including bank & agency	**98.41%**
90% of maternity support workers and health care assistants	**94.44%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**93.75%**
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	**95.24%**

January 2025

Staff Group	Prompt Compliance Jan 25
90% of Obstetric Consultants & SAS Drs	**88.89%**
90% of all other obstetric doctors contributing to the obstetric rota	**94.29%**
90% of midwives including bank & agency	**92.91%**
90% of maternity support workers and health care assistants	**87.50%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**87.50%**
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	**95.24%**

Table 5 & 6 - NLS figures

December 2024

Staff Group	NLS Compliance Dec 24
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**94%**
90% of neonatal junior doctors (who attend any births)	**100%**
90% of neonatal nurses (Band 5 and above who attend any births)	**100%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of midwives including bank & agency	**94.86%**

January 2025

Staff Group	NLS Compliance Jan 25
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)	**97%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of midwives including bank & agency	**91.73%**

Due to staffing and clinical need a number of training session have had to be cancelled, this will reflect in the training compliance numbers until April 2025. There is a plan in place to manage this proactively, and catch up on the missed training sessions.

6. Safety Champion meetings

A meeting was held on 23rd January 2025, where the board safety champion and non-executive director met with the perinatal quadrumvirate leadership team.

6.1 Positive Points recognised

The last visit was on the Doncaster site, staff were spoken to on the central delivery suite (CDS), and the ante-natal post-natal ward. There was recognition that the atmosphere particularly on CDS has improved, and staff of all disciplines gave positive feedback about working at DBTH. The ward M2 has recently reopened providing s dedicated induction of labour bay and an enhanced recovery area for elective caesarean sections supporting suitable birth people to return home after 24 hours.

Sophia Peart (Maternity and Neonatal Partnership Strategic Lead) attended the meeting to ensure that the user voice was represented. She is keen to support the service until a resolution is found for the current MNVP chair vacancy. A MNVP meeting has been arranged for April 2025.

6.2 Concerns raised by the visit and staff

There were no concerns raised by the staffing working during the visit.

6.3 Concerns raised by service users

Ongoing work continues with the LMNS and ICB as the Trust remains without an MNVP chair. An interim solution has been agreed with the LMNS and ICB, with the Rotherham MNVP chair supporting DBTH and as previously described she has already attended the Safety Champions Walk round and subsequent meeting. The funding for the MNVP remain in place, and an ICB/LMNS representative is expected to attend agreed meetings where possible. 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.

There is a programme of sessions being planned for the multidisciplinary teams. These have commenced in January 2025, and will continue through the year. Quad and senior leadership time out days are planned to consider progress and make plans for improving maternity and neonatal services.

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

Nothing identified for the Trust Board at present.

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.

Work is ongoing with collecting and uploading evidence to the portal. Progress is being made with an aim to be 100% compliant as soon as possible. Progress is overseen at regular assurance meetings with the local maternity and neonatal system. Q2 progress in attached in Appendix 4.

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

Work continues to progress Year 6 CNST, overseen by the CNST/ SDP oversight committee and reported to the maternity and neonatal safety quality group (MNSQG), chaired by Chief Nurse as the maternity board safety champion. A planned assurance visit from the LMNS took place in October 2024 and a further one in December, to assess evidence.

The Trust has achieved 9/10 of the safety actions. Requirement 3 in safety action 1 - PMRT was not met due to an error with electronic submission. The Trust has discussed the issue with NHS Resolution (MIS) and MBRRACE (PMRT), and this will be reviewed as part of the external verification process at the end of the scheme in March 2025 when MIS hope to upgrade the status to compliant for year 6.

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

December -18
15 patient safety incidents were unexpected admission to neonatal unit for term babies, these are reviewed as part of the reducing admissions to neonatal unit (ATAIN).

The other 3 are variable reasons including a third degree tear, and one intrauterine death which was identified during ante-natal check.

January - 8
6 were reported due to unexpected admission to the neonatal unit, 2 were due to other reasons.

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

Midwifery staffing
Midwifery staffing remains stable, and currently the service has 219.12 WTE contracted midwives (Band 3-7), against 221.07 WTE recommended. This includes 22 newly qualified midwives having already commenced at the trust with a further two MSC students commencing in April/May.

The next cohort of newly qualified midwives graduate in October 2025, and all four organisation in South Yorkshire and Bassetlaw will undertake recruitment collaboratively offering all available vacancies.

All rotas were planned to have a supernumerary coordinator on every shift for December 2024 and January 2025.

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

10.1 Neonatal Nursing - Fill rates planned versus actual

Neonatal staffing is 85% recruited with 82% of establishment at work. All vacancies are out to advert. The Qualified in Speciality ratio is below the 70% standards at 65% on the Neonatal Unit (NNU) at DRI. Overall across BDGH and DRI the QIS ratio is 71%. During January there was 1 shifts at DRI and 0 shifts at BDGH below BAPM standards. The 1 shift at DRI was due to being over acuity.

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 the recruitment of 6 new band 6 Sisters/ charge nurses and the other vacancies currently out to advert.

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 in due course

Ongoing monthly monitoring of compliance of short-term locums and engagement of long term locums is continuing. In December 2024 / January 2025 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 December 2024 / January 2025.

10.3 Neonatal medical staffing

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 resident doctor for neonates.

An action plan to address this has been developed and approved by Trust Board in September 2024.

10.4 Anaesthetic Workforce

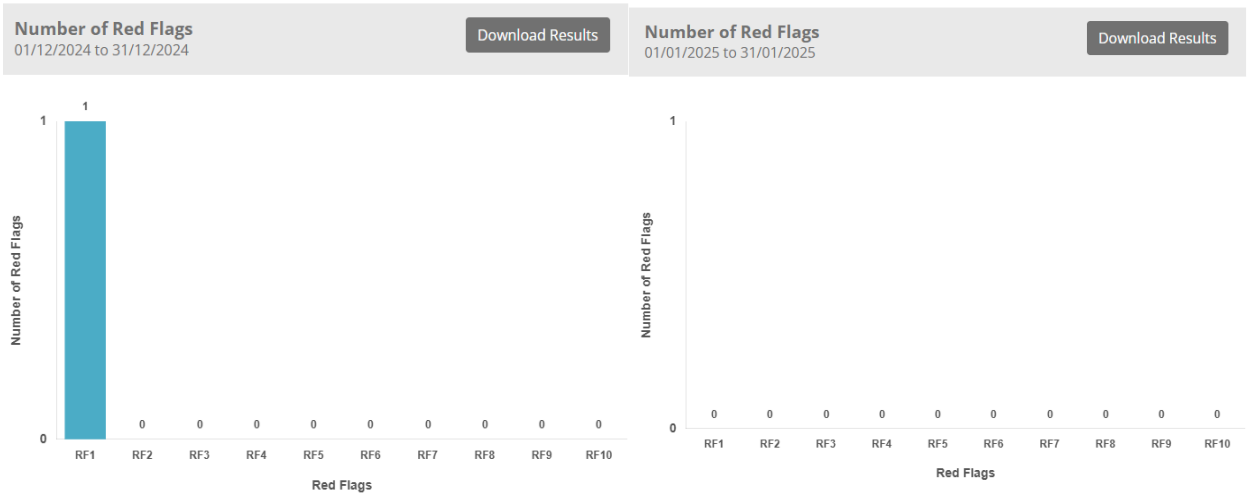
Weekly rotas for the anaesthetic medical workforce are collated to evidence ongoing compliance with the Anaesthetic Clinical Services Accreditation (ACSA) standard 1.7.2.1. The Trust is compliant with this standard.

10.5 Red Flags

The red flags are recorded on the birth rate+ ® app on a four hourly basis and for October and November 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

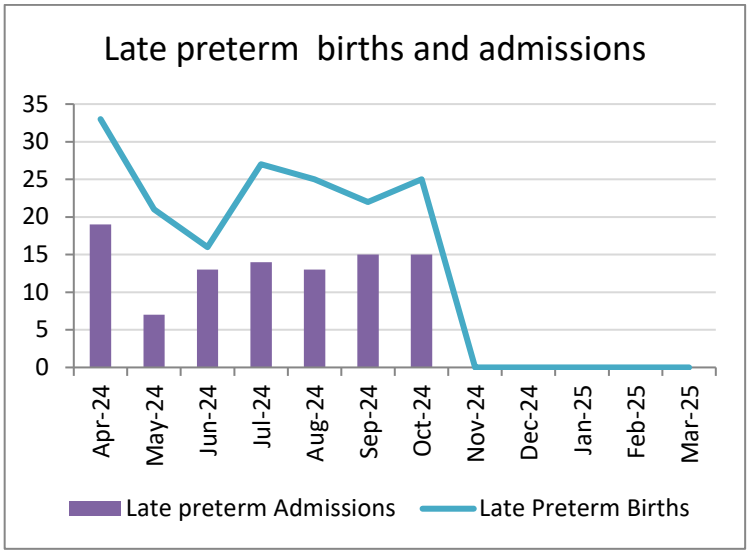
The service has an annual plan that has been developed in conjunction with the MNVP, and this work is ongoing.

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.

ATAIN dashboard and action plan in Appendix 2.

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 a bay ward M2 will assist in creating a transitional care area, and this is planned for quarter one 25/26.

13. Red Risks / Risk Register Highlights

Risk	Mitigation in place	Plan to address risk
Neonatal difficult airway standards have been updated	Escalated to divisional governance. Discussions ongoing about additional training/education and workforce model	Survey sent out to clinicians to identify gaps, following the return action plan to be put in place.

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. There are challenges around the small estate due to not having space for Parent sleeping facilities at the cot side.

Improvements have been made in the last year to provide Parent meals and snack/microwave available in the Parents room.

An LMNS representative came to visit at DRI in January and are planning to visit BDGH in we are waiting for this feedback.

15. Perinatal Metrics

The Trust maternity dashboard has been included in Appendix 3.

Metrics with significant deterioration:

- PPH > 1500mls

Whilst overall the PPH rate has deteriorated, since the intervention of stopping aspirin in the later part of pregnancy we have seen a small improvement. This will continue to be observed over the next couple of months to ascertain if this improvement will continue.

Metrics with no significant change are:

- Number of births
- Stillbirth average days between
- Hypoxic-Ischaemic encephalopathy (HIE) average days between
- Unexpected admission to the neonatal unit

Metrics with a significant improvement:

- HIE rate
- Stillbirth rate
- Neonatal deaths
- 3rd and 4th degree tears

This data is reviewed at all governance meetings in the division, and there are a number of streams of work ongoing.

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:

- Q3 PMRT Report (Appendix 1)
- Q3 ATAIN Report (Appendix 2)

And formally record that:

- the 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.
- Board Safety Champions are meeting with the perinatal leadership team bi monthly and any support required of the Trust Board has been identified and is being implemented
- Progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support.

PMRT - Perinatal Mortality Reviews Summary Report

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

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

Quarter 3 period: 01/10/2024 to 31/12/2024

1. Introduction

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

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

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

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

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

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

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

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

The definition of labour used by MNSI is

- Any labour diagnosed by a health professional, including the latent phase of labour at less than 4cm cervical dilatation.
- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).

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

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

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

The Trust annual stillbirth rate for 2024 **from 24+0 weeks** of pregnancy and above across both sites is to 3.12 stillbirths per 1,000 births. In numerical values this was 11 stillbirths. During this same period from **22 weeks of pregnancy to full term** there were in addition to the 11 stillbirths there were 3 late fetal losses.

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

During the third quarter of 2024-2025, from 1st October 2024 to 31st December 2024 there has been **1** stillbirths of the 1,044 births across both sites (1 at BDGH) and **1** medical termination of pregnancy (MTOP) for fetal abnormality above 24 weeks gestation (1 at DRI). Of this time period, there were a total of 1,044 births, of which 685 births at DRI and 359 Births at BDGH.

There have been **2** late fetal losses between 22+0-23+6 weeks gestation during this quarter (1 at each site). During the same timescale, there have been **0** MTOP's of this same gestation.

This provides a trust adjusted stillbirth rate of **0.96 per 1000 births for this quarter 3**, from 24 weeks gestation; which is a decrease from last quarter (quarter 2 of 2024-2025 adjusted stillbirth rate of 3.7 per 1000 births).

Combining the figures from quarters 4 of 2023-2024 and quarters 1, 2 and 3 of 2024-2025 the rolling adjusted stillbirth rate is **2.5** per 1000 births. This equates to 11 stillbirths from 24 weeks of gestation (total births for this period is 4,366 for both sites).

3. Neonatal Deaths

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

Deaths that are included in the Trust rates are those of babies that were born and died within the trust. The Trust annual 2024 stabilised and adjusted rate for 2024 was 0.2 per 1000. In numerical values this was 1 early neonatal death.

During the third quarter of 2024-2025, from 1st October 2024 to 31st December 2024 there have been **1** Neonatal and post-Neonatal deaths of the 1,044 births across both sites. 685 births being at DRI and 359 Births being at BDGH.

This provides the Trust with a stabilised and adjusted rate for this quarter 3 of 2024-2025 of **0.96** per 1,000.

Combining the figures from quarters 4 of 2023-2024 and quarters 1, 2 and 3 of 2024-2025 (excluding the deaths under 22+0 and MTOP resulting in NND) the rolling adjusted neonatal and post-neonatal deaths rates of 1 equates to a rate of **0.2** per 1000 births from 22 weeks of gestation (total births for this period is 4,366 for both sites).

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

CNST requirements - Safety Action 1

Requirements	CNST requirement compliance	CNST Trust Compliance
a) All eligible perinatal deaths from 8 December 2023 should be notified to MBRRACE-UK within seven working days.	**100%**	**100%**
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions / comments they have sought from 8 December 2023 onwards.	**95%**	**100%**
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8th December 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	**95%**	**81%**
	60%	**100%**
d) Quarterly reports should be submitted to the Trust Executive Board from 8 December 2023.		**Q3 detailed within this report will be reported at Board in March**

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

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *4*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
4	1	1	2	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal death reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
2	1	0	1	0

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

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

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

Case ID **(SB)**	Date	Gestation	Antenatal/ Intrapartum	Initial review findings	PMRT and investigation /review outcome
[redacted]	[redacted]	23+6	Antenatal	[redacted]	Care graded A, A Review outcome: It was highlighted during the review that there was good use of interpreter services, and everything was managed well. It was also noted that cultural beliefs were supported.
		23+6	Antenatal		Care graded A, B Review outcome: Pre-conceptual care not provided by GP at patient request, contacted and requested for pathways to be reviewed. Has been put in place for future pregnancies. During labour, progress not documented on partogram.

[redacted]			[redacted]	
	37+6	Antenatal		Care graded: C, C Review Outcome: Further discussion to take place around diabetic management, timing of delivery between 37-37+6 should have been organised, during the review it was apparent no delivery date was organised leading to a grade of C. Discussions around the emotional impact of emergency situation during delivery, the review group concluded the emergency situation could have been managed differently which lead to a grading of C

[redacted]				[redacted]	
Case ID **(NND)**	Date	Gestation and Age	Initial review findings care until the birth of the baby & Initial review findings care of the baby		PMRT and investigation /review outcome
[redacted]		34+3 Died 5 hours 31 minutes of age	[redacted] Cytogenetics – unable to offer as out of criteria.		Care graded C, B, A Review outcome: Antenatal - C Noted during review that several ultrasound scans were performed resulting in delay in transfer to theatre. Has been discussed at PSII and to undertake further investigation. Care of baby – A Discussions around earlier blood products was discussed, some group members felt the grading should be a B and not an A the majority vote was an A and the group agreed to go with the majority for grading. Postnatal care - A

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

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

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	2	--	--	--	--	2
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*2*	*0*	*0*	*0*	*0*	*2*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	1	0	1
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	2	0	0	1	0	3
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	2	0	0	1	0	3
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	2	0	0	1	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	2	0	0	1	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	1	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	1	0	1

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

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	2	0	0	0	0	2
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	0	0	0	0	2
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	1	0	0	0	0	1
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	1	0	1
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	1	0	1
Hospital post-mortem declined	0	0	0	0	1	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	1	0	0	0	0	1
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	2	0	0	0	0	2
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 2)

Role	Total Review sessions	Reviews with at least one
Chair	1	50% (1)
Vice Chair	1	50% (1)
Admin/Clerical	2	100% (2)
Ambulance Team	0	0%
Bereavement Team	6	100% (2)
Community Midwife	2	50% (1)
External	4	100% (2)
Management Team	8	100% (2)
Midwife	20	100% (2)
MNVP Lead	0	0%
Neonatal Nurse	5	100% (2)
Neonatologist	16	100% (2)
Obstetrician	20	100% (2)
Other	4	100% (2)
Risk Manager or Governance Team	7	100% (2)
Safety Champion	2	100% (2)
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	2	100% (1)
Community Midwife	1	100% (1)
External	3	100% (1)
Management Team	5	100% (1)
Midwife	10	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	7	100% (1)
Neonatologist	10	100% (1)
Obstetrician	12	100% (1)
Other	0	0%
Risk Manager or Governance Team	3	100% (1)
Safety Champion	2	100% (1)
Sonographer or Radiographer	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	0	0	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	1	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	1	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Timing of death	Cause of death
Late fetal losses	**2 causes of death out of 2 reviews**
	The cause of death was undetermined
	The cause of death was undetermined
Stillbirths	**0 causes of death out of 0 reviews**
Neonatal deaths	**1 causes of death out of 1 reviews**
	The cause of death was undetermined
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis	1	PSII commenced to understand the factors influencing the delays around admission identification of vaginal bleeding and decision for delivery.
This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines	1	PSII commenced to understand the factors influencing the delays around admission identification of vaginal bleeding and decision for delivery.

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

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

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
It is not possible to assess from the notes whether the pain and sedation management of the baby during the first 24 hours on the neonatal unit was appropriate	1	No action entered
The baby had to be transferred elsewhere for the post-mortem	1	No action entered
This mother's progress in labour was monitored on a partogram but the partogram was only partially completed	1	No action entered

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

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

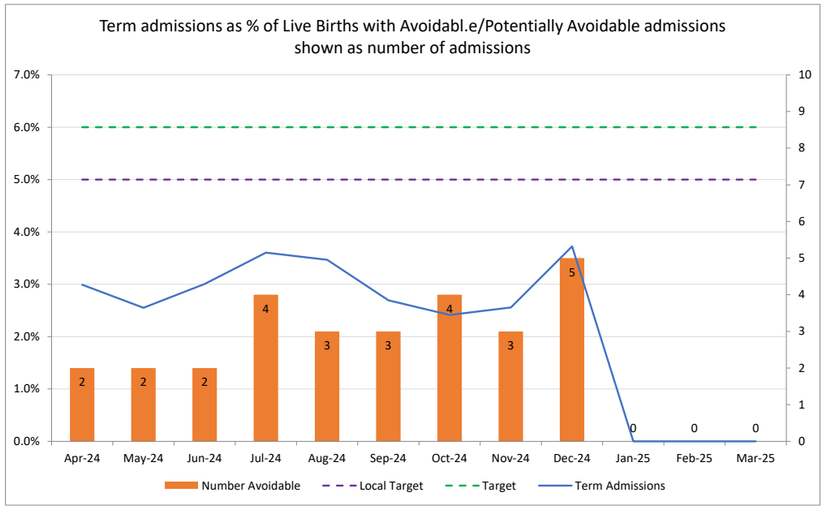
Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines
Task Factors - Decision making aids – Difficulties in accessing senior / specialist advice	1	This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis

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

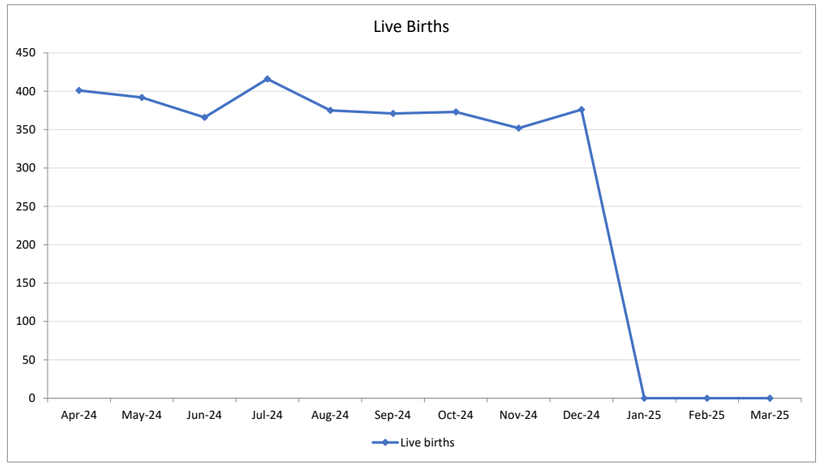
Month	Live Births All Gestations	All Inborn Admissions (excl transfers)	Inborn TERM admissions (37/40)	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions	Case Reviews MDT	Case Reviews Other
Apr-24	401	39	12	3.0%	5.0%	6.0%	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	373	29	9	2.4%	5.0%	6.0%	4	44.4%	9	
Nov-24	352	34	9	2.6%	5.0%	6.0%	3	33.3%	9	
Dec-24	376	41	14	3.7%	5.0%	6.0%	5	35.7%	14	
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	1	2				5
Hypothermia/temperature management									1	1				2
Hypoglycaemia/management of blood glucose		1		1										2
Antibiotics								1						1
Requires period of observation														0
Observation following resuscitation														0
Suspected sepsis														0
Jaundice after 24h					1			1						2
Seizures where concerns with clinical care														0
Diagnosed NAS				1					1					2
Other: Social Reasons														0
Other: Congenital anomaly manageable on PNW														0
Other: Other	Fall				1		1							2
Other: Other	HIE					1	1							2
Other: Other	Feed intolerance							1						1
Other: Other	Jaundice less than 24hours old									2				2
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**	**3**	**4**	**3**	**5**	**0**	**0**	**0**	**28**

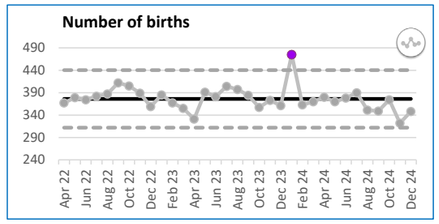


Maternity overview

Trust Total

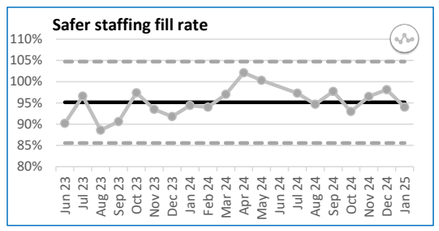
Latest month 01/12/24
Number of births **348**

No significant change



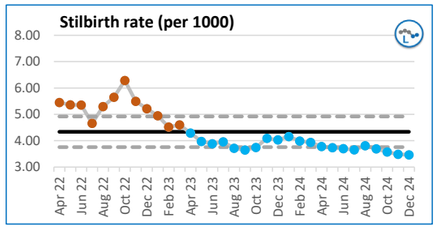
Latest month 01/01/25
Safer staffing fill rate **94%**

No significant change



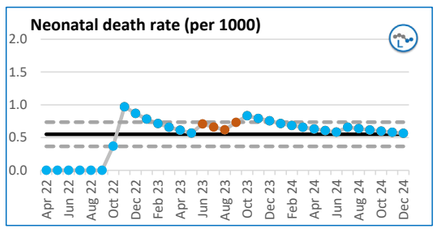
Latest month 01/12/24
Still birth rate/1000 **3.5**

Significant Improvement



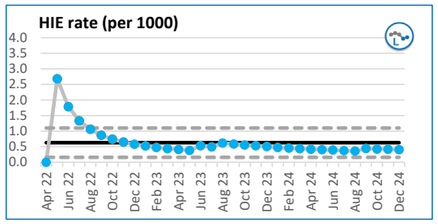
Latest month 01/12/24
Neonatal Death rate/1000 **0.6**

Significant Improvement



Latest month 01/12/24
HIE rate/1000 **0.4**

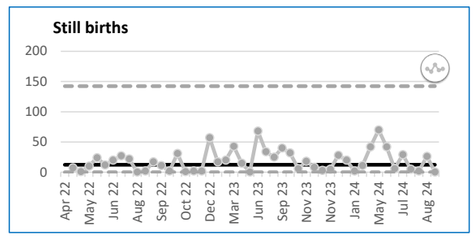
Significant Improvement



Date of last stillbirth 29/08/24

Average days between stillbirths **12.3**

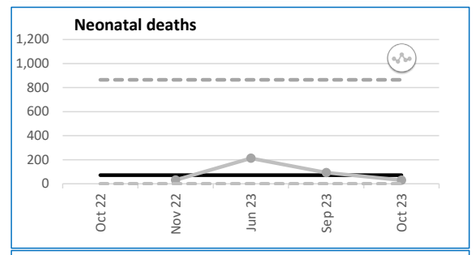
No significant change



Date of last neonatal death 01/10/23

Average days between deaths **71.6**

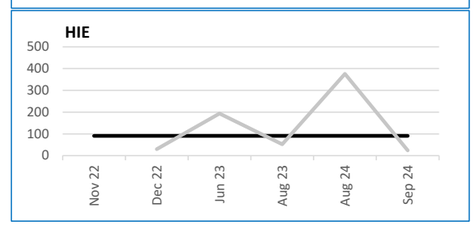
No significant change



Date of last HIE 11/09/24

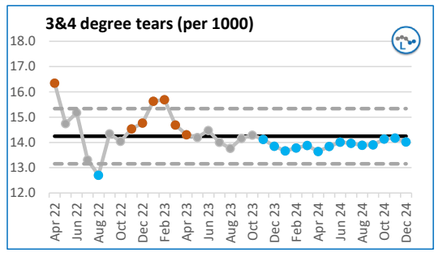
Average days between HIE **90.8**

No significant change



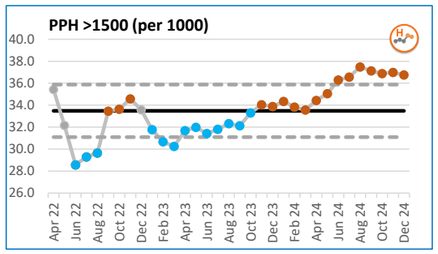
Latest month 01/12/24
3&4 degree tears (per 1000) **14.0**

Significant Improvement



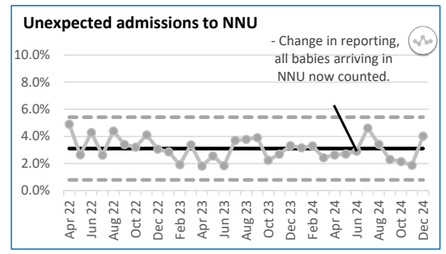
Latest month 01/12/24
PPH >1500 (per 1000) **36.7**

Significant deterioration



Latest month 01/12/24
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	**10-Dec-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.

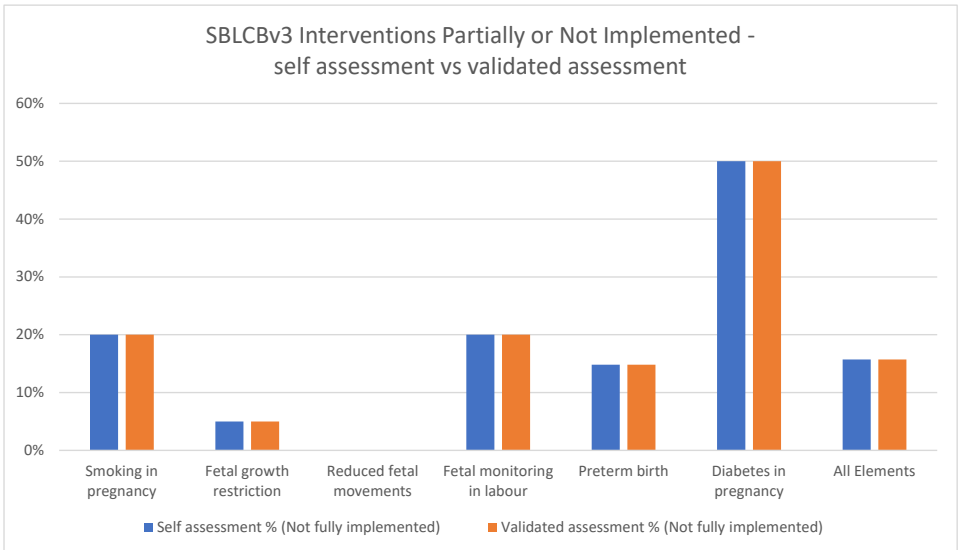
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

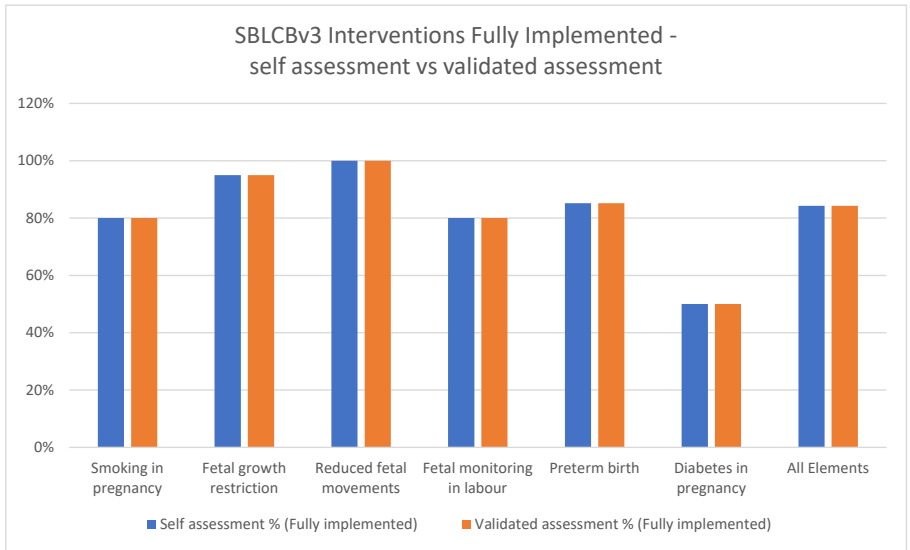
Implementation Grading

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	85%	CNST Met
Element 6	Diabetes	Partially implemented	50%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	84%	Partially implemented	84%	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.	Dec 24 - discussed: % of women referred who set a quit date (1c) is around 11% target > 30%. ABL is 8% and RDaSH are 14%. Target achieved for 1e (quit at 4 weeks) but to note ABL are low at 33%
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.	Dec 24 - remains partially implemented. Note progress in training compliance (now 78%) 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.	Dec 24 - remains partially implemented. Note progress in training compliance (now 78%) 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

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
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.

Element 3

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
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.	Dec 24 - had requested risk assessment on admission screen (K2)
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	Fully implemented	Evidence not in place - improvement required.	Dec 24 - JDs / job plans now available. Fully implemented.
5.2	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Dec 24 - partial - PTB rate >national ambition but note improvements. Local actions fully implemented and note
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.	Dec 24 - discussed. 50% so <target trajectory. QI plan developed
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.	Dec- 24: discussed. Fully implemented during 23/24. Continue with quarterly monitoring of implementation. Trust have reviewed birth interval data and provided evidence.
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 - note 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	Fully 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.

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

Element 6	6.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Dec 24 - 100% of women offered CGM (fully implemented) Staff training element - some information received - continue to chase in order to evidence.
	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.	Dec 24 - discussed. Was previously fully implemented. Evidence uploaded and 40% indicated (improvement). Note that HbA1c is
	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

2503 - B3 LEARNING FROM DEATHS REPORT

Discussion Item | Dr Nick Mallaband, Acting Executive Medical Director | 10:15

10 minutes

REFERENCES

Only PDFs are attached

B3 - Learning from Deaths Report Q2 2024-25.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**B3**
Report Title:	**Learning from Deaths Quarterly Report – Quarter 2 2024/25**		
Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Mandy Cumberbatch (nee Dalton), Interim Learning From Deaths Manager		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

Purpose of the Report

To provide the Trust Board of Directors with the quarterly learning from deaths report.

Executive Summary

This reports provides information on the deaths of patients under the care of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as required by the Learning from Deaths Guidance, March 2017. It covers Quarter 2 (1 July – 30 September 2024) and includes the most recent data on crude mortality, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) metrics and presents key metrics on the mortality case review process, namely Structured Judgement Reviews (SJRs) and provides insight into the learning from SJRs.

There were 434 inpatient deaths and 51 deaths within the Emergency Department during Q2. The Medical Examiner's office scrutinised 100% of all adult deaths in both acute and community settings during the period, with 137 deaths being reported to HM Coroner.

The process for learning from deaths following the structured judgement review (SJR) process has been reintroduced, along with a monthly mortality MDT. Of the deaths subject to SJR, no death was judged more likely than not to be due to problems in care.

This report is cascaded through divisions via their clinical governance groups and more widely with the ward and department staff to suggest, design and implement change to ensure improvements are made.

Recommendation:	To note and take assurance from 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**	**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
		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, NHS England, March 2017.		
Resources:	Increased workload and IT investment		

Assurance Route	
Previously considered by:	Quality Committee
Date:	11 February 2025
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

LEARNING FROM DEATHS QUARTERLY REPORT 2024/25 - Quarter 2

1. Introduction

This is the quarterly learning from deaths report to be received by the Mortality Governance Group and the Effectiveness Committee. It reports on the deaths of patients under the care of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as required by the Learning from Deaths Guidance dated March 2017. It covers Q2 (1st July – 30th September) and includes the most recent data on crude mortality, HSMR and SHMI metrics and presents key metrics on the mortality case review process, namely Structured Judgement Reviews (SJRs) and provides insight into the learning from SJRs.

2. Key Points

- There have been 434 in patient deaths at the Trust during the quarter and 51 in the Emergency Department.
- Four deaths following an elective admission and four deaths of patients with a learning disability.
- 137 deaths were reported to HM Coroner
- 39 inquests were opened during the quarter and 30 were were concluded
- 19 Structured Judgement Reviews (SJRs) were requested by the Medical Examiner office
- A further 25 SJRs were requested for patients who died of Pneumonia
- Of the deaths subject to SJR, no death was judged more likely than not to be due to problems in care.
- Two deaths have been reported via the Learning from patient safety events (LFPSE) process. Neither were concluded to be PSIIs.
- The 12 month rolling Hospital Standardised Mortality Ratio (HSMR) is 108.72. This rate has been relatively consistent though showing a slight downward trend this month. The Summary Hospital Level Mortality Indicator (SHMI) rolling 12 month figure is 113.94.

- 100% of all in hospital deaths have been scrutinised by the Medical Examiner's office. The process became statutory on 9th September and the team have successfully embraced the scrutiny of the non-acute deaths. They review most cases referred in within one working day and engagement with GP practices is good.
- Learning points from the completed SJRs are:
  - Oxygen must be prescribed before administering.
  - Administration of antibiotics in sepsis must be within 1 hour of diagnosis.
  - Recognition of the need for fluid resuscitation in the case of significant hypotension and blood loss must be improved.

3. Deaths by month- Crude Mortality July 2024- September 2024

3.1 There were a total of 485 deaths in Doncaster & Bassetlaw Teaching Hospital Foundation Trust (DBHFT) in the 3 months between July 2024 and September 2024, of which 10.5% (51) were in the ED department and 89.5% (434) were inpatient deaths. (source: Information services)

3.2 Figure 1 shows inpatient deaths per month split by hospital site, figure 2 shows deaths in the Emergency Department split by site and figure 3 shows the inpatient deaths split by treatment function code.

Figure 1

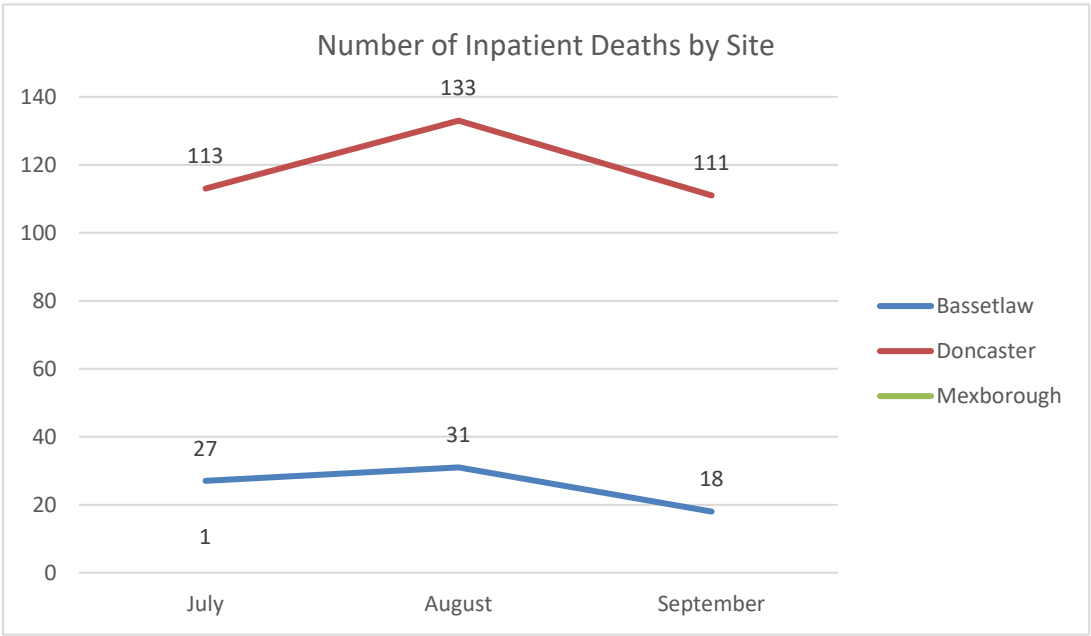


Figure 2

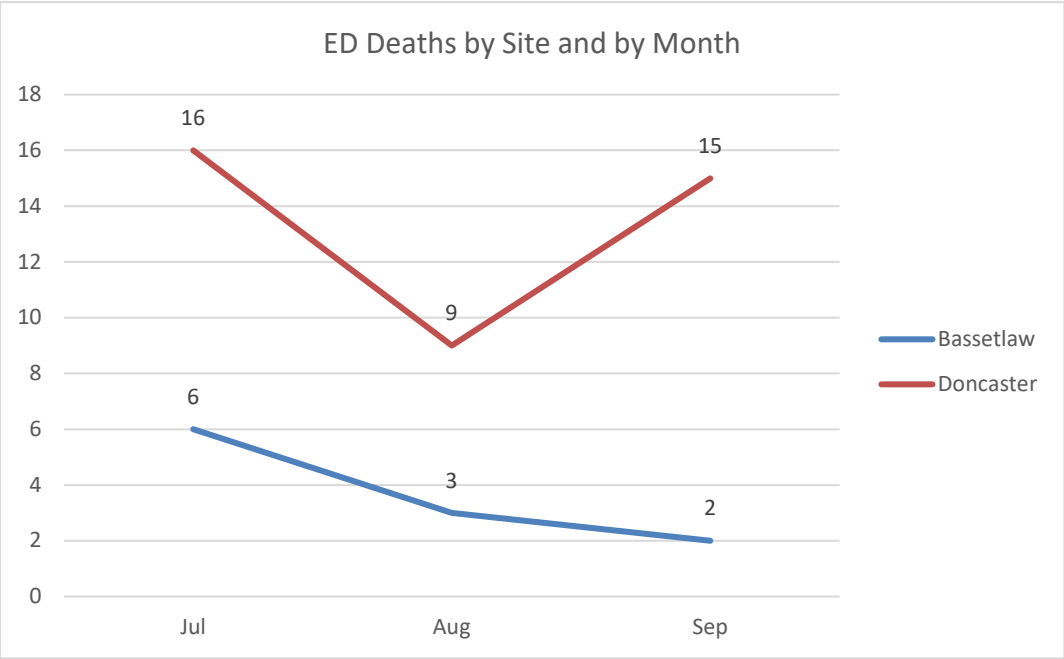
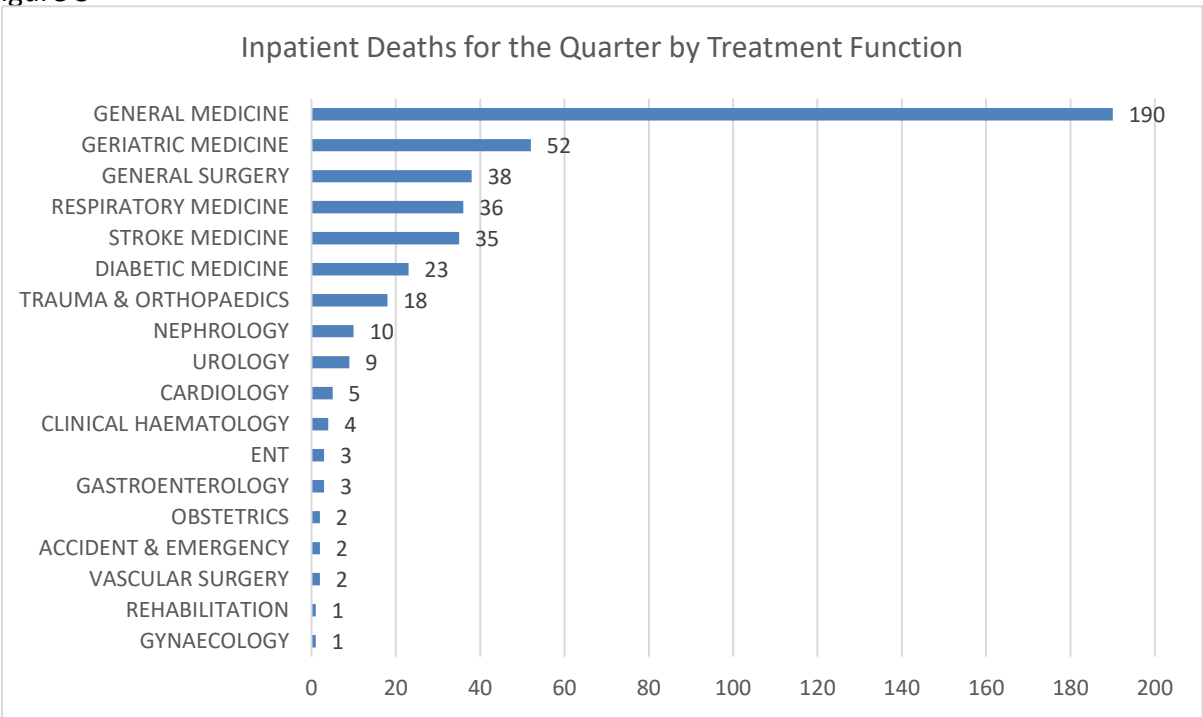


Figure 3



3.3 A total of five patients were admitted electively and died. Each of these cases have been discussed at the monthly Mortality Governance meetings. One of the cases, following review, was concluded not to be an elective admission. The trust are currently identifying how to change the source of admission and we will continue to monitor this via this work stream. There were four patients recorded as having

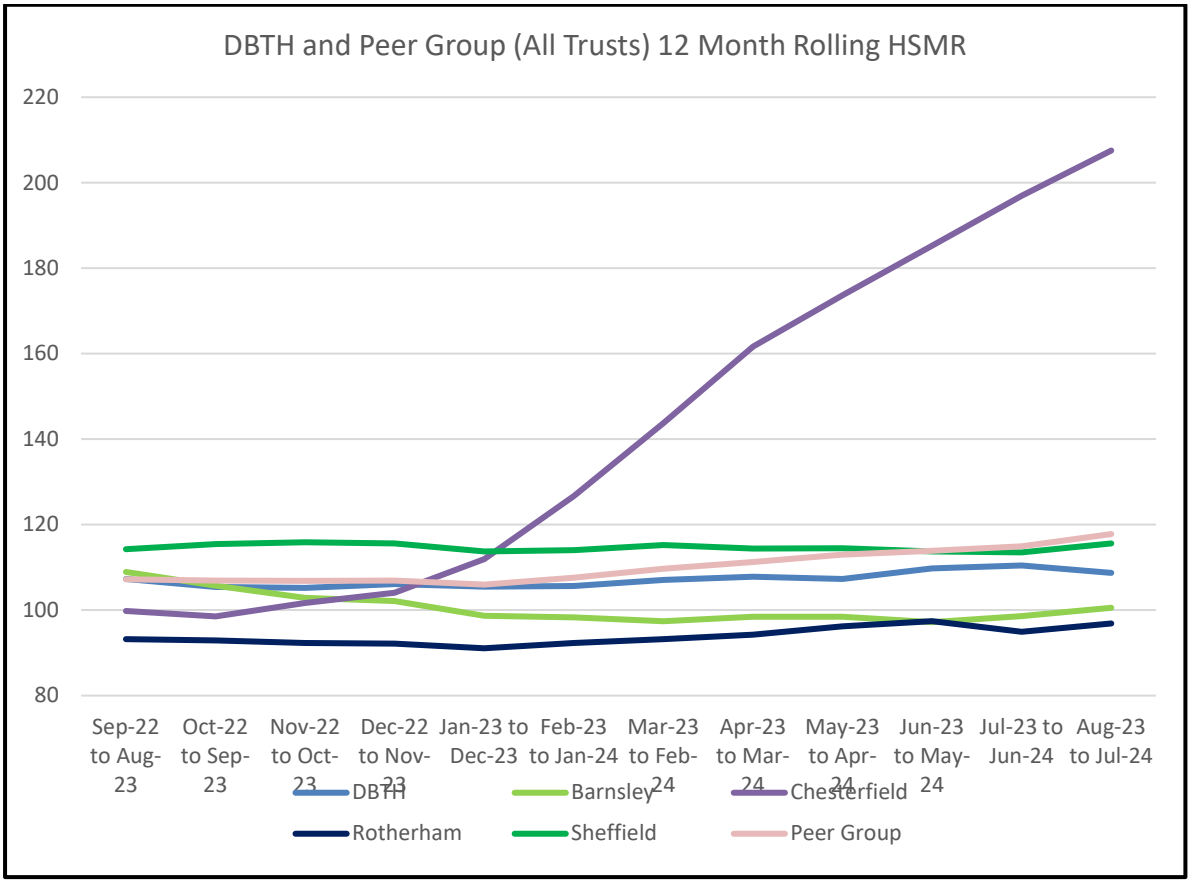
either a Learning Disability or significant mental health issue and/or Autism. All of these cases are reported to the LeDeR programme and also have an SJR undertaken.

4. Hospital Standardised Mortality Ratio (HSMR) August 2023 to July 2024

4.1 The 12 month rolling HSMR from August 23 to July 24 is 108.72. This is a reduction from 110 last quarter. There is always a lag of approximately 2 months in the data. This figure is accurate as of 11th October 24.

See Figure 4 for our most recent HSMR against our peer group.

Figure 4

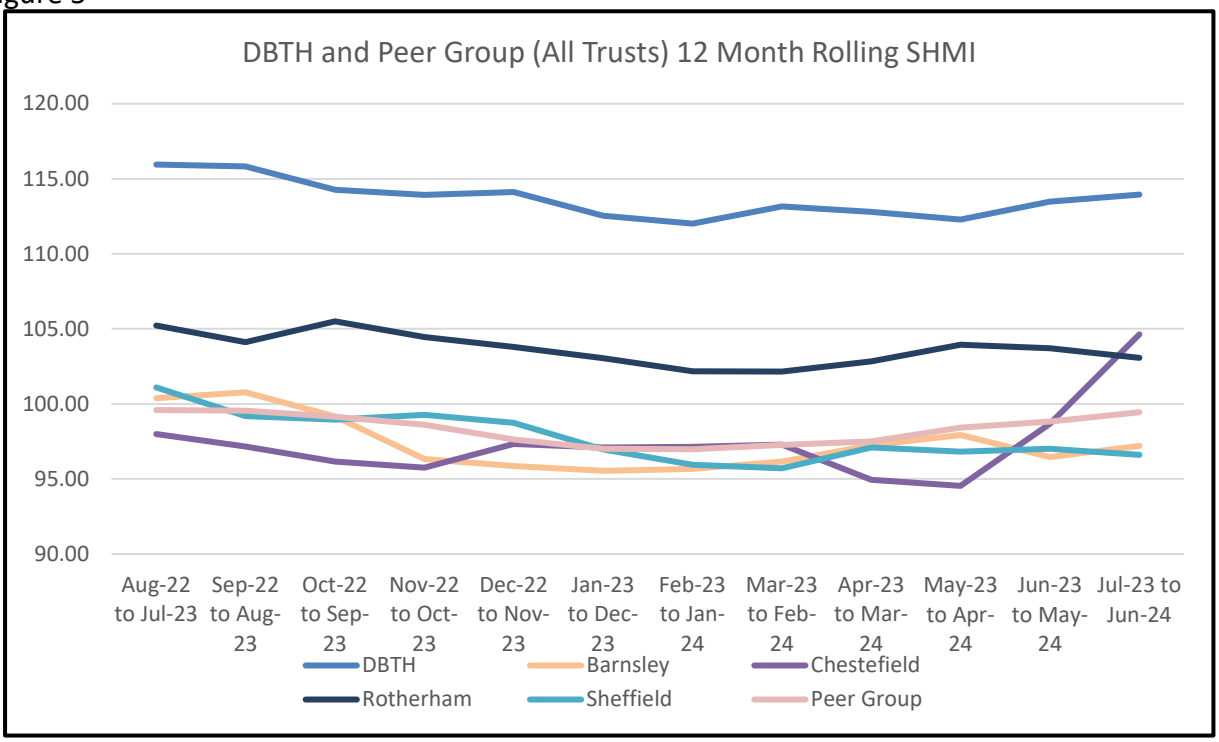


4.2 Monthly Mortality Governance meetings provide an update on data quality findings, clinical coding and clinical reviews. Workstream updates cover data quality and clinical coding so that any correction of recorded admission method/source can be actioned.

5. Summary Hospital–Level Mortality Indicator (SHMI) Aug 23 to Jul 24

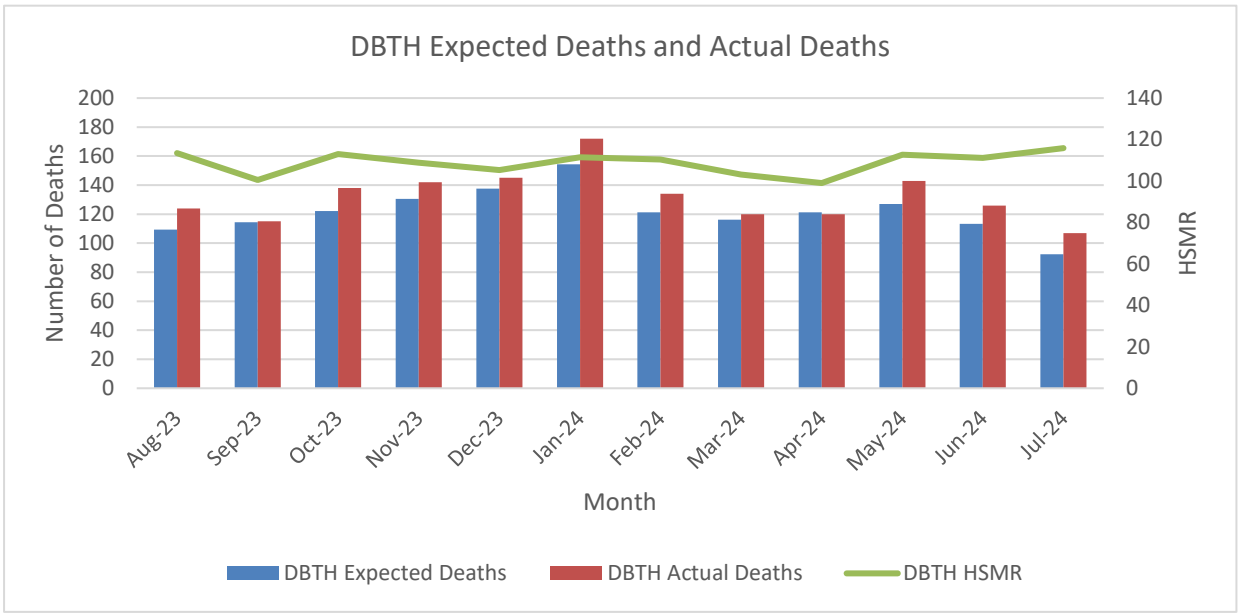
5.1 The Trust SHMI value for this period can be seen in Figure 5. The most recent figure is 113.94 and we are the highest within our peer group. The key difference between SHMI and HSMR is that the SHMI includes deaths following a patient's discharge within 30 days.

Figure 5



5.2 Figure 6 demonstrates the expected deaths and actual deaths at the Trust. The data from the Healthcare Evaluation Data (HED) system is lagging at present, for the purpose of this report; the data is only available up to July 2024.

Figure 6



6. Cause of Death

6.1 Lobar pneumonia remains the most frequently coded diagnosis in the final episode before death. Figure 7 shows the top 5 coded reasons for death for each month.

Figure 7

July-24	Diagnosis ICD Code	Description	Number of Patients who Died
1	J181	J181: Lobar pneumonia, unspecified	16
2	J189	J189: Pneumonia, unspecified	8
3	I500	I500: Congestive heart failure	8
4	UO71	UO71: Emergency use of UO7.1 (covid)	7
5	J690	J690: Pneumonitis due to food and vomit	7

August-24	Diagnosis ICD Code	Description	Number of Patients who Died
1	J181	J181: Lobar pneumonia, unspecified	26
2	A419	A419: Sepsis, unspecified	16
3	I500	I500: Congestive heart failure	8
4	J189	J189: Pneumonia unspecified	7
5	J841	J841: other interstitial pulmonary disease with fibrosis	5

Sept-24	Diagnosis ICD Code	Description	Number of Patients who Died
1	J181	J181: Lobar pneumonia, unspecified	14
2	A419	A419: Sepsis, unspecified	8
3	J690	J690: Pneumonitis due to food and vomit	7
4	C341	C341:Malignant neoplasm:upper lobe, bronchus or lung	6
5	J189	J189: Pneumonia, unspecified	5

7. Mortality Case Review Process- Structured Judgement Review (SJR)

7.1 A Structured judgement review (SJR) blends traditional, clinical-judgement based review methods with a standardised format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments and to score each phase of care. The result is a relatively short but rich set of information in a form that can be aggregated to produce knowledge about clinical services and systems of care. Throughout the year several clinicians including advanced nurse practitioners, consultants and senior nurses have received training in how to undertake SJRs as approved by the Yorkshire and Humber Improvement Academy. The plan for a central team of reviewers to undertake SJRs going forward continues. However, this quarter has seen some challenges with regards to some consultants not having protected time agreed within their job planning. As a result, more senior nurses are completing the SJRs. This is being addressed by the Medical Director as it is important that the process is primarily consultant led. It may be that specialties where more deaths feature, due to the nature of the conditions, more senior medical staff will need to support the process. The crucial aspect of this whole process is the identification of themes for learning and also to recognise good care. It is the responsibility of clinical teams, via their various governance teams to ensure the learning is translated into actions, audit topics and quality improvement.

7.2 The Medical Examiner (ME) team alert the trust to the following cases after their scrutiny and interaction with bereaved relatives:

- Deaths in areas where patients are not expected to die e.g. elective admissions for elective procedures
- Deaths of those with Learning Disabilities, significant mental health issues and/or Autism
- Deaths where a significant concern about the quality of care provided is raised the bereaved families and carers
- Deaths where a significant concern about the quality of care provided is raised by medical examiner or staff.

However, it must be remembered that the ME team are an independent body and once they have alerted the trust via their agreed process, they have no further involvement with the case or with the reviewer undertaking the SJR.

This quarter 19 hospital deaths (4%) have been referred for SJR by the medical examiner office and a further 25 (5%) have been undertaken of patients who died of Pneumonia. To date 34 SJRs have been completed. This is 7% of all deaths and

a significant improvement from 2% last quarter. A trajectory of 5% was set by the mortality Governance group for this quarter which we have achieved. A further improvement trajectory of 10% has been set for Quarter 3.

8. Learning from Structured Judgement Reviews (SJRs)

8.1 Of the 34 SJRs completed to date this quarter, figure 8 shows the breakdown of the overall assessment scores. There are a further 10 SJRs due for return which are being actively chased.

Figure 8

1. Very Poor	0
2. Poor	3
3. Adequate	4
4. Good	18
5. Excellent	8

Those SJRs where exemplary care was identified, individual feedback has been provided to the clinician and/or team. Three SJRs this quarter were judged to have had poor overall care. These were all completed by different reviewers. As per the process, two of these have been discussed at the multidisciplinary SJR team meeting were it was agreed that in one of the cases the management of sepsis was poor in terms of recognition and administration of antibiotics. In the second case, fluid resuscitation and the management of hypotension was poor. The third case will be discussed at the next team meeting as this involves a patient with a learning disability (LD) and so the LD liaison nurse will be part of the MDT review.

8.2 Pneumonia as direct cause of death

During this quarter patients who have “Pneumonia” at 1a or 1b on their MCCD are being captured on a spreadsheet by the bereavement team and forwarded to the LFD manager each week. An SJR is then requested and the specific management as laid down by the British Thoracic society has been incorporated into the SJR proforma.

As well as the usual judgement of care the following specific questions are being asked:

- Was the diagnosis correct (i.e. does the CXR or CT confirm consolidation)?
- Was the CURB65 completed?
- Were appropriate antibiotics given?

- Did the team request atypical screen if CURB 3 or above (i.e. serum mycoplasma, urinary legionella antigen)?
- If positive to mycoplasma and legionella did they receive 14 days clarithromycin?
- Was the patient on oxygen? If so, was it prescribed?

Analysis of the 25 pneumonia death SJRs revealed that in general the diagnosis was correct based on the CXR findings. The CURB score was documented in all of the cases but in two of the cases the atypical screening was not requested. There was good compliance with antibiotic choice though timeliness of administration could be improved. There also needs to be improvement in the prescribing of oxygen.

8.3 Sepsis as direct cause of death

Drs Ken Agwuh and Hugh Wilson, along with other senior nursing staff are undertaking SJRs on patients who die from sepsis and these are discussed at the Sepsis action group. The SJR proforma has been amended slightly to include the requirements for sepsis 6. This extremely valuable work continues and further analysis will be provided in Q3.

An important aspect of the SJR process is that it highlights good care as well as poor care. As can be seen in Figure 8 above the majority of cases reviewed have recorded "4" (good care). Frequently seen examples of "good care" include:

- Senior review was good
- Prompt assessment and management plan was evident
- Communication with family was very good and clear concise documentation evident.
- Good MDT input from specialist nurses.

Points for learning from the SJRs this quarter were the reviewer judged the overall care to be "poor" are:

- Oxygen must be prescribed before administering.
- Administration of antibiotics in sepsis must be within 1 hour of diagnosis
- Recognition of the need for fluid resuscitation in the case of significant hypotension and blood loss must be improved

The learning must happen at ward and department level. It is the responsibility of specialty and Divisional Governance leads to ensure this report is shared widely. Linking with the education department and the quality improvement team is crucial for the wider organisational learning.

8.4 SJR PLUS

This application has now been purchased and preliminary work has been undertaken with regards individual licenses to use the app. Some members of the SJR review team dialled in to an SJR plus workshop in October. It is hoped that from December, the team will begin completing SJRs via the app so that by Q4 it can used so that we will then be able to capture the SJR compliance rates and findings much more easily.

9. Referral to His Majesty's Coroner (HMC)

9.1 This quarter there have been 137 referrals to the coroner.

Referral to the Coroner does not necessarily mean the case will go to Inquest. In many cases, the Coroners will review the referral and the Medical Examiner Scrutiny and proposed cause of death as documented on the MCCD. Following communication and agreement with the family, if the proposed cause of death is accepted a form 100A is issued. This is commonly known as an 'APASS' An interim death certificate can be issued by the coroner, this could be due to the post mortem result being inconclusive, an investigation is ongoing by the coroner or there is to be an inquest. The interim certificate replaces a certified copy of the death certificate until the inquest or investigation is concluded. This enables the death to be registered and therefore families can move forwards with their plans. Similarly, if no medical practitioner can state the cause of death to the best of their knowledge and belief, the coroner will have to be notified. It would then be for the coroner to determine the cause of death.

39 inquests have been opened this quarter and 30 concluded. The details of these are reported to the Patient Safety Review Group on a quarterly basis and to the Patient Safety Committee 6 monthly.

9.2 Regulation 28 Prevention of Future deaths reports

0 Regulation 28: Prevention of future deaths reports were issued to the Trust this quarter.

TO NOTE:
The Regional Mortality Group have published an analysis of prevention of future deaths reports for the time period January 2023 to September 2024 to acute Trusts in the Yorkshire and Humber region. This report will be discussed at the November 2024 Mortality Governance meeting. During this period of time the Trust received

2 PFDs and the issues highlighted in them will be further discussed at the meeting too prior to being included in the Q3 report.

10. Patient Safety Incident Response Framework (PSIRF) investigations

10.1 There have been two inpatient deaths that have been referred to the Trust Learning from Patient Safety Events Panel (LFPSE) for review.

PSIRF guidance stipulates if a patient safety event meets any of the national priorities then a patient safety incident investigation (PSII) report is required. None of these cases were considered more likely than not due to problems with care and are currently undergoing PSII to thoroughly review all aspects of care delivery and to identify learning.

11. Conclusion

The Mortality Governance Group and Effective Committee are asked to note the content of the report.

12. Recommendations

- All Divisions to share this report via their clinical governance groups and more widely with the ward and department staff. Clinical Governance groups to suggest, design and implement change to ensure improvements are made.
- The Mortality Governance (MG) group to review the trajectory for the numbers of SJRs to be completed each month for the next 12 months.
- The Mortality Governance group to note the changes to the reporting schedule below now that the date of the MG meeting has been changed.
- Reporting schedule:

QUARTER	Mortality Governance	Effective Committee	Quality Committee	Clinical Quality Review Group
Q1 : April - June	Sept 2024	Nov 2024	Dec 2024	
Q2: July - Sept	Nov 2024	Jan 2025	Feb 2025	
Q3: Oct - Dec	Feb. 2025	Mar 2025	Apr 2025	
Q4: Jan - March	May 2025	July 2025	Aug 2025	

Mandy Cumberbatch (nee Dalton), Interim LFD Manager.
November 2024

2503 - B4 ADDRESSING HEALTH INEQUALITIES

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

10 minutes

REFERENCES

Only PDFs are attached

B4 - Addressing Health Inequalities Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**B4**
Report Title:	**Addressing Health Inequalities Update (Post-Board Development Session)**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Dr Kelly Mackenzie, Consultant in Public Health (DBTH) and Clinical Senior Lecturer in Public Health (University of Sheffield) Richard Woodhouse, Health Inequalities Development Manager		
Appendices:			

Report Summary

Purpose of the report & Executive Summary:

To provide an update on the tackling health inequalities work. The information provided in the report provides a summary of the key work undertaken by the Health Inequalities Team and the discussions that were had at the Trust Board Development Session on the 4th February 2025. Based on those discussions, an action plan has been produced to provide clear direction to the Trust, the Board and the Health Inequalities Team as to how to progress the health inequalities work.

Recommendation:	The Board of Directors is asked to note the progress to date, key priorities, risks and issues highlighted by the divisions so far and forthcoming next steps in the process and support for Annual Planning actions/timescales and amendments.			
Action Required:	~~Approval~~	**Review and discussion**	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all

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

Implications

Relationship to Board assurance framework:			
	X	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	X	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
	X	BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues

	X	BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	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:	There are 8 CQC Key Lines of Enquiry Measures relating to health inequalities. The strategy document presented in this paper will support the provision of evidence that we are meeting these Key Lines of Enquiry Measures. Tackling health inequalities is mandated in the Health and Social Care Act 2022 – "…considerations also need to be given to the effects [of decisions] in relation to health inequalities. This applies to ICBs, NHS England and foundation trusts, and trust in England (the relevant bodies)." The strategy document presented in this paper will support the provision of evidence that we are taking action to tackle health inequalities.
Resources:	N/A

Assurance Route		
Previously considered by:		N/A
Date:	N/A	
Any outcomes/ next steps	N/A	
Previously circulated reports to supplement this paper:	• Tackling Health Inequalities Quarterly Update (F&P Committee 24/09/2024) • Tackling Health Inequalities Quarterly Update (F&P Committee 25/01/2024) • DBTH Tackling Health Inequalities Strategy 2023-2028 (Trust Board 28/11/2023) • DBTH Tackling Health Inequalities Strategy 2023-2028 (F&P Committee 30/10/2023) • Draft DBTH Tackling Health Inequalities Strategy and "Plan on a Page" (F&P Committee 24/07/2023)	

DBTH Tackling Health Inequalities Update Post-Board Development Session

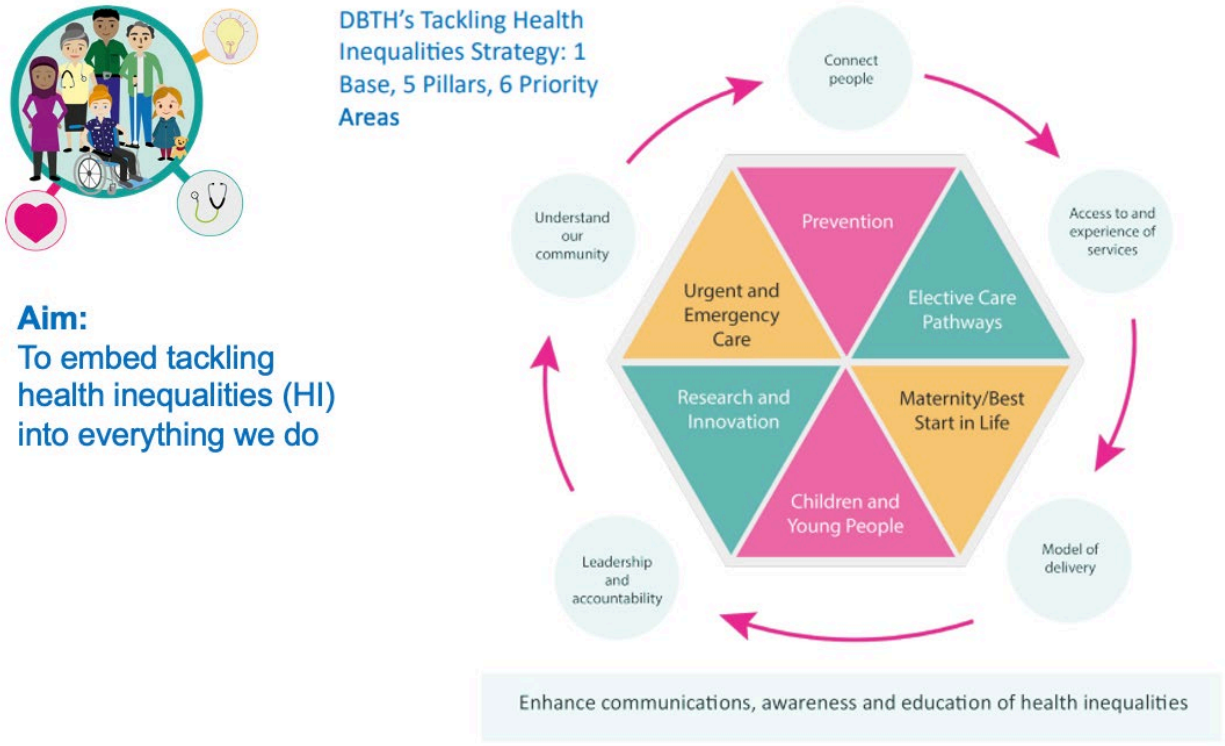
1. Background

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". They mean that some population groups have significantly worse health experiences and outcomes than others. Health inequalities are experienced by our people as well as our patients.

DBTH's Health Inequalities Team, led by Dr Kelly Mackenzie, Consultant in Public Health, and Richard Woodhouse, Health Inequalities Development Manager, has been progressing the health inequalities agenda across the Trust at pace, with the direction and support of the Deputy Chief Executive Zara Jones.

The Trust's first Tackling Health Inequalities Strategy was launched on 18 March 2024, following approval by the Trust Board on 28 November 2023. The aim of the strategy is to embed the reduction of health inequalities in everything we do to ensure equitable access and excellent experience, thereby providing optimal outcomes for our patients and the communities that we serve. To achieve this aim, our strategy has set out 6 priority areas of focus which include: Prevention, Elective care pathways / recovery, Urgent and emergency care pathways, Maternity and best start in life, Children and young people, and Research and innovation opportunities. These priority areas are underpinned by 1 base and 5 pillars (see Figure 1).

Figure 1: Summary of DBTH's Tackling Health Inequalities Strategy



The base provides the foundation to the delivery of this strategy and refers to enhancing our communications, awareness and education of health inequalities for our people, our patients and our local communities.

The 5 pillars encompass behaviours, models of practice and a general ethos/culture shift which when implemented will support all the work across all priority areas. These pillars include:

1. Understanding our communities – to ensure accurate, complete and timely access to population health data in conjunction with community voices to better understand the health inequalities and where to focus our action.
2. Connecting people – to work closely with partners and build on existing relationships, networks, and trust. This will ensure work is aligned and supported and will prevent silo-working allowing health inequalities to be addressed using a whole system approach.
3. Model of delivery – to move towards a more needs-led, compassionate social model of care and to use co-production to improve existing services and/or develop new services based on the needs of our communities.
4. Access to and experience of services – to focus on the Core20PLUS5, ensuring targeted support is provided for the Core20 and PLUS groups, including inclusion health groups, particularly (but not exclusively) across the 5 service areas for adults and children and young people.
5. Leadership and accountability – strong leadership and clear accountability and governance structures will support a culture shift and help to embed heath inequalities in everything we do, acknowledging that our colleagues may also be experiencing health inequalities.

Over the past year, significant strides have been made in embedding health inequalities (HI) into core decision-making processes and operational practices. The Health Inequalities Steering Group continues to drive the conversation, whilst ensuring alignment with national and local priorities. HI is now integrated into annual business planning templates, reinforcing accountability across all teams.

To deliver the strategy aim, the HI Team has three main areas of focus for the coming year (2025/26):

1. **Training and raising awareness** of health inequalities amongst DBTH staff to build capacity across the Trust, acknowledging that the HI Team cannot tackle inequalities alone.
2. **Evidence-based interventions** which encompasses several discrete projects including research and innovation opportunities, which the HI Team will either lead on or support others to undertake.
3. **Developing a culture where tackling health inequalities becomes business as usual for our Trust** which links back the overall aim of our Tackling Health Inequalities Strategy and essentially refers to our pillars (including the development of data systems – Figure 1 above) and three-tiered framework (Figure 2 below).

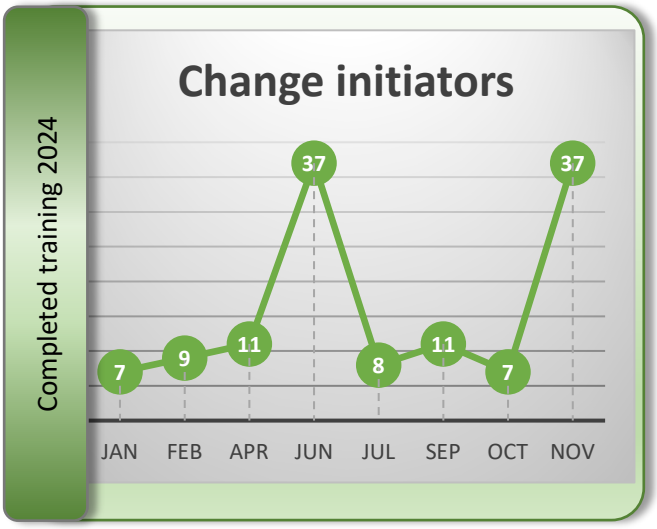
Figure 2: Three-tiered framework for improving health and tackling health inequalities (adapted with permission from Barnsley's Integrated Care Partnership framework)

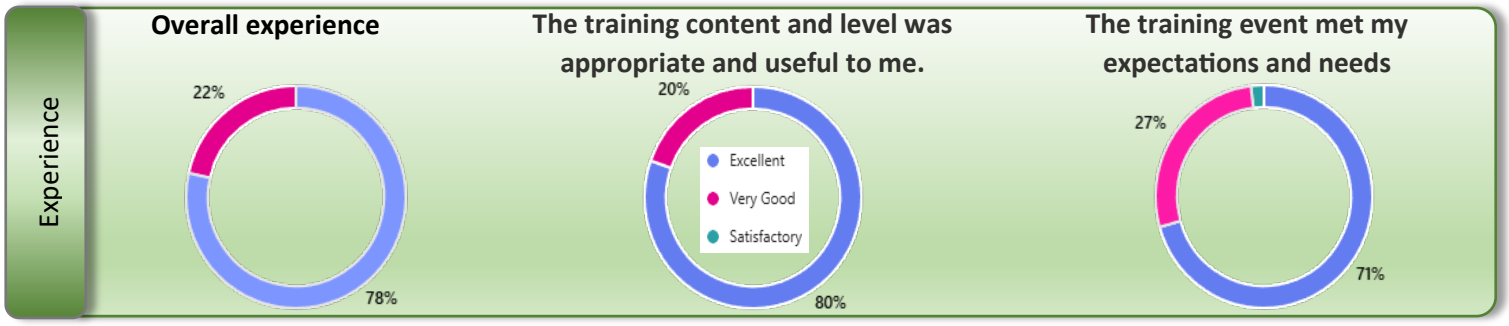
2. Training and Education

This has been the main area of focus for the HI Team over the last year and will continue to be going forwards. Building capacity within the Trust by training staff about what health inequalities are and how to tackle them ensures that tackling inequalities becomes a focus for everyone and part of business as usual.

Here are some specific achievements:

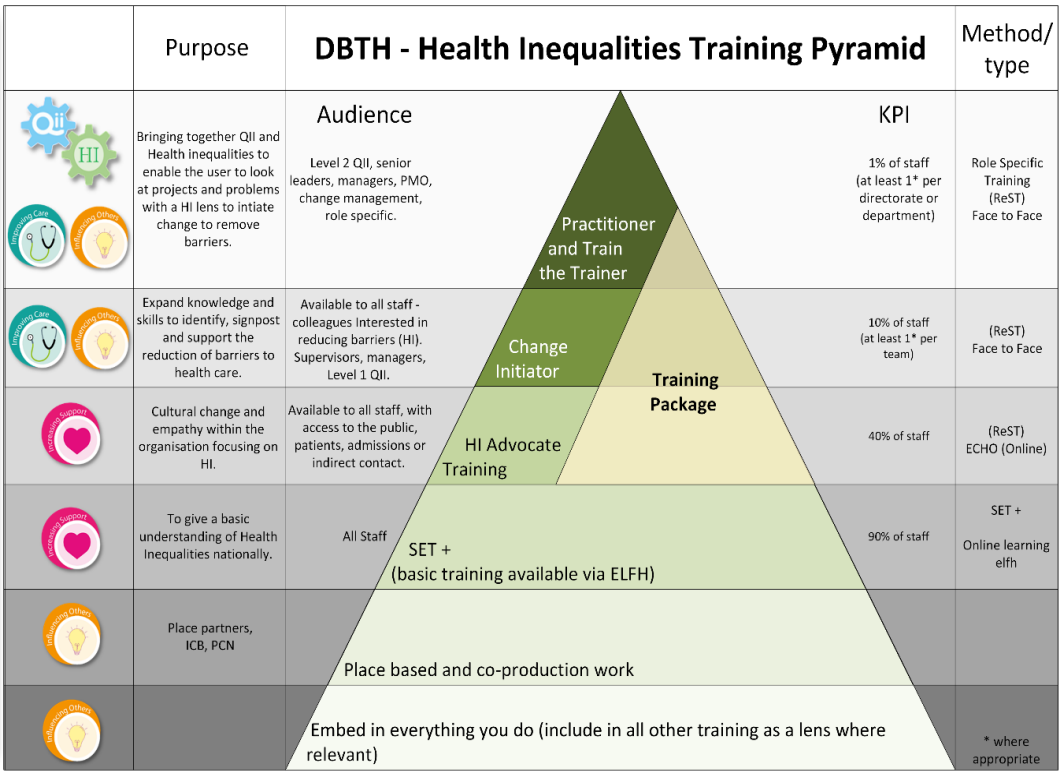
- Roll-out of the Change Initiator Training, with 139 staff trained to date, receiving overwhelmingly positive feedback.
- Launch of Heath inequalities training in SET +.
- Development of Health Inequalities Advocate Training module, using the ECHO model to enhance accessibility.
- A pilot of Practitioner-level training has been initiated, focusing on actionable strategies to tackle health inequalities, incorporating health inequalities into the Quality Improvement (QI) methodologies.
- ICB endorsement of the training model with the prospect of rolling out regionally.





Testimonial

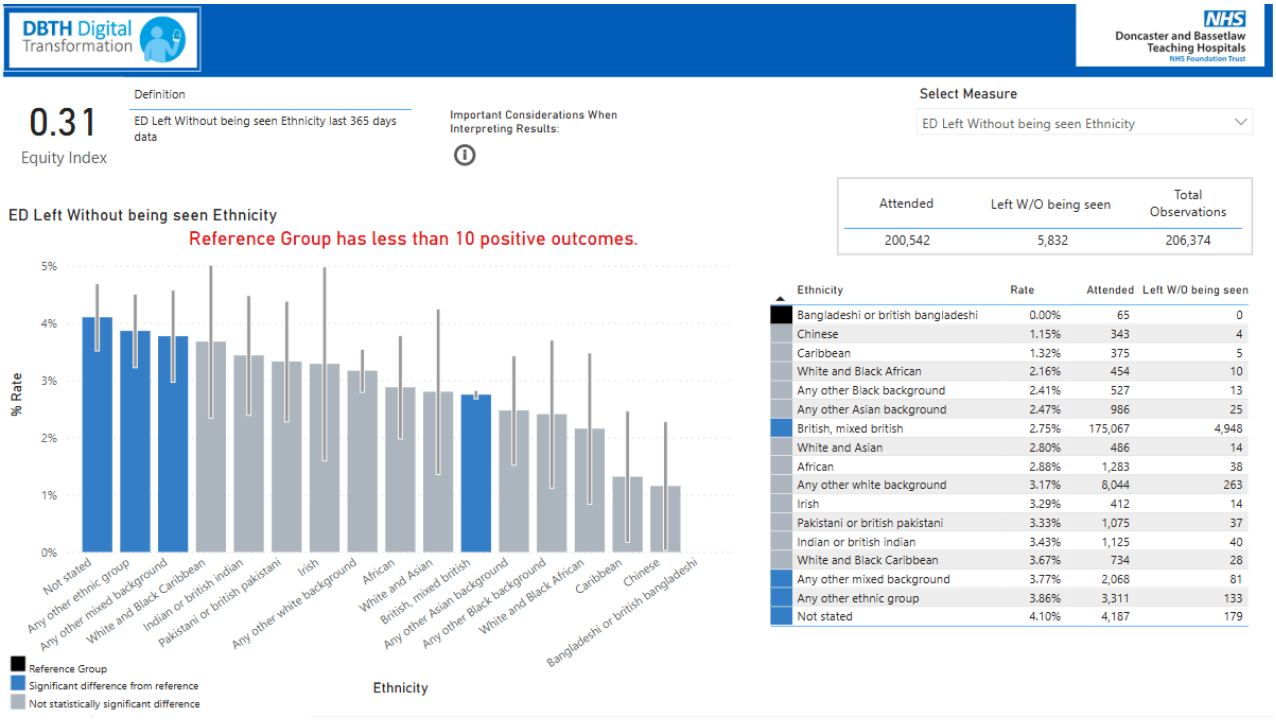
"I felt the training was really helpful, informative and really did make me think very differently about the diverse population we care for on the Neonatal Unit. We have since adopted all kinds of adaptations on the unit, for example, lots of welcome signs in different languages, lots of information around the unit in sign language, we have also applied for funding for staff to learn sign language as effective communication is paramount everywhere."



3. Data

- The DBTH Health Inequalities Dashboard is in development, which will provide robust reporting on disparities across patient populations.
- The DBTH Equity Index prototype has been developed (see Figure 3) – this provides a number between 0 (complete inequity) and 1 (no inequity) which highlights the extent of the inequity.

Figure 3: Screenshot of prototype Equity Index dashboard showing patients who left the Accident and Emergency Department before being seen, broken down by ethnicity



4. Research

There is involvement in research projects (particularly because of Kelly Mackenzie's joint clinical academic post). Current planned/ongoing research includes:

- A National Institute for Health and Care Research (NIHR) intervention development project which aims to understand the barriers to accessing perinatal mental health care for women/pregnant people whose needs are not met by existing services. This project began in October 2024 and will run for 18 months. KM is the Principal Investigator on this project.
- A large NIHR maternity inequalities challenge which is looking to tackle the "causes of the causes" of maternity inequalities. KM is part of a larger team at the University of Sheffield which is working together on this project as part of a consortium with colleagues from the London School of Hygiene and Tropical Medicine and the Institute for Fiscal Studies. The consortium is currently in the research priority-setting phase with specific projects anticipated to begin in 2025/26.
- KM has also been shortlisted for a grant aiming to increase vaccination uptake in underserved population groups.

5. Service Development and Impact

Work is currently underway to align our strategy to recent publications and guidance such as the NHS England's "Reforming Elective Care for Patients" report and the Darzi report.

A project is underway to assess the access, experience, and outcomes for inclusion health groups (e.g., homeless individuals, sex workers, those with substance misuse issues) within Emergency Departments (ED). A workshop on 6th March will bring key stakeholders together to develop targeted interventions.

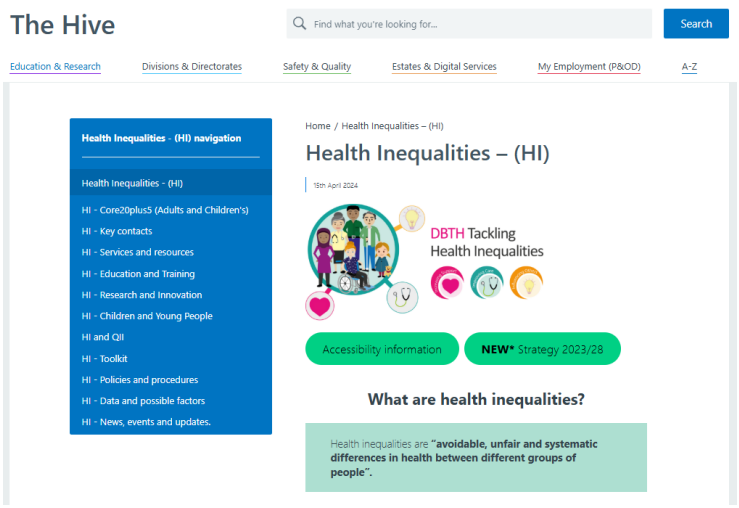
Within maternity and children's health we are collaborating with maternity and paediatric teams to provide specialist HI support.

6. Engagement and Communications

An Executive Team development session was held on 4th Feb 2025 to look at the trust's future direction in tackling Health Inequalities.

A structured communications plan is now in place, supported by a dedicated web space on The Hive and a Microsoft Teams platform for collaboration.

We are partnering with the People Focused Group (PFG – DBTH's formal engagement partner) to ensure lived experiences shape decision-making.



7. Next Steps

On 4th February 2025, the HI Team attended the Trust Board Development Session to summarise the above update and to gain feedback to the following questions:

1. What should be the HI team priorities going forwards? Long-term culture shift vs quick wins
2. How do we complete the HI Self-Assessment Tool as a Trust? This tool provides a score and maturity rating for the Trust's position in each of these domains:
    a) Building public health capacity and capability
    b) Data insight, evidence and evaluation
    c) Strategic leadership and accountability
    d) Systems partnerships
3. How can we ensure we empower everyone to tackle health inequalities?
4. How can we ensure tackling health inequalities is embedded in all decision-making processes for both our people and patients?
5. What is the role of the Board in supporting the above?
6. Is there an appetite to continue to be innovate and lead on the health inequalities agenda?

Based on the discussions in the Board Development Session, we have developed the action plan (below) which we would like you to review, feedback on and then approve.

8. Risks and Issues

- Capacity – the HI Team comprises 1 x FTE HI Development Manager (Band 7) and 0.5 x FTE Consultant in Public Health. Thus, we are limited in what we can achieve in a timely manner. We are also working to build capacity across the Trust.
- Prioritisation – there is no specific ring-fenced budget to support the delivery of agreed HI priorities. Funding for discrete projects and other initiatives would accelerate delivery and impact, yet it is recognised that the financial environment is constrained, and investments would require business cases to support.
- Cultural change and embedding improvements – whilst addressing health inequalities remains a key priority for the organisation, wider changes to working practices, processes and governance will be required to truly embrace the agenda and underpin delivery of the transformative improvements required.

Action Plan – derived from Board Development discussions January 2025

	Actions	Lead	Timescale	Next Steps	Expected Outcomes
Data and evidence	Start using national and local dashboards to report our HI data as part of IQPR and other reports as relevant	HI Team & Performance Team	6 months	HI & Performance teams to meet to discuss	HI data incorporated into IQPRs and other reports as appropriate allowing us to determine the extent of the inequality, prioritise work and track progress over time.
	Look at Coventry and Warwickshire tool and whether it is a good investment to use and compare to the pilot being developed in Barnsley NHS FT and have follow up discussions re. ethics and approach of HI prioritisation of waiting lists	HI Team & Deputy COO (elective)	2 months	HI Team to undertake a review of the UHCW wait-list prioritisation tool	Decision to be made about whether to incorporate this tool or the Barnsley model or neither into our waiting lists.
	Examine whether there is evidence of changes in deprivation in areas where there has been investment to support future decision making and benefits realisation	HI Team & Place partner colleagues (LA / ICB)	2 months	HI Team to contact Place partner colleagues	Provide a short report assessing the changes in deprivation in areas where there have been significant investments.
Leadership and Board action	Complete self-assessment tool (small sub-group of the Board) and use as a benchmark to improve on over 12 months	HI Team, Deputy CE plus other Board member volunteers	2 months	HI Team & Dep CE to establish a sub-group	Baseline completion of HI Self-Assessment Tool which we can then use to monitor progress over time.
	Agree Board member HI pledges which can be communicated across the organisation to share the word	Deputy CE	2 months	Deputy CE to communicate with the Board to obtain each member's pledge	A series of pledges on what the Board and its members will do to tackle health inequalities.
	Include HI case studies / presentations on agenda of Public Board	HI Team & Place partner colleagues (inc PFG)	Ongoing	HI Team to reach out to HI Steering Group members and Place partners for ideas and suggestions	Increased awareness and focus on the health inequalities agenda at a Board-level.

Process and governance	Include HI impacts and opportunities on coversheets and in business cases to ensure HI is more evident in our decision making	Trust Board Secretary & HI Team	2 months	Trust Board Secretary to liaise with HI Team to determine appropriate wording	Health inequalities impacts explicitly considered in decision-making, raising awareness and encouraging our people to focus on initiatives that tackle inequalities.
Specific initiatives	Determine 'top' priorities the Board should focus on which would have the biggest impact, then select these. Elective, UEC and DNAs mentioned as well for consideration.	HI Team	4 months	HI Team to review initiatives that have the greatest impact	Report with a list of top priorities for the Board to consider in terms of areas of focus for the HI Team and the Trust as a whole.
	Summarise HI elements of Division/Directorate 25/26 planning returns for a stocktake on priorities and gaps	HI Team	2 months	HI Team to review all annual planning returns and summarise HI areas of focus	Summary report to share with the Board and Divisions / Directorates with key learning / future considerations.
	Identify opportunities for HI action within current wellbeing offer	POD/Health and Wellbeing & HI Teams	6 months	POD/HWB & HI Teams to work together to map current wellbeing offer to HI opportunities	Mapping report with a view to establishing actions on HI linked to wellbeing initiatives.
	Explore potential for 'competitions' to encourage teams to deliver HI improvements	Comms & HI Teams	4 months	Scope out what such a competition might look like and develop a pilot competition as a trial	Develop a pilot competition and trial it – gain feedback as part of an evaluation.

2503 - C PEOPLE

2503 - C1 GUARDIAN OF SAFE WORKING ANNUAL REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 10:35

Mohammad Khan, Guardian of Safe Working
10 minutes

REFERENCES

Only PDFs are attached

C1 - Guardian of Safe Working Annual Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**C1**
Report Title:	**Guardian of Safe Working Annual Report**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Mohammad I Khan, Guardian of Safe Working Hours		
Appendices:	N/A		

Report Summary

Purpose of the report & Executive Summary

This report includes data for a 12 month period between 1 February 2024 and 31 January 2025. The reporting system changed in August 2024 from Allocate to HealthRota and data has been merged from both systems to provide the full 12 month record.

The total number of Exception Reports (ERs) filed in this period were 335. The majority of Exception Reports have been by Trainees working in larger specialties like General Surgery and General Medicine followed by Obstetrics/Gynecology and Paediatrics. The majority of ERs were submitted in relation to additional hours worked, reflecting the high workload of Resident Doctors, often compounded by rota gaps, inadequate locum provision, extra cover and unpredictable emergency care. There have been very few reports in relation to missed educational opportunities.

The cost of 'locum' cover increased over this period by a significant proportion. The main two 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 are broadly able to access educational opportunities as envisaged in the 2016 contract, 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.

Recommendation:	The Board is asked to note and take assurance from the 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
	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
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		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:	-
Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

ANNUAL 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 Hours

Report date: 4 March 2025

Executive Summary

The number of overall and education-related Exception Reports (ERs) is higher as compared to the previous 12 months' period. This is likely linked with the increase in spreading awareness and encouraging to exception report (335 as compared to 204 for the same period in 2024). 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 specialties.

In August 2024, the trust moved from Allocate as the system to report ERs to the newer system of HealthRota. Both systems have differences and it has been challenging not only to assess data but to get all supervisors to learn the newer system. HealthRota has made it easier for the trainees to file ER with the user friendly app that can be downloaded on the mobile phone. There was an effort to train and engage supervisors to get used to the newer system and sessions were arranged as ad hoc as well as in the Trust other forums like the Trust Medical Committee (TMC).

Over the past year, the majority of Exception Reports have been submitted by Trainees working in General Medicine, General Surgery, Obstetrics/Gynaecology and Paediatrics. However, the Paediatrics Department had participated in a successful regional Exception Reporting drive with encouragement to exception report. Other specialties can learn from this and implement similar ER drives within their own departments in order to increase awareness of and support for reporting.

The majority of ERs are 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 are broadly able to access educational opportunities as envisaged in the 2016 contract, 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 with regards the 2016 Terms and Conditions for Junior Doctors to assure the Board of the safe working of resident doctors. This annual report is for the period 01 February 2024 to 31 January 2025. The Board should regularly receive a 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.

Table 1. Number of exception reports by month, 1 February 2024 to 31 January 2025.

Month	Complete	Pending	Total
February 2024	24		24
March 2024	24		24
April 2024	20		20
May 2024	10		10
June 2024	5		5
July 2024	10		10
August 2024	41		41
September 2024	64		64
October 2024	48		48
November 2024	29		29
December 2024	37		37
January 2025	18	5	23
Grand Total	**330**	**5**	**335**

There is seasonal variation in Exception Reporting (ER) with the highest number of monthly reports usually occurring during the winter months and also in August to October time period. 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.

Table 2. Number of exception reports by specialty, 1 February 2024 to 31 January 2025.

Specialty	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	Grand Total
General medicine	12	8	7	3	1		21	31	16	10	17	14	140
General surgery		2	5	2		3	13	17	21	6	3	5	77
Geriatric medicine			1										1
Renal Medicine		1											1
Accident and emergency		1	2				4	5					12
Obstetrics + gynaecology	6	2	4	3		2		6	5	2	4	3	37
Paediatrics	6	10	1							2	5	1	25
Respiratory Medicine						1							1
Otolaryngology (ENT)				2	1	4	1	5	4	5			22
Ophthalmology							2		1	1	2		6
Urology					3				1	3	6		13
Grand Total	**24**	**24**	**20**	**10**	**5**	**10**	**41**	**64**	**48**	**29**	**37**	**23**	**335**

Over the past 12 months, the majority of ERs have been submitted by Trainees working in General Medicine and in General Surgery.

No exception reports were received from both the GP training schemes for which the Trust is the lead employer.

Table 3. Reason for submission of Exception Report, February 2024 to end of January 2025

Additional Hours Worked	65%
Change in pattern of work	1%
Service Support	10%
Educational opportunities	10%
Breaks	14%
Total	**100%**

Over the past 12 months, the vast majority (65%) 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. Ten percent reports were made in relation to missed educational opportunities and 14% were for missed breaks. Trainees are missing educational opportunities due to workload and understaffing. Senior members of the Team are responsible for facilitating Trainees to attend by reviewing the barriers to attendance within their Specialty and mitigating these.

a) Work schedule reviews

There has been one review of a rota in Urology, led by Specialty Doctors on the same rota due to the out of hours' intensity on the non-resident rota. There are 2 Resident Doctors on the rota (ST4-ST6 level) who are paid by Sheffield Teaching Hospital and the monitoring resulted in an increase to the PAs for the Specialty Doctors. It also led to a small increase for the Resident Doctors as previously no 'night' hours were in their schedule which is now 1.5 hours per week.

b) Locum bookings

The data below details bank and agency shifts covered by training grade doctors.

Table 4. Hours covered by bank usage in respective specialities, 1 January 2024 to 31 January 2025.

Sum of Estimated Quantity	Column Labels													
Row Labels	01/01/2024	01/02/2024	01/03/2024	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	Grand Total
Acute Medicine	749.75	1416.75	1571.5	1020.75	298	288.5	280	332.75	230.5	421.75	297.5	1030	887	8824.75
Anaesthetics and Critical Care	140	91	142.5	119	206.5	206.5	75	129	65.5	25.5	38.5	38	50.5	1327.5
Anaesthetics and Maternity		75					15							90
Anaesthetics and Theatres	26	13				25	22.5	23	39	23	48.5	45	13	278
Breast Surgery	195	175	195	218	250	178	187.5	345	407	368	345.5	160.5	225	3249.5
Cardiology (Medical)	36.75	95.25	135.5	66.75	102.5	147.25	20.75	91	36.75	86.5	136.5	87.5	101	1144
Cardiothoracic Medicine		13	37.25	17										67.25
Care of the Elderly	353.25	639.5	615.5	335.5	522	435.25	446.5	445.25	172.5	334.75	267.75	229.25	680	5477
Dermatology			112	160	144	160	184	128	160	152	152	112	120	1584
Emergency Medicine	4486	4738.5	5906	5359.5	5235.5	5736.5	5550.5	5376.5	5050	3976.5	4212.75	4325.5	4643.25	64597
Endocrinology and Diabetes	668.25	400.25	396.5	144	34	84.25	235.25	250.75	203.75	189	122	542	607	3877
Endoscopy - Medicine				32										32
ENT	685	639	629.5	483	492	551	514.5	458	644.25	595	533	397.5	292.5	6914.25
Gastroenterology	119	119.75	190.5	133.25	78.25	336.75	121	162	36.75	121.25	165	137.25	187	1907.75
General Medicine	1234.75	199.25	25	33.5	107	165	195.75	57.75	8.25	28	109.5	191.25	559.5	2914.5
General Surgery	182.5	344.5	286.5		43	21.5	138.5	207.5	265	176	286.5	323.5	263.5	2538.5
Haematology	34	17	41.5	8.5					7.5		17		17	142.5
Infectious Diseases	17			131.5	256.5	170.5	245.5	121.5	56.25	21	58.5	37.5	36.75	1152.5
Intensive Care		65	38	13	13	117	39	13	13		26	52		389
MEOC Orthopaedic and Trauma								12						12
Obstetrics and Gynaecology	1243.5	1371	1033	1259.5	1327	1586	1566.25	1759.5	1158	1052.5	518	721	688.5	15283.75
Orthopaedic & Trauma for Emed	6	23.5	24	12	24	28.25		56		22	47	11.5		254.25
Orthopaedic and Trauma Surgery	1784.5	1624	1780.5	1997	1800.5	1821	2204.75	1814.25	1615	1493.5	1447.5	1478.25	1675	22535.75
Paediatrics		12.5				9.5		25			11			58
Paediatrics and Neonates	816.75	796.5	741	913.75	911.75	1402.75	1127.5	1451.25	671.5	553.75	823.5	999.25	1145	12354.25
Palliative Medicine			37.75		24.75	12.5						13		88
Renal Medicine	168	157.5	102			37.5	25				49.5	26		565.5
Respiratory Medicine	164.75	271.75	259.25	314	308.25	334.75	236.75	195.75	25	61.25	121.5	33	186	2512
Rheumatology	20.75	87	87	199	51	50	49			17			8.5	569.25
Stroke Medicine	32	24.5	64.5	24.5	184.25	206.5	44	21	62.5	41	8	18	16.5	747.25
Urology	144	173	218	111	108	162	123	182.5		232	389.5	221	314.5	2378.5
Vascular Surgery	33.5	396.5	636.5	560.5	650	581	454	390.5	218.5	16		12.5		3949.5
Grand Total	**13341**	**13979.5**	**15306.25**	**13666.5**	**13171.75**	**14854.75**	**14101.5**	**14048.75**	**11146.5**	**10007.25**	**10232**	**11242.25**	**12717**	**167815**

The cost of 'locum' varies somewhat month on month from February 2024 until January 2025. This coincides with the variations in unfilled training posts as well as other reasons like sickness or strike actions. The monthly cost of locum cover varied between £703,232.30 and £1,066,969.88 leading to annual cost of £11,900,146.47.

Table 5. Reasons for locum and bank usage, 1 January 2024 to 31 January 2025.

Count of Job No	Column Labels													
Row Labels	01/01/2024	01/02/2024	01/03/2024	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	Grand Total
Additional session													1	1
Annual Leave	9	8	3	7	14	10	17	10	13	11	15	3	26	146
Compassionate/Special leave	20	6		10	7	1	1			4	3	6	3	61
Deanary gap - Vacancy								1		2	15	72	112	202
Entrustability										3	6	3	9	21
Exempt from on calls for health reasons										7	20	16	20	63
Extra Cover	101	93	93	99	75	91	103	119	86	57	98	112	99	1226
Induction/Rotation												4		4
Less Than FT Trainee Gap	30	33	25	29	55	56	54	53	36	28	49	51	46	545
Maternity/Paternity leave		1	4	5	1		4			11	6	38	72	142
Pregnancy/Maternity Leave		4	16	1	2	2	10	8	5	11	4		2	65
Restricted Duties	7	8	18	19	16	30	19	24	21	27	18	4	5	216
Seasonal Pressures	84	81	146	107	51	20	26	4	1	18	11	132	125	806
Sick	109	97	110	52	65	44	52	39	39	70	100	78	119	974
Strike	161	126	25	17	23	105	38	1				2		498
Study Leave	9	12	4	4	1	2	6	2		2	5		16	63
Unknown Reason	11	9	6	20	89	171	127	200	82	65	16	1		797
Vacancy	807	939	1127	1021	941	958	1006	950	846	713	690	636	658	11292
Grand Total	**1348**	**1417**	**1577**	**1391**	**1340**	**1490**	**1463**	**1411**	**1129**	**1029**	**1056**	**1158**	**1313**	**17122**

The majority of locum cover since January 2024 was to provide staffing for seasonal pressures/rota vacancies/strike/less than FT gaps or extra cover. The number of locum shifts covering rota vacancies has, in general, remained steady from February 2024 to January 2025. The resident medical workforce has now resolved the national pay dispute and the gaps due to strike actions and the associated costs should not be an ongoing concern.

Vacancies

Rota vacancies have fluctuated over the course of the year, with the highest numbers of monthly vacancies occurring in July prior to the new intake of Resident Doctors in August 2024. Of the current rota vacancies in January 2025, 11% of the Medical Specialty posts and 12% of Urgent and Emergency care posts were unfilled compared with 40% of posts in Trauma and Orthopaedics, 17% in General Surgery, 11% in Obstetrics/Gynaecology, and 17% in Paediatrics.

In the last 12 month period, monthly rota vacancies have varied between 36.7 WTE and 48.3 WTE as shown in table below.

Table 6. Trainee vacancies by specialty, February 2024 to January 2025.

	VACANCIES (WTE)	Posts	February	March	April	May	June	July	August	September	October	November	December	January
Medicine	**Specialty Medicine**	**73**	**4**	**4**	**5.1**	**5.5**	**5.5**	**5.5**	**8.2**	**9.2**	**5**	**5.4**	**7.9**	**7.9**
	FY1	**16**	0	0	1	1	1	1	0.2	1.2	0.6	0.6	1.6	1.6
	FY2	**7**	1	1	0.6	0.6	0.6	0.6	1.4	1.4	0.4	1	1	1
	CT/ST GPST 1-3	**25**	2.4	2.4	2.9	2.9	2.9	2.9	0	0	0.6	0.4	0.5	0.5
	ST3+	**25**	0.6	0.6	0.6	1	1	1	6.6	6.6	3.4	3.4	4.8	4.8
	Elderly Medicine	**22**	**2.9**	**2.9**	**2.7**	**2.7**	**3.3**	**3.3**	**1.2**	**1.2**	**1.2**	**1.2**	**1.4**	**1.4**
	FY1	**3**	0	0	0	0	0	0	0	0	0	0	0	0
	FY2 (No FY2 placements)	**No FY2 placements**												
	CT/ST GPST 1-3	**15**	1.9	1.9	1.7	1.7	2.3	2.3	1.2	1.2	1.2	1.2	1.4	1.4
	ST3+	**4**	1	1	1	1	1	1	0	0	0	0	0	0
	Renal	**7**	**0.4**	**0.4**	**0.2**	**0.2**	**0.2**	**0.2**	**1**	**1**	**1**	**1**	**2**	**2**
	FY1 (No FY1 placements)	**No FY1 placements**												
	FY2	**6**	0.2	0.2	0	0	0	0	0	0	0	0	1	1
	CT/ST GPST 1-3	**No CT/GPST placements**												
	ST3+	**1**	0.2	0.2	0.2	0.2	0.2	0.2	1	1	1	1	1	1
U&EC	**Urgent & Emergency Care**	**39**	**5.4**	**4.9**	**6.3**	**6.5**	**6.5**	**6.5**	**5.4**	**5.4**	**4.4**	**4.4**	**4.8**	**4.8**
	FY1	**5**	0	0	0	0	0	0	0	0	0	0	0	0
	FY2	**6**	0	0	1.2	1.2	1.2	1.2	0	0	0	0	0.4	0.4
	CT/ST GPST 1-3	**26**	4.9	4.9	5.1	5.3	5.3	5.3	5.4	5.4	4.4	4.4	4.4	4.4
	ST3+	**2**	0.5	0	0	0	0	0	0	0	0	0	0	0
Women's & Children's	**Obstetrics & Gynaecology**	**28**	**6.4**	**6.4**	**5.4**	**5.4**	**5.4**	**5.4**	**2.8**	**1.4**	**2.4**	**3.4**	**3.2**	**3.2**
	FY1	**4**	0	0	0	0	0	0	0	0	0	0	0	0
	FY2	**1**	0	0	0	0	0	0	0.2	0.2	0.2	0.2	0	0
	CT/ST GPST 1-3	**12**	4.8	4.8	3.8	3.8	3.8	3.8	1.4	0	0.2	1.2	1.2	1.2
	ST3+	**11**	1.6	1.6	1.6	1.6	1.6	1.6	1.2	1.2	2	2	2	2
	Paediatrics	**33**	**5.2**	**4**	**4**	**4**	**3.8**	**3.8**	**5.9**	**3.4**	**2.6**	**2.6**	**4.6**	**5.6**
	FY1	**4**	0	0	0	0	0	0	0	0	0	0	1	1
	FY2	**1**	1	1	1	1	1	1	0	0	0	0	1	1
	CT/ST GPST 1-3	**20**	4.2	2.6	2.6	2.6	2.6	2.6	3.4	3.4	2.6	2.6	2.6	2.6
	ST3+	**8**	0	0.4	0.4	0.4	0.2	0.2	2.5	0	0	0	0	1
	GU Medicine	**No longer taking GUM trainees**												

	VACANCIES (WTE)	Posts	February	March	April	May	June	July	August	September	October	November	December	January
Surgery & Cancer	**ENT**	**8**	**2.4**	**2.4**	**1.2**	**1.2**	**1.2**	**1.2**	**3**	**3**	**3**	**3.2**	**3.2**	**3.2**
	FY1	No FY1 placements												
	FY2	2	1.2	1.2	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	3	0.2	0.2	0.2	0.2	0.2	0.2	2	2	2	2.2	2.2	2.2
	ST3+	3	1	1	1	1	1	1	1	1	1	1	1	1
	General Surgery	**24**	**2.8**	**2.8**	**2**	**2**	**2**	**2**	**4.6**	**5**	**4.2**	**4.2**	**4**	**4**
	FY1	9	0.8	0.8	0	0	0	0	0.4	0.4	0.4	0.4	0.2	0.2
	FY2	1	0	0	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	7	2	2	2	2	2	2	3	3	3	3	3	3
	ST3+	7	0	0	0	0	0	0	1.2	1.6	0.8	0.8	0.8	0.8
	Ophthalmology	**11**	**0**	**0**	**0**	**0**	**1**	**2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**
	ST3+	1	0	0	0	0	1	2	0.2	0.2	0.2	0.2	0.2	0.2
	Urology	**6**	**7.2**	**7.2**	**7.2**	**7.4**	**7.4**	**7.4**	**5.6**	**8.8**	**6.8**	**6.8**	**5.8**	**5.8**
	FY1	2	0	0	0	0	0	0	1	1	1	1	0	0
	FY2	2	0	0	0	0.2	0.2	0.2	0.2	1	1	1	1	1
	CT/ST GPST 1-3	No CT/GPST placements												
	ST3+	2	0	0	0	0	0	0	0	0	0	0	0	0
	Trauma & Orthopaedics	**6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**2.2**	**3.4**	**2.4**	**2.4**	**2.4**	**2.4**
	FY1	No FY1 placements												
	FY2	1	0	0	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	5	2.4	2.4	2.4	2.4	2.4	2.4	1.2	1.4	1.4	1.4	1.4	1.4
	ST3+	5	1.2	1.2	1.2	1.2	1.2	1.2	1	2	1	1	1	1
	Vascular	**7**	**1**	**1**	**4**	**4**	**4**	**4**	**2**	**2**	**2**	**2**	**2**	**2**
	FY1	3	0	0	0	0	0	0	0	0	0	0	0	0
	FY2	No FY2 placements												
	ST3+	4	1	1	4	4	4	4	2	2	2	2	2	2
Clinical Specialties	**Anaesthetics**	**16**	**1.2**	**1.2**	**1.2**	**1.2**	**1.2**	**1.2**	**0**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**
	FY1 (No FY1 placements)	No FY1 placements												
	FY2	No FY2 placements												
	CT/ST GPST 1-3	11	1.2	1.2	1.2	1.2	1.2	1.2	0	0	0	0	0	0
	ST3+	5	0	0	0	0	0	0	0	0.8	0.8	0.8	0.8	0.8
	ICT	**12**	**1.9**	**1.9**	**1.4**	**1.4**	**1.4**	**2.2**	**1**	**1.3**	**0.7**	**0.7**	**0.9**	**0.9**
	FY1 (No FY1 placements)	No FY1 placements												
	FY2	6	0.4	0.4	0.4	0.4	0.4	1.2	0.2	1	0.4	0.4	0.4	0.4
	CT/ST GPST 1-3	4	1.5	1.5	1	1	1	1	0.5	0	0	0	0.2	0.2
	ST3+	2	0	0	0	0	0	0	0.3	0.3	0.3	0.3	0.3	0.3
	Total	**325**	**42.5**	**40.8**	**42.9**	**43.7**	**45.1**	**48.3**	**43.1**	**46.1**	**36.7**	**38.3**	**43.2**	**44.2**

c) **Fines**

A total of two fines have been levied during the last 12 months. The details of these fines are as below and the money collected from the fines is held in a separate account which can be used for the benefit of resident doctors at the trust:

1. FY1 Medicine Rota due to breaks having been missed on at least 25% of occasions across a four week reference period (this involved 3 different FY1s).
2. FY1 Surgery Rota due to a shift of more than 13 hours, relating to the clocks going back in October 2024 (this was reported by one resident doctor).

Qualitative information

The last Resident Doctors' Forum (RDF) meeting took place on 29 November 2024 which had a special focus on Just Culture and its minutes can be provided on request. The next RDF meeting is taking place on 21 February 2025. 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.

The November RDF meeting was poorly attended by trainee doctors and following that meeting a survey was setup and sent to all resident doctors. The aim of the survey was to try to improve trainees' attendance and engagement in RDF meetings. Despite reminders, there was a small proportion of trainees who responded to the survey and the days and timings of the future RDF meetings have been changed according to the trainees' wishes. We hope this will improve their attendance and participation in the future meetings.

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.

A specific issue has been highlighted with regards staffing the nightshift when the clocks go back and the need to review work schedules to ensure that Trainees are not scheduled to work more than a 13 hour shift on that night. However it is quite difficult to change the rotas for one day in the year however the teams have been aware to try everything possible to mitigate the risk of trainees working beyond the 13 hours.

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.

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 taken place. 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 taken place in the Trust Medical Committee (TMC) for senior colleagues and has hopefully helped to iron out some of the anxieties. There are regular meetings now between the GOSW and HR team to discuss the outstanding ERs and the team regularly chases supervisors to ensure timely action on ERs. This is been successful in dealing with open ERs in a timely fashion.
- Quarterly GOSW reports are submitted to the Joint Local Negotiation Committee (JLNC) and TMC with regular involvement and discussion. Some Trainees had expressed concern about the lack of support they receive from senior colleagues to exception report; some had 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 may be planned as and when needed.

Recommendation

The Board of Directors can be assured that a clear majority of Trainee doctors are able to work safely. The number of training posts has increased and the proportion of training posts that have been appointed has increased significantly over time. Trainees and the supervisors are getting used to the new system of reporting through HealthRota and there is positive feedback on the ease of using the app. There was a face to face session at the August 2024 induction for new starters on exception reporting as well as the use of the new system which will continue on annual basis. Monthly regular meetings are also set up between GOSW and HR colleagues to action any outstanding ERs. This also helps in regularly chasing supervisors for timely action on open ERs to ensure they are dealt with in a timely fashion.

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.

2503 - D PARTNERSHIP

2503 - D1 DONCASTER & BASSETLAW HEALTHCARE SERVICES UPDATE

Discussion Item | Sam Wilde, Chief Financial Officer | 10:45

5 Minutes

2503 - D2 TRUST STRATEGY UPDATE REPORT

Discussion Item | Zara Jones, Deputy Chief Executive | 10:50

10 minutes

REFERENCES

Only PDFs are attached

D2 - Trust Strategy Update.pdf

D2 - Appendix 1 - Draft design - Trust Strategy.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**D2**
Report Title:	**Trust Strategy Update**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Authors:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance Emma Shaheen, Director of Communication and Engagement		
Appendices:	Appendix 1 : Draft design Trust Strategy		

Report Summary

Purpose of the report

This paper updates the Board of Directors on the work around the Strategy, the strategic ambitions and the next steps.

Background

The Board has agreed on the 4P's framework, Patients, People, Pounds, and Partnerships. We have used these to frame the discussions with our key stakeholders including governors, partners, and colleagues, on what should be the Trusts ambitions over the next 1-3 years. Following a further Board Development and Trust Leadership Team Sessions in February 2025, these have further been developed.

The Strategic Ambitions

These ambitions will describe how DBTH do things, what is important we deliver, and where our focus will lie. They will support the Trusts decision-making, allocation of resources and prioritisation of work going forward and have been defined as:

- **Tackling Health inequalities**, to include how decisions are made through the lens of health inequalities and how we capture this information about our patients and population, supporting services to intervene earlier and moving to a preventative approach to healthcare. This aligns to the national priority.

- Becoming a **digitally enabled and digitally mature** organisation, including the implementation of an electronic patient record system, and all of the additional workstreams that will be required in order to maximise the benefit of digital for patients and our people. This aligns to the national priority.

- Improving the Trusts estate to provide the **best care environment** for our patients and people, including the ability to deliver healthcare where it is most needed, which is not always within a specialist hospital setting, but in community locations away from the hospital site. This aligns to the national priority.

- Developing our **education and research** offer to become a centre of excellence, aligned to progressing with our ambition to become a university teaching hospital, which supports the wider people plan of attracting and retaining the best people and embedding a learning culture within the Trust.

It should be noted that the introduction of the strategic ambitions does not signal a change in direction, or another programme of work to be delivered. Much of the work contained within the ambitions is already underway. The new strategic direction simply aligns focus, resources and priorities to where they are needed.

Monitoring our progress

These ambitions are supported by several enabling strategies and plans that will move us forward and ensure delivery of these ambitions. In order to monitor progress and therefore delivery of these ambitions it is proposed that reporting frameworks that already exist within these defined areas are used. Many of the key success measures are already being monitored through the Board of Directors and various other committees so this approach will more efficiently support reporting.

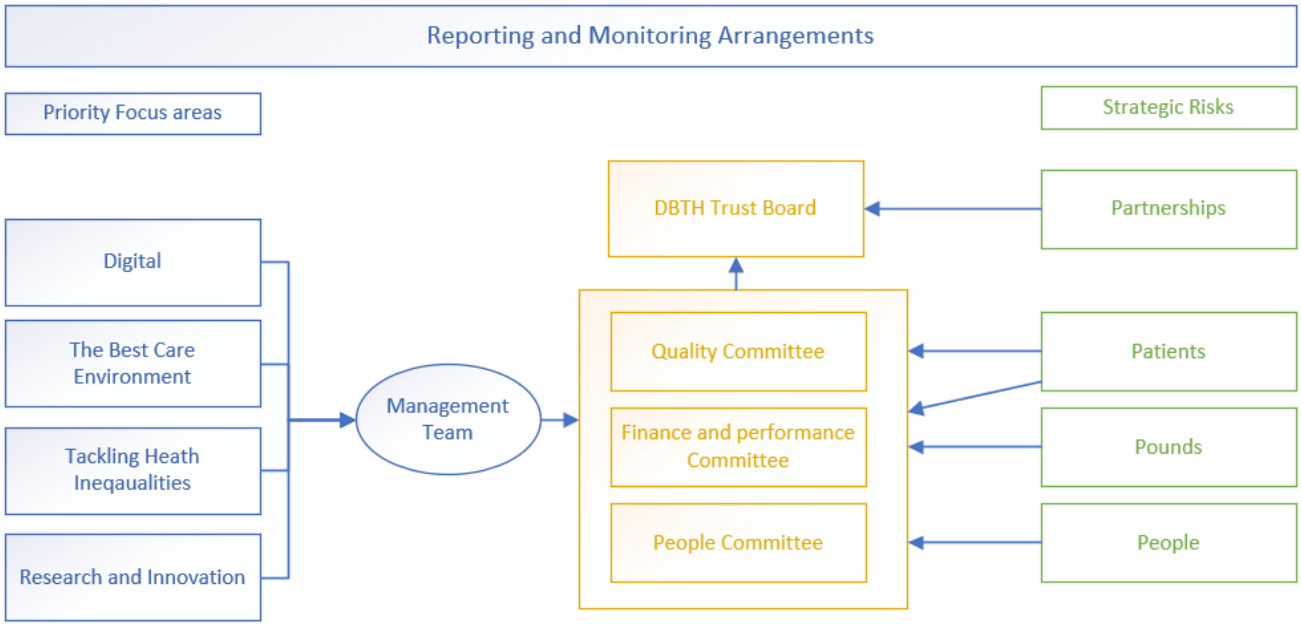
In addition to this high-level reporting structure that will support the Board of Directors to monitor progress, each enabling strategy and plan has a full suite of key success measures that are managed and reported internally within the operational management structure.

The Board Assurance Framework will identify current or emerging risks to delivery of the strategy and will be monitored through the existing assurance structures.

The clarity around these strategic ambitions will support wider decision making, in terms of allocation of resources and the Trusts annual planning approach.

Next Steps

Following feedback and approval of the details outlined above a final summary strategy document will be produced. Attached as an appendix is a concept of the proposed design for feedback. Work will also then take place to create an online version and this will be shared at the next Board Development session. Thus the strategy document itself will be maintained as an on-line interactive tool which supports the integration and monitoring of the ambitions, rather than a traditional stand-alone document. This will enable the focus to be on the strategies delivery, through the existing mechanisms that are in place, thus reducing duplication of effort and reporting burdens.



Strategic Ambitions	Strategic Key Success Measures	Operational reporting Groups	Assurance reporting Groups/ Committee
Digital	**Year 1:** Full EPR National Business Case Approved & Upgrade Core Digital Infrastructure **Year 2:** Commence EPR implementation &increase NHS App use **Year3:** EPR Successfully implemented & HIMMS Level 5 achieved	Digital Data & Technology Group Digital Performance Group Trust Leadership Team Executive Team	Finance and Performance Committee Board of Directors
The Best Care Environment	**Year 1:** Strategic Business cases approved (accommodation & Carpark) & refresh Green Plan **Year 2:**Select Primary Care Co-Location & Accommodation delivered **Year3:** Full business case for East Block and Car park delivered	Programme Directed Project Teams Programme steering group	Finance and Performance Committee Board of Directors
Tackling Heath Ineqaualities	**Year 1:** Building HI capacity through training; HI dashboards and index **Year 2:** Identify the top HI Priorities **Year 3:** Targeted HI projects, embedding prevention and MECC	Operational steering group to be re-established	Finance and Performance Committee Board of Directors
Research and Innovation	**Year 1:**Business Case development **Year 2:** Establish infrastructure and networks **Year 3:** Grow Talent and Innovation expertise and increase research investment	Research and Innovation Group Strategic Partnership Teaching Forum Executive team	People Committee Board of Directors

Conclusion

The Trust has engaged with colleagues and partners in the development of the Trust's strategy and ambitions. The agreed approach focussed on fewer aligned ambitions. This approach maps to the recently published national priorities and to both our partner ICB's strategic ambitions and approach. The methodology to managing and monitoring delivery of these strategic ambitions are aligned to current governance structures and reporting mechanisms, thus also supporting colleagues with effective and efficient reporting arrangements. This strategy is also focussed on the change in culture around how we are doing things and making decisions as much as the process for managing the progress of our ambitions.

Recommendation:	The Board is asked to: • Approve the Trust Strategy and Ambitions (Appendix 1) • Approve the governance structure that will monitor success			
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
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 Boards strategic ambitions should inform the strategic priorities, and align to the decision making framework for the Trust.		
Resources:			

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

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Healthier together – delivering exceptional care for all.

Doncaster and Bassetlaw Teaching Hospitals Strategy


NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust
Introduction
In 2024, we at Doncaster and Bassetlaw Teaching Hospitals (DBTH) undertook a consultation with patients, colleagues, communities and partners to refocus our organisational strategy, aligning with the national priorities and evolving healthcare landscape.
Our vision, Healthier Together – delivering exceptional care for all, reflects this new focus and guides our goal to deliver outstanding care.
Alongside the DBTH Way, as well as documents developed by our local and regional partners, this strategy draws upon the insights of the Lord Darzi report, which emphasised quality, safety, and innovation. It also aligns with the Government's three strategic shifts outlined in late 2024: empowering people to take greater control of their health, transforming care delivery models, and harnessing the power of technology to drive improvements across the NHS.
Our vision, Healthier Together – delivering exceptional care for all, reflects this new focus and guides our goal to deliver outstanding care.
Name goes here
02
Doncaster and Bassetlaw Teaching Hospitals Strategy
03

Who we are

We are an acute NHS Foundation Trust and teaching hospital, serving a diverse population of over 440,000 people across South Yorkshire, North Nottinghamshire, and surrounding areas. We provide a wide range of high-quality healthcare services through our three main hospitals – Doncaster Royal Infirmary, Bassetlaw Hospital, and Montagu Hospital – as well as additional services at smaller sites like Retford Hospital.

As a teaching hospital, we proudly work closely with local universities, contributing to the development of future healthcare professionals while advancing research and innovation. Our links with Integrated Care Partnerships and system partners, spanning South Yorkshire and Nottinghamshire, enable us to deliver seamless, person-centred care in collaboration with other health and social care organisations.

We are also home to one of the busiest emergency services in the region, offering essential services ranging from emergency care to specialist tertiary care, such as vascular surgery. With a strong foundation rooted in excellence, we were proud to be one of the first 10 NHS trusts to achieve Foundation Trust status in 2004.

> With a **strong foundation** rooted in excellence, we were proud to be one of the first 10 NHS trusts to achieve **Foundation Trust status** in **2004**

Name goes here


Our hospitals include:
Doncaster Royal Infirmary (DRI):
A large acute hospital with over 600 beds, a 24-hour Emergency Department, and trauma unit status, offering a comprehensive range of services, including specialist care.
Bassetlaw Hospital (BH):
An acute hospital with over 170 beds, a 24-hour Emergency Department and a full range of district general hospital services, including a dedicated breast care unit and obstetrics services.
Montagu Hospital (MH):
A non-acute hospital providing rehabilitation, day surgery, and outpatient services. The site is home to the Mexborough Elective Orthopaedic Centre of Excellence, the Community Diagnostic Centre and our Rehabilitation Centre.
NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
Doncaster Royal Infirmary
Bassetlaw Hospital
Montagu Hospital
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Another name goes here
06
Doncaster and Bassetlaw Teaching Hospitals Strategy
07


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06
Doncaster and Bassetlaw Teaching Hospitals Strategy
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
Doncaster Royal Infirmary
Bassetlaw Hospital
Montagu Hospital
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07


We are committed to delivering safe, high-quality care and are fully licensed by NHS England and registered with the Care Quality Commission (CQC). At DBTH, we focus on improving the health and well-being of the communities we serve, supporting our colleagues, and striving to be an employer of choice.
511,463 Outpatients
130,952 Inpatients
198,662 Emergency
4,572 Babies
Montagu Hospital cared for 76,132 patients
Doncaster Royal Infirmary cared for 566,475 patients
Retford Hospital cared for 4,765 patients
Bassetlaw Hospital cared for 190,232 patients
M180
M18
A1
Thorne
08
Doncaster and Bassetlaw Teaching Hospitals Strategy

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
09


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08
Doncaster and Bassetlaw Teaching Hospitals Strategy

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
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Achieving our vision
To achieve our vision, Healthier together – delivering exceptional care for all, we have adopted an approach that focuses on four Strategic Priorities, identified and developed with over 800 colleagues, patients, communities, and partners. Our four priorities describe our core focus as an organisation and they will never change.
Our Strategic Priorities are:
Patients: Delivering safe, exceptional, person-centred care tailored to individual needs.
People: Creating a supportive, inclusive, and welcoming environment for all colleagues.
Partnerships: Collaborating with stakeholders to enhance services and achieve shared goals for our communities.
Pounds: Ensuring financial responsibility and efficient use of resources to sustain and improve healthcare services.
Our Strategic Ambitions are:
Tackling Health Inequalities.
Becoming a leading centre for research and education.
Becoming a digitally enabled and digitally mature organisation.
Improving the Trust's estate to provide the best care environment.
Our Strategic Priorities and Ambitions are also supported by Enabling Strategies. Together they create a framework which outline the key principles, actions and work plans, driving us to achieve our vision. See the DBTH Strategic Wheel (see page 7).
Our Vision
Healthier together – delivering exceptional care for all
Patients
People
Partnership
Pounds
We deliver safe, exceptional person-centred care
We are supportive, inclusive and welcoming
We work together to achieve our ambition with shared goals for our communities
We are efficient and make money work
NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
10
Doncaster and Bassetlaw Teaching Hospitals Strategy
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DBTH
Strategic Priorities
Patients:
Providing safe, exceptional, person-centred care.
Delivering safe, exceptional, and person-centred care is the shared goal of everyone who works for and with DBTH. This means a commitment to ensuring that patients can access timely, high-quality, person-centred care, with a particular focus on supporting those who face barriers to receiving the care they need.
Our approach focuses on delivering the right care, in the right place, in the best environment, to achieve the best possible outcome for every individual. This will include empowering patients to take an active role in their care, supported by digital developments. We will:
Improve timeliness and quality of care, reducing waiting times and ensuring patients are seen in the most appropriate setting for their needs.
Deliver innovative treatments and research opportunities.
Enhance care environments to ensure they are safe and welcoming.
Ensure underserved communities receive the support they need to access services.
Empower patients to take an active role in their care.
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NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
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Doncaster and Bassetlaw Teaching Hospitals Strategy
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Doncaster and Bassetlaw Teaching Hospitals Strategy
NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
13

BREAK 11:00 - 11:10

2503 - E POUNDS

2503 - E1 FINANCIAL POSITION UPDATE

Information Item | Sam Wilde, Chief Financial Officer | 11:10

10 minutes

REFERENCES

Only PDFs are attached

E1 - Financial Position Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**E1**
Report Title:	**Financial Position Update**		
Sponsor:	Sam Wilde, Chief Financial Officer		
Author:	Yasmin Ahmed, Deputy Director of Finance		
Appendices:			

Report Summary

Overall

The Trust's reported deficit in Month 10 was £0.1m, £0.2m adverse to budget, £0.3m adverse to forecast but £2.0m better than Month 9. The Trust's reported deficit YTD at Month 10 was £4.4m, £2.4m adverse to budget and £3.3m adverse to forecast.

YTD variance - £2.4m adverse to budget and £3.3m adverse to forecast

The Trust's reported deficit YTD at Month 10 was £4.4m, which was £2.2m adverse to budget and £3.3m adverse to forecast.

The key drivers of this variance are elective activity underperformance, pay award funding pressures, premium costs for medical staffing and CIP underperformance.

Year-End Forecast

At month 10 the finance team have refreshed the detailed financial forecast for the remaining months of the year. This is based on month 10 actuals adjusted for one-off costs and seasonality. Based on this forecast the Trust would report a full-year deficit of £2.4m, in line with plan.

Capital

YTD capital spend excluding donated assets/charitable funds is £19m, compared to a YTD budget of £19.6m, an underperformance of £0.6m.

Cash

Cash has decreased by £3.2m to £26.4m at the end of Month 10.

CIPs (Cost Improvement Programme)

In month 10 the Trust has delivered £3.5m of savings versus the plan submitted to NHSE of £2.6m, an over-delivery of £833k mainly due to non-recurrent savings. The YTD position is a net under-delivery of £2.3m with a year-end forecast in line with plan of £21.2m.

Recommendation:	The Board is asked to note; • The Trust's reported deficit in Month 10 was £0.1m, £0.2m adverse to budget, £0.3m adverse to forecast and £2.0m favourable to Month 9. • The year-end forecast assumes the Trust will achieve its planned deficit of £2.4m with a number of risk that require close monitoring

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

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

Implications			
Relationship to Board assurance framework: 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:	

Assurance Route	
Previously considered by:	Finance and Performance Committee
Date:	27th January 2024
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

FINANCIAL PERFORMANCE

Month 10 – January 2025

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M10 January 2025

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	(621,863)	(51,993)	(49,284)	2,709	A	(52,735)	3,451	A	(522,282)	(510,426)	11,857	A	(513,762)	3,336	A
Pay	394,787	32,198	31,403	(795)	F	30,392	1,011	A	329,696	331,258	1,562	A	331,719	(460)	F
Non Pay	220,914	18,965	17,321	(1,644)	F	21,378	(4,057)	F	187,380	177,091	(10,290)	F	175,998	1,092	A
Financing Costs	8,590	716	615	(101)	F	737	(122)	F	7,158	6,447	(711)	F	7,118	(670)	F
(Profit)/Loss on Asset Disposals	0	0	0	0	F	0	0	F	0	0	0	F	0	0	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**2,428**	**(113)**	**56**	**169**	**A**	**(228)**	**283**	**A**	**1,953**	**4,370**	**2,418**	**A**	**1,073**	**3,298**	**A**

Key

F = Favourable **A** = Adverse

Income		Expenditure	
Over-achieved	F	Under-achieved	A
		Underspent	F
		Overspent	A

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual Plan
	Plan	Actual		Plan	Actual		
	£'000	£'000		£'000	£'000		£'000
Drugs	64	100	F	371	387	F	500
Income (Other Operating Income)	51	231	F	890	987	F	992
Income (Patient Care Activities)	396	22	A	2,573	22	A	3,351
Non-Pay	879	217	A	3,554	2,195	A	5,288
Pay	21	42	F	208	375	F	250
Pay (Skill Mix)	619	2,565	F	4,088	6,285	F	5,350
Pay (WTE Reductions)	619	305	A	4,024	3,195	A	5,469
Total CIP	**2,649**	**3,482**	F	**15,708**	**13,446**	A	**21,200**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**296,229**	**301,649**	**5,420**
Current Assets	84,293	75,088	**-9,205**
Current Liabilities	-90,881	-87,931	**2,950**
Non Current liabilities	-14,022	-13,854	**168**
Total Assets Employed	**275,619**	**274,952**	**-667**
Total Tax Payers Equity	**-275,619**	**-274,952**	**667**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan
	Plan	Actual	Plan	Actual	
	£'000	£'000	£'000	£'000	£'000
Cash Balance	17,770	26,384	17,770	26,384	18,250
Capital Expenditure	5,159	3,457	19,608	18,970	53,326

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,849.2	6,160.1	346.3	66.7	6,573.2
Previous Month	6,854.5	6,226.3	290.0	86.7	6,603.0
Movement	-5.3	-66.2	56.3	-19.9	-29.9

1. Month 10 Financial Position Highlights

1.1 Summary

The Trust's reported deficit in Month 10 was £0.1m, £0.2m adverse to budget, £0.3m adverse to forecast but £2.0m better than Month 9. The Trust's reported deficit YTD at Month 10 was £4.4m, £2.4m adverse to budget and £3.3m adverse to forecast.

1.2 YTD variance to budget - £2.4m adverse

The Trust's reported deficit YTD at Month 10 was £4.4m, £2.4m adverse to budget. The key drivers of this are below:

Income: £11.9m adverse to budget – Clinical Income adverse to budget £10.7m

- ERF income is £5.4m adverse to budget, mainly relating to T&O performance (£7.7m), which is partially offset with a favourable variance of £3.8m on independent sector delivery.
- MEOC income is £5.2m adverse to budget, with CDC being £0.6m adverse to budget. Both MEOC and CDC are in the process of scaling up activity and this is largely offset with reduced pay and non-pay expenditure
- Other small net adverse contract variations £0.2m
- Depreciation clawback is driving a £1.4m adverse to plan. This is offset by a favourable variance on depreciation expenditure
- Favourable variances on Drugs & Devices income (£1.6m). This is offset by increased expenditure in drugs and clinical supplies
- South Yorkshire ICB contract £0.5m favourable due to industrial action funding.
- Other operating income is adverse by £1.1m - CIP performance being £2.5m adverse to budget mainly due to theatres and outpatients, offset by favourable variances on Pathology (£0.3m), MEOC (£0.5m), IT (£0.1m), Education (£0.1m), Estates (£0.3m) and other net favourable variances (£0.2m).

1.2.2 Pay: £1.6m adverse to budget

- MEOC is £2.1m favourable to budget, offsetting the lower income
- CDC is £0.5m favourable to budget, offsetting the lower income
- Pay CIP delivery is £1.5m favourable to plan
- £1.4m as a one-off benefit identified from accruals and a review of accounting policies

Offset by adverse variances mainly due to:

- Pay award funding adverse £1.9m
- Industrial Action costs of £0.5m, offset by clinical income
- Continuing pressure on medics pay, agency expenditure and additional sessions covering sickness and vacancies £1.5m

1.2.3 Non-pay: £10.3m favourable to budget

- Independent sector expenditure is £3.8m favourable to budget due to reduced outsourcing activity
- Services received from NHS organisations are £2.1m favourable to budget mainly relating to MEOC (£2.0m) and pathology (£0.1m)

- CDC favourable by £1.8m due to reduced activity (commercial sector/external contracts/clinical supplies)
- £1.1m favourable variance on Utilities due to the renegotiation of the contract
- Lower expenditure on bad debts (£0.5m) and course fees (£0.5m)
- Lower YTD depreciation charge (£1.4m) being recovered by SYICB clinical income
- Clinical supplies favourable by £1.8m reflecting reduced activity
- £4m as a one-off benefit identified from accruals and a review of accounting policies and release of reserves

Offset by adverse variances mainly due to:

- Increased drug costs being £3.0m adverse to budget, offset partially by increased income
- Adverse non-pay CIP variance of £1.3m
- Increased commercial sector costs (£0.7m), postage & printing costs (£0.6m), CNST costs (£0.4m) and legal fees (£0.3m)
- Complex care patient in the Division of Women and Children one-off cost of £0.4m

1.2.4 Financing Costs: £0.7m favourable to budget

This relates to increased interest income due to higher than budgeted cash levels.

1.2.5 MEOC and CDC

Overall impact on the position for CDC is £1.7m favourable. MEOC is £0.5m adverse due to the expected planned surplus not being achieved fully as activity is lower than planned.

1.3 YTD variance to forecast - £3.3m adverse

The Trust's reported deficit YTD at Month 10 was £4.4m, which was £3.3m adverse to forecast. As a reminder, the forecast was developed more recently than the budget but delivers the same £2.4M deficit in the full year. The key drivers of the variance to forecast are:

1.3.1 Income: £3.3m adverse to forecast

- Clinical income is £4.4m adverse to forecast due to ERF under performance (£6.6m), CDC performance lower than forecast (£0.3m), capital charges are (£1.3m) adverse to forecast, offset by API over recovery on forecast of £2.8m (Drugs £0.4m related), MEOC improvement on forecast of £0.9m and industrial action funding (£0.5m).
- Non-clinical income is £1.2m favourable to forecast in respect of additional educational income (£0.7m) and increased salary and other recharges of £1.4m. These are offset by lower P2P income (£0.4m), a lower level of CIP achievement (£0.3m) and lower RTA income (£0.3m).

1.3.2 Pay: £0.5m favourable to forecast

This is mainly due to vacancies, largely in nursing and midwifery

1.3.3 Non-Pay: £1.1m adverse to forecast

- MEOC £1.5m adverse to forecast

- Reserves are £2.1m adverse to forecast
- Drugs costs are £0.8m adverse to forecast

  These are offset by:
- Clinical services and supplies and other costs being £1.6m favourable to forecast
- CDC £0.4m favourable to forecast
- Depreciation £1.3m favourable to forecast recovered by SYICB clinical income

1.3.4 Financing costs: £0.7m favourable to forecast

- This relates to increased interest income due to higher than forecast cash levels.

1.4 Month 9 vs Month 8 - £2.0m favourable

The Trust's reported deficit in Month 10 was £0.1m, which was £2.0m better than in Month 9. The key drivers of this are:

1.4.1 Income - £0.1m favourable to Month 9

- Advice and Guidance income (£1.5m) has been recognised following reconciliations internally and discussion with the ICB
- Depreciation funding has reduced by £1.4m as the ICB has adjusted our contract to fund our actual spend in line with national guidance

1.4.2 Pay - £1.9m favourable to Month 9

- Additional non-recurrent releases of £0.5m
- £0.6m of HOLT and NHSP shifts removed from the position in line with the 3 months payment policy
- One-off costs in month 9 for complex care patient (£0.1m), agency (£0.2m) and CSS consultants (£0.2m).
- Additional sessions reduction in the surgery division of £0.3m

1.4.3 Non-pay is £0.1m adverse to Month 9

- Adverse movement of £0.1m mainly relating to depreciation

1.5 Year-end Forecast

At month 10 the finance team have refreshed the detailed month 9 financial forecast for the remaining months of the year. This is based on month 10 actuals adjusted for one-off costs and seasonality. Based on this forecast the Trust would report a deficit of £3.8m adverse which is £1.4m adverse to the £2.4m deficit plan.

In addition to this, a series of potential risks and mitigations have been identified. 3 scenarios have been identified using those detailed risks and mitigations:

- Best case scenario £1.8M of net mitigations/(risks)

- Most likely scenario £1.3M of net mitigations/(risks)
- Worse case scenario (£1M) of net mitigations/(risks)

	Best	Likely	Worse
	£'m	£'m	£'m
Forecast Surplus/(Deficit) - Based on Month 10	**(3.8)**	**(3.8)**	**(3.8)**
Risks (R)	(3.3)	(3.6)	(5.1)
Mitigations (M)	5.1	4.9	4.1
Net Mitigations/(Risks)	**1.8**	**1.3**	**(1.0)**
Forecast Surplus/(Deficit) Adjusted for R&M	**(2.0)**	**(2.4)**	**(4.8)**
Planned Surplus/(Deficit)	**(2.4)**	**(2.4)**	**(2.4)**
Better/(Worse) than Plan	**0.5**	**0.0**	**(2.4)**

Overlaying the net mitigations/(risks) onto the £3.8M deficit forecast would result in the following outcomes:

- Best case scenario £2.0 deficit (£0.5m better than plan)
- Most likely scenario £2.4m deficit (In line with plan)
- Worst case scenario £4.8m deficit (£2.4m worse than plan)

The main risk relates to the pathology service of £1.9m included in the most likely scenario. Discussions are ongoing with STH and the ICB.

1.6 Capital

Capital spend excluding donated assets/charitable funds was £19M year to date, compared to a budget of £19.6m. YTD capital spend for charitable funds is £2.6m which relates to the Da Vinci Robot. The YTD total capital spend is £21.6m. The planned programme requires cash support to underpin. The cash support request of £7.3m has been approved by the Department of Health and Social Care/ Treasury, with the Trust receiving a Memorandum of Understanding on 17th January 2025 enabling it to draw funds as required. All funds for MOU's have now been fully drawn down for their remaining values in February.

1.7 Cash

Cash has decreased by £3.2m to £26.4m at the end of Month 10. This is as a result of the underlying deficit and Education expenditure without quarterly income being received in month (£2m), partially offset by Capital PDC cash received in month (£0.7m).

1.8 CIPs (Cost Improvement Programme)

In month 10 the Trust has delivered £3.5m of savings versus the plan submitted to NHSE of £2.6m, an over-delivery of £833k mainly due to non-recurrent savings. The YTD position is a net under-delivery of £2.3m with a year-end forecast to plan of £21.2m.

Although a number of workstreams are delivering effectively a number are significantly behind plan and the release of reserves has bridged this gap. For the remaining 2 months of the financial year the message from E&E is clear that maximum CIP is to be delivered, in which case any surplus reserve release will be retracted.

1.9 South Yorkshire ICB Position Month 10

- The deficit for the system at Month 9 was a deficit of £53.5m (ICB £46.6m and providers £6.9m)
- This has deteriorated by £6.2m in the month (M8 £3.9m improvement) (ICB £4.8m and provider £1.4m)
- The adverse variance against plan is £42m (ICB £16.5m, providers £6.4m, "system risk" £19.1m)
- The variance against plan has deteriorated by £6.9m in the month (ICB £0.3m, 'system risk' £8.2m offset by providers £1.6m)
- The ICB variance against plan of £35.6m is due to:
    - Cost pressures on CHC (£7.8m), high-cost drugs and hybrid closed loop and glucose monitors (£5.7m) a total of (-£13.5m)
    - Shortfall against the £41m savings target for slippage and cost pressure mitigation (-£1.3m)
    - Shortfall on ERF benefit built into the budget (-£5.5m)
    - Phasing in of the £49m system deficit (-£19.1m)
    - Other net favourable variances (+£3.8m)

8. Recommendations

The Board is asked to note:

- The Trust's reported deficit in Month 10 was £0.1m, £0.2m adverse to budget, £0.3m adverse to forecast and £1.9m favourable to Month 9.
- The Trust's reported deficit YTD at Month 10 was £4.4m, £2.5m adverse to budget and £3.3m adverse to forecast.
- The year-end forecast assumes the Trust will achieve its planned deficit of £2.4m with a number of risks and mitigations that require close monitoring. There is also the need to continue to develop plans and sustain them going forwards on a recurrent basis which is imperative for future years.

2503 - F ASSURANCE & GOVERNANCE

2503 - F1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Zara Jones, Deputy Chief Executive | 11:20

Executive Directors
20 minutes

REFERENCES

Only PDFs are attached

F1 - Integrated Quality & Perfomance Report.pdf

F1 - IQPR.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**F1**
Report Title:	**Integrated Quality & Performance Report (IQPR)**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr N Mallaband, Acting Executive Medical Director Sam Wilde, Chief Financial Officer Denise Smith, Chief Operating Officer		
Appendices:			

Report Summary

Executive Summary

The Trust has continued to have challenges in meeting expected standards for urgent and emergency care in January. Improvement work undertaken to date has however had a positive impact in 24/25 with a statistically significant increase in 4 hours performance. This change, although positive, is not sufficient to meet expected target levels so further interventions will be required.

The Trust continues to deliver less activity than planned in 2024/25. 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. The number of 78+ week waiters continues to increase.

Both urgent and emergency care and elective recovery are also impacted by sickness and vacancy rates being higher than planned for. There does however continue to be statistically significant improvements in vacancy rates, turnover, and time to recruit but these remain below target levels. Work continues on the medical appraisal performance metrics to ensure an accurate report is presented. Work continues to improve job planning performance against a national target of 95%.

The Trust continues to have positive trends in performance for reducing MRSA infections, VTE risk assessment compliance and increasing the proportion of >18 deaths scrutinised by the medical examiner. There are however several metrics which without further intervention will not consistently achieve target levels. Hospital Standardised Mortality Ratio (HSMR) continues to be significantly higher than target. Work on action plans is ongoing to improve clinical coding/depth of coding and Structured Judgement Reviews (SJRs) to improve the learning from deaths process. Internal improvements can be seen in the newly developed mortality dashboard, although this will take time to be reflected in HSMR and Summary Hospital-level Mortality Indicator (SHMI) data due to the time lag in reporting.

Work has taken place with executive directors to review all metrics and consider those that require re-basing to support more meaningful analysis of trends, all changes have been enacted. Work has commenced to review the IQPR metrics required for 25/26.

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

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

Implications			
Relationship to Board assurance framework:	**X**	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	X	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
	X	BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
	X	BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
		BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	N/A		
Legal/ Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements		
Resources:	N/A		

Assurance Route	
Previously considered by:	Contents shared with Finance & Performance Committee, Quality Committee 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

January 2025

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision is:

Healthier together – delivering exceptional care for all.

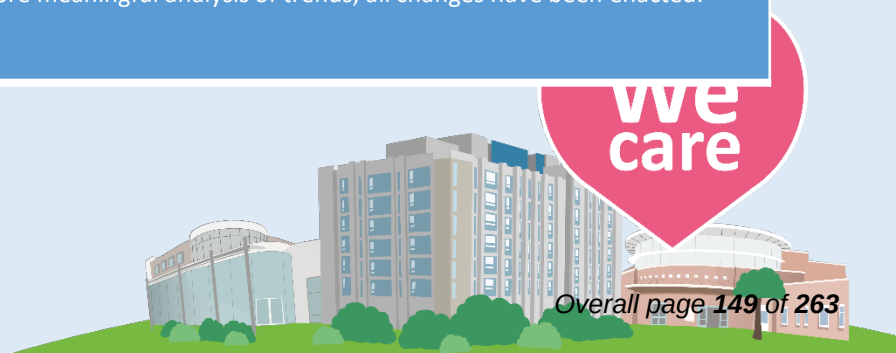
Our four strategic priorities are:

We care

Contents

Executive Summary

Overview	Of the metrics that have been identified based on their significance to be presented within the IQPR report to the Trust board, 11 require further development to report (summarised on slide 41). For the metrics included in this document against an applicable standard 24 are currently meeting or exceeding the standard, this is broken down as follows: Access – 26 metrics. 6 being met, 15 not meeting target, 5 not reportable due to changes with the national reporting portal Quality – 30 metrics, 12 being met, 15 not meeting target, 3 without target People – 6 metrics monitored monthly, 5 not meeting target, 1 data not provided by the service 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 January. Improvement work undertaken to date has however had a positive impact in 24/25 with a statistically significant increase in 4 hours performance. This change, although positive, is not sufficient to meet expected target levels so further interventions will be required. The Trust continues to deliver less activity than planned in 2024/25. 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. The number of 78+ week waiters continues to increase. Both urgent and emergency care and elective recovery are also impacted by sickness and vacancy rates being higher than planned for. There does however continue to be statistically significant improvements in vacancy rates, turnover, and time to recruit but these remain below target levels. Work continues on the medical appraisal performance metrics to ensure an accurate report is presented. Work continues to improve job planning performance against a national target of 95%. The Trust continues to have positive trends in performance for reducing MRSA infections, VTE risk assessment compliance and increasing the proportion of >18 deaths scrutinised by the medical examiner. There are however several metrics which without further intervention will not consistently achieve target levels. HSMR continues to be significantly higher than target. Work on action plans is ongoing to improve clinical coding/depth of coding and Structured Judgement Reviews (SJRs) to improve the learning from deaths process. Internal improvements can be seen in the newly developed mortality dashboard, although this will take time to be reflected in HSMR and SHMI data due to the time lag in reporting. Work has taken place with executive directors to review all metrics and consider those that require re-basing to support more meaningful analysis of trends, all changes have been enacted. Work has commenced to review the IQPR metrics required for 25/26.



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

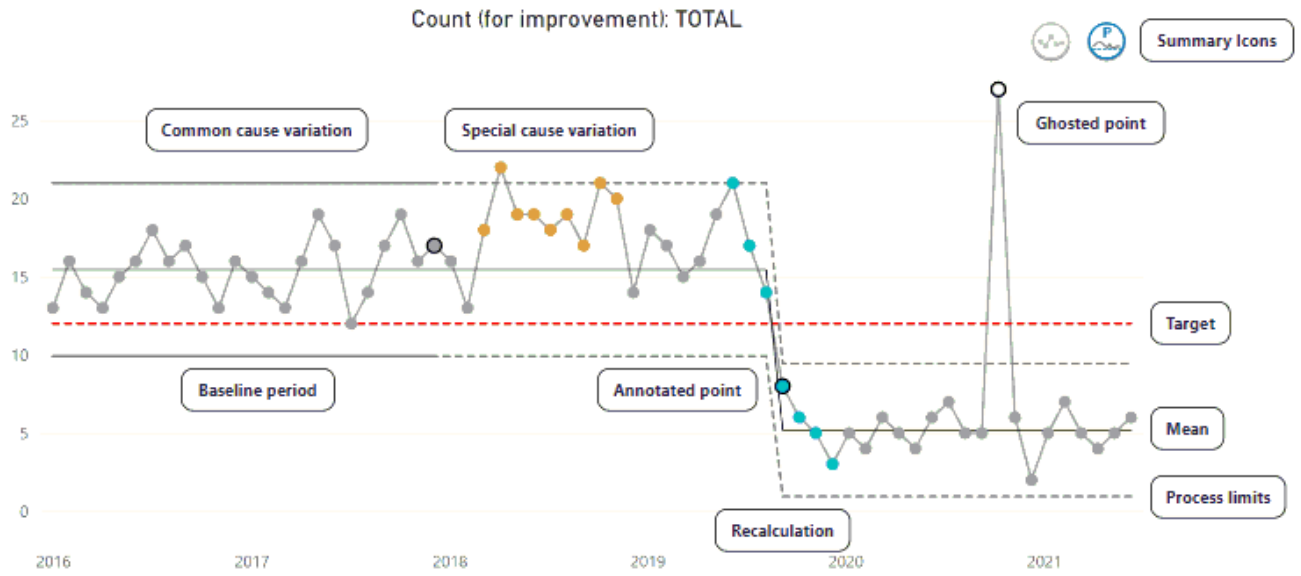
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

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.

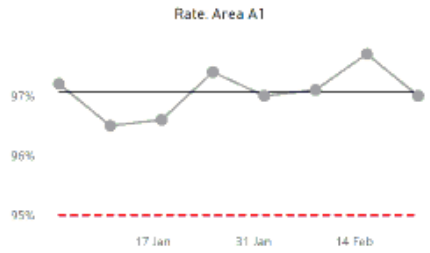
Annotations

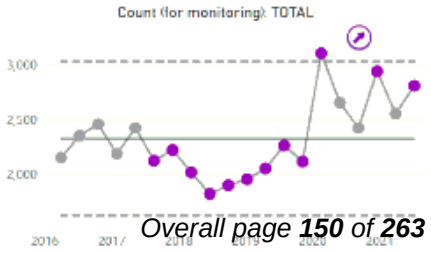
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



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.

At a Glance

Assurance

Variation

	Will consistently achieve the target if nothing changes	Will not consistently pass or fall below the target if nothing changes.	Will consistently fall below the target if nothing changes	No Target
Improving variation (High or Low).	NICE Guidance Response Rate Compliance Planned Vs Actual CHPPD RN	MRSA (Bacteraemia) Cases Reported in month NICE Guidance % Non & Partial Compliance Planned Vs Actual CHPPD RM Time to Hire Completed SET Training	4 hour Performance Employee Turnover	
No significant change.	Planned Vs Actual CHPPD Total	12 hours in department Ambulance handovers - 60 minutes Average ambulance handover times – YAS Faster Diagnosis Standard 31 day combined 62 day combined Cancelled Operations Not Rebooked within 28 Days MRSA (Colonisation) Cases Reported in Month COHA & HOHA C.Diff cases in month % Over 18 in-hospital deaths scrutinised by Medical Examiner Team Claims CNST (patients) - new in month Claims LTPS - (staff) new in month FFT (% positive) – IP/Maternity MSA VTE Never Events PSIIs in Month Incidents 48 Hour Holding HAPU Cat 4	Ambulance handovers - 15 minutes Ambulance handovers - 30 minutes Diagnostic waiting times 65 weeks HSMR: Non-Elective (rolling 12 Months) FFT (% positive) – Trust/A&E/OP SEPSIS 1 Hour Antibiotics SEPSIS 1 Hour Screening Consultants Signed off Job Plans Overall Sickness Absence	Number of arrivals Diagnostic activity against plan (including NOUS & CT IR) Outpatient New Activity against plan Outpatient Follow Up Activity against plan Severe harm falls Number of Complaints Received in Month Number of Complaints Not Signed Off in Agreed Timeframe
Concerning variation (High or Low).	HSMR: Elective (rolling 12 Months)		% patients waiting less than 18 weeks from referral to treatment HSMR: (rolling 12 Months - Combined) 78 weeks	
Variance where up or down is may not be improving or concerning.				Day Case Activity against Plan Inpatient Elective Activity against Plan

Key Performance Indicators – Metric Notes

Metrics with a * denote that the figures for the metric will always show a Year to Date (YTD) position when being reported for the most recent month. This is because the metric is showing the current number of patients who are actively waiting for further action (appointment/admission/test) to take place which would cause their waiting time clock to stop. Therefore, the most recent month and year to date position will always match.

Metrics with a ** denote that these figures are based on a rolling 12-month position therefore, the most recent month and year to date position will always match.

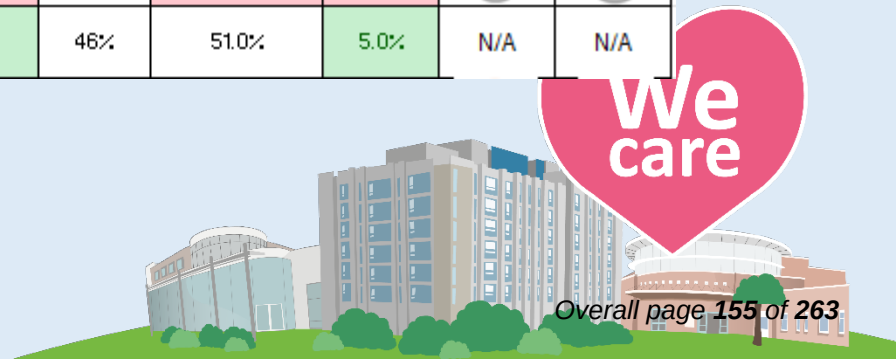
Metrics with a *** denote that these figures are based on snapshot taken of the current number of open incidents therefore, the most recent month and year to date position will always match.

Key Performance Indicators - Access

			Current month			Year to date				
Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
4 hour ED	78% by March 2025	Jan-25	73.1%	69.9%	-3.3%	75.1%	71.6%	-3.5%	F	H
12 hours in department	No more than 2%	Jan-25	2.0%	4.9%	2.9%	2.0%	2.9%	0.9%	?	
Number of arrivals		Jan-25	16681	17076	395	171120	173449	2329	N/A	
Ambulance handovers - 15 minutes	65%	Jan-25	65%	33.8%	-31.2%	65%	36.1%	-28.9%	F	
Ambulance handovers - 30 minutes	95%	Jan-25	95%	66.6%	-28.4%	95%	68.8%	-26.2%	F	
Ambulance handovers - 60 minutes	0%	Jan-25	0%	13.6%	13.6%	0%	11.9%	11.9%	?	
Average ambulance handover times - YAS		Jan-25	30	0:34:08	00:04:08	21	0:31:45	00:10:45	?	
Diagnostic waiting times *	DM01 99%/ Operational guidance 95%	Jan-25	85.6%	72.6%	-13.0%	85.6%	72.6%	-13.0%	F	
Diagnostic activity against plan (including NOUS & CT IR)		Jan-25	19435	20563	1128	189516	190166	650	P	
% patients waiting less than 18 weeks from referral to treatment *	92%	Jan-25	92.0%	58.8%	-33.2%	92.0%	58.8%	-33.2%	F	L
65 weeks *	0 by September 2024	Jan-25	0	240	240	0	240	240	F	
78 weeks *	0	Jan-25	0	60	60	0	60	60	F	H
Faster Diagnosis Standard	77% by March 2025	Dec-24	81.3%	81.3%	0.0%	80.1%	81.9%	1.7%	?	
31 day combined	96%	Dec-24	96.0%	96.0%	0.0%	96.0%	94.0%	-2.0%	?	
62 day combined	70% by March 2025	Dec-24	74.1%	78.8%	4.7%	73.8%	73.9%	0.1%	?	

Key Performance Indicators - Access

			Current month			Year to date				
Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Day Case Activity against Plan		Jan-25	4759	4122	-637	44624	39319	-5305	N/A	
Inpatient Elective Activity against Plan		Jan-25	680	666	-14	6630	6334	-296	N/A	
Outpatient New Activity against plan		Jan-25	15188	15526	338	147440	145800	-1640	N/A	
Outpatient Follow Up Activity against plan		Jan-25	31724	30969	-755	309829	293581	-16248	N/A	
Proportion directly admitted to a stroke unit within 4 hours of clock start	75%	Data not available for November 2024 due to changes with the reporting outputs in the national portal, ongoing work with national team								
Proportion of patients scanned within 1 hour of clock start	48%	Data not available for November 2024 due to changes with the reporting outputs in the national portal, ongoing work with national team								
Percentage of eligible patients given thrombolysis	90%	Data not available for November 2024 due to changes with the reporting outputs in the national portal, ongoing work with national team								
Percentage treated by a stroke skilled Early Supported Discharge Team	>24%	Data not available for November 2024 due to changes with the reporting outputs in the national portal, ongoing work with national team								
Percentage discharged given a named person to contact after discharge	80%	Data not available for November 2024 due to changes with the reporting outputs in the national portal, ongoing work with national team								
Cancelled Operations Not Rebooked within 28 Days	0	Jan-25	0	4	4	0	40	40		
Proportion of all outpatient attendances that are for first appointments or Fus attracting a procedure tariff	46%	Jan-25	46%	51.0%	5.0%	46%	51.0%	5.0%	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	£2.4m year-end deficit (Revised)	Jan-25	-113	56	169	A	1,953	4,370	2,418	A
ERF position		Jan-25	10,256	10,857	601	F	97,799	92,374	-5,425	A
CIP delivery -vs Plan	£21.2m year-end CIP target	Jan-25	2,649	3,482	833	F	15,708	13,446	-2,262	A
Substantive pay spend against plan		Jan-25	30,549	27,890	-2,659	F	315,308	294,548	-20,759	F
Additional sessions pay spend against plan		Jan-25	770	1,439	668	A	7,763	12,701	4,938	A
Bank pay spend against plan		Jan-25	2	1,334	1,332	A	438	14,356	13,918	A
Agency pay spend against plan		Jan-25	877	741	-137	F	6,188	9,653	3,465	A
Capital position YTD versus plan	£53.3m revised year-end plan	Jan-25	5,159	3,457	-1,702	F	19,608	18,970	-638	F
Cash balance		Jan-25	17,770	26,384	8,614	F	17,770	26,384	8,614	F
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	Jan-25	95.0%	80.4%	-14.7%	A	95.0%	84.7%	-10.3%	A

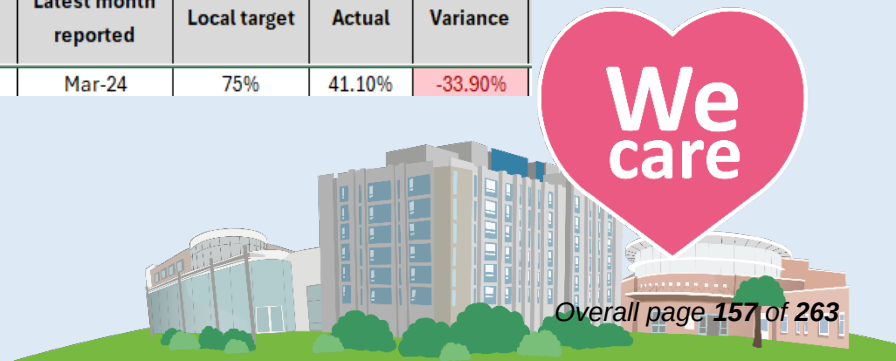
Key Performance Indicators - People

Metric	Standard/ threshold 24/25	Latest month reported	Current month			Year to date			Assurance Status	Variation Status
			Local target	Actual	Variance	Local target	Actual	Variance		
Consultants with Signed Off Job Plans in EJP	90%	Jan-25	90.0%	69.0%	-21.0%	90.0%	66.1%	-23.9%	F	
Employee Turnover (Rolling 12 months) **	10%	Jan-25	10.0%	11.1%	1.0%	10.0%	11.1%	1.0%	F	L
Overall Sickness Absence	5%	Jan-25	5.0%	6.1%	1.1%	5.0%	5.9%	0.9%	F	
Time to hire (from TRAC authorisation - unconditional offer) A4C posts only ***	47 days	Jan-25	47	53.7	6.7	47	53.7	6.7	?	L
Completed SET Training	90%	Jan-25	90.0%	89.0%	-1.0%	90.0%	88.8%	-1.2%	?	H
Completed Appraisals	90% end July	Data not provided by service								

Annual metrics

Metric	Standard/ threshold 24/25	Available	Latest month reported	Current month		
				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

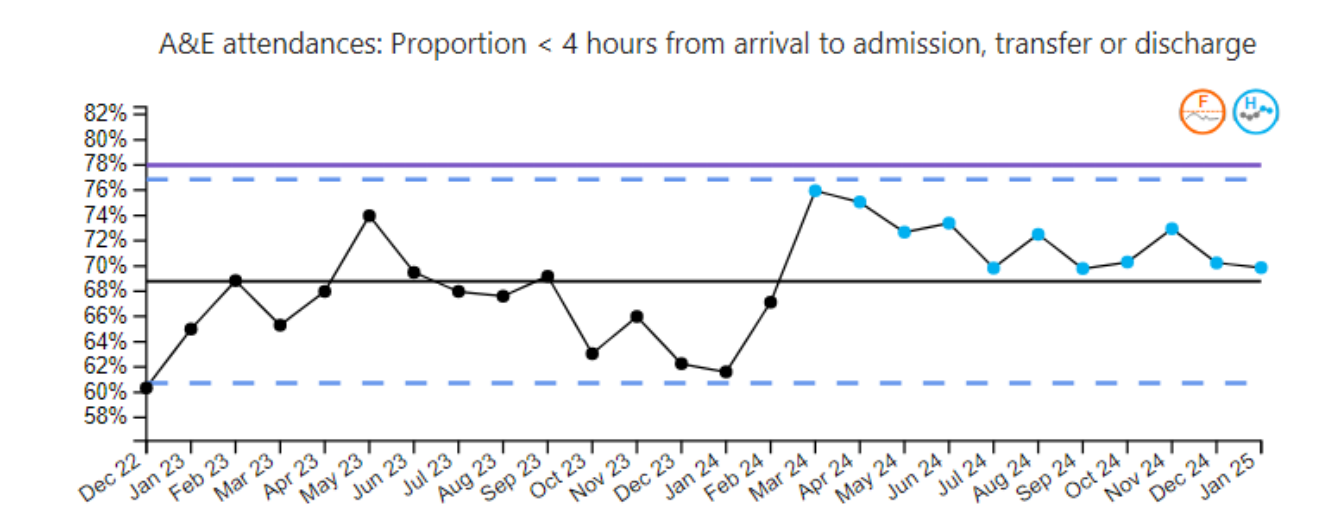
				Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Mortality	Hospital Services Mortality Rate (HSMR): (rolling 12 Months - Combined) **	<100	Nov-24	100	109.4	9.35	100	109.4	9.35	F	H
Mortality	Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months) **	<100	Nov-24	100	86.3	-13.7	100	86.3	-13.7	P	H
Mortality	Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months) **	<100	Nov-24	100	109.6	9.59	100	109.6	9.59	F	
IPC	Hospital Acquired MRSA (Colonisation) Cases Reported in Month		Jan-25	1.2	0	-1.2	11.6	11	-0.6	?	
IPC	Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0	Jan-25	0	0	0	0	0	0	?	L
IPC	Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month		Jan-25	3.5	20	16.5	35	70	35	?	
IPC	Number of Community Onset Healthcare associated (COHA) C.Diff cases in month		Jan-25							?	
IPC	Hospital Acquired Pressure Ulcers (HAPU) Cat 4		Jan-25	0	2	2	0	5	5	?	
Falls	Severe harm falls	0	Jan-25	0	1	1	0	8	8		
Complaints	Number of Complaints Received in Month		Jan-25		55	55		532	532		
Complaints	Number of Complaints Not Signed Off in Agreed Timeframe		Jan-25	0	0	0	0	68	68		
Claims	Claims CNST (patients) - new in month		Jan-25		13	13		89	89	?	
Claims	Claims LTPS - (staff) new in month		Jan-25		2	2		16	16	?	

					Current month			Year to date				
Group	Section	Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Quality	FFT	Friends & Family Test (% positive) - Trust Total		Jan-25	95%	86.7%	-8.3%	95%	89.7%	-5.3%		
Quality	FFT	Friends & Family Test (% positive) - A&E		Jan-25	78%	72.5%	-5.5%	78%	70.4%	-7.6%		
Quality	FFT	Friends & Family Test (% positive) - Inpatient		Jan-25	94.8%	94.1%	-0.7%	94.8%	93.8%	-1.0%		
Quality	FFT	Friends & Family Test (% positive) - Outpatient		Jan-25	94.2%	90.2%	-4.0%	94.2%	91.2%	-3.0%		
Quality	FFT	Friends & Family Test (% positive) - Maternity		Jan-25	92.3%	79.5%	-12.8%	92.3%	91.0%	-1.3%		
Quality	Audit & Effectiveness	Mixed Sex Accommodation - nationally reported breaches in month	0	Jan-25	0	0	0	0	29	29		
Quality	Audit & Effectiveness	% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%	Jan-25	100.00%	100.00%	0.0%	100%	100.0%	0.0%		
Quality	Audit & Effectiveness	VTE - % of patients having a VTE Risk Assessment	95%	Jan-25	95.00%	95.82%	0.8%	95%	96.0%	1.0%		
Quality	Nice Guidance	NICE Guidance Response Rate Compliance	90%	Jan-25	90.00%	95.72%	5.7%	90%	96.0%	6.0%		
Quality	Nice Guidance	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%	Jan-25	10.00%	11.33%	1.3%	10.00%	11.4%	1.4%		
Quality	CHPPD	Planned Vs Actual CHPPD RM	90%	Jan-25	90.00%	92.4%	2.4%	90.00%	94.0%	4.0%		
Quality	CHPPD	Planned Vs Actual CHPPD RN	90%	Jan-25	90.00%	99.5%	9.5%	90.00%	98.2%	8.2%		
Quality	CHPPD	Planned Vs Actual CHPPD Total	90%	Jan-25	90.00%	98.8%	8.8%	90.00%	98.7%	8.7%		
Quality	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%	Jan-25	90.00%	57.7%	-32.3%	90.00%	52.5%	-37.5%		
Quality	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%	Jan-25	90.00%	60.8%	-29.2%	90.00%	56.7%	-33.3%		
Quality	Patient Safety	Never Events - Reported in month	0	Jan-25	0	0	0	0	4	4		
Quality	Patient Safety	PSIIs reported in month		Jan-25	0	5	-5	0	18	-18		
Quality	Patient Safety	Number of incidents over 48 hours in the holding area		Jan-25	0	11	-11	0	11	-11		

Assurance report

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

Summary of challenges & risks	Performance in January 2025 was 69.9%, against the trajectory of 73.1%. ED attendances for the month were 17076 which was above the plan of 16681. Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER.** This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Senior clinical leadership oversight of the Department provided by the ''Emergency Consultant in Charge' Operational oversight of the Department provided 8:00am – 8:00pm, 7 days a week 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
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

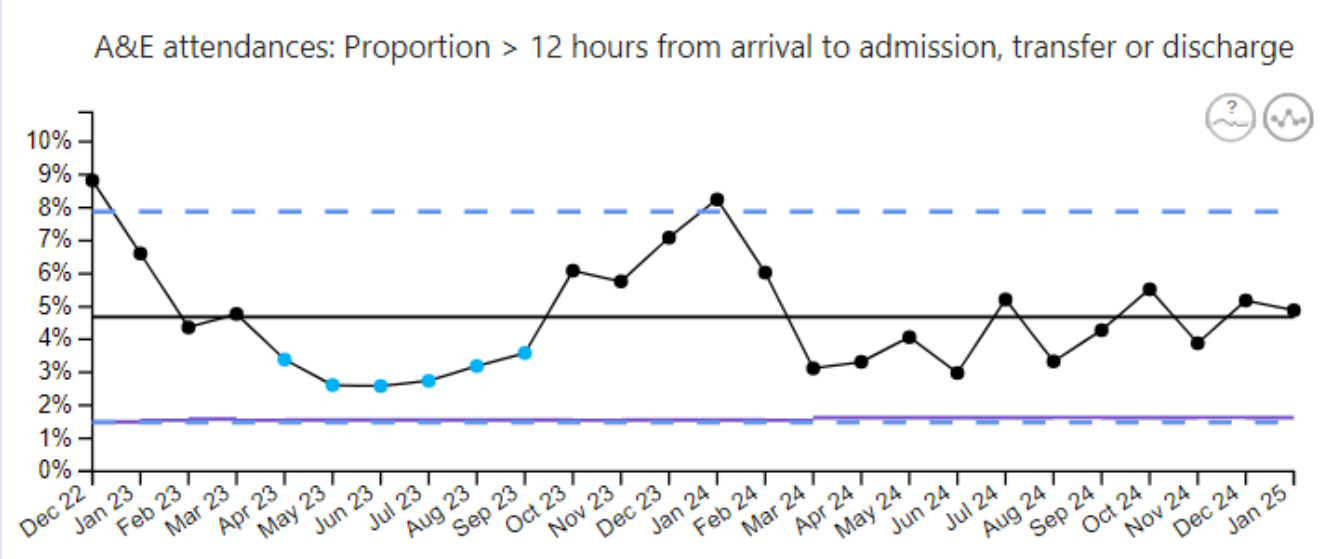


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

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

Summary of challenges & risks	In January 2025, 4.9% of patients were in the Emergency Department > 12 hours from arrival, against the national standard of no more than 2% Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Improved escalation and communication with specialty teams to address any delays earlier in the pathway Creating patient flow earlier in the day through improved discharge planning, utilisation of the discharge lounge and reducing discharge delays will improve patient flow out of ED prior to the peaks in demand in ED Implementation of the winter plan, providing additional inpatient capacity at Bassetlaw. Daily escalation calls with Doncaster Place and Nottingham ICB to maintain timely discharge, escalate delays and agree actions to address, including increased flexibility of the community bed base to expedite supported discharges
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

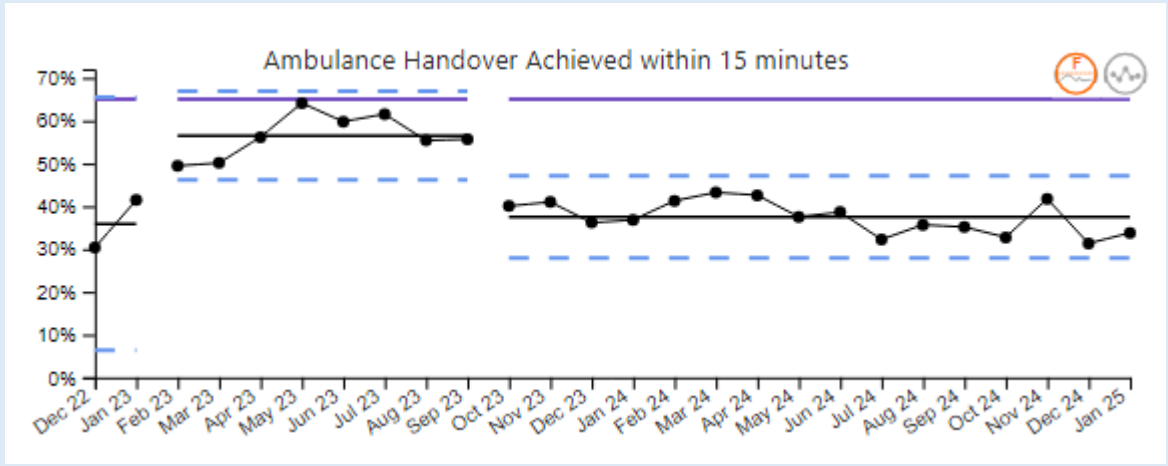


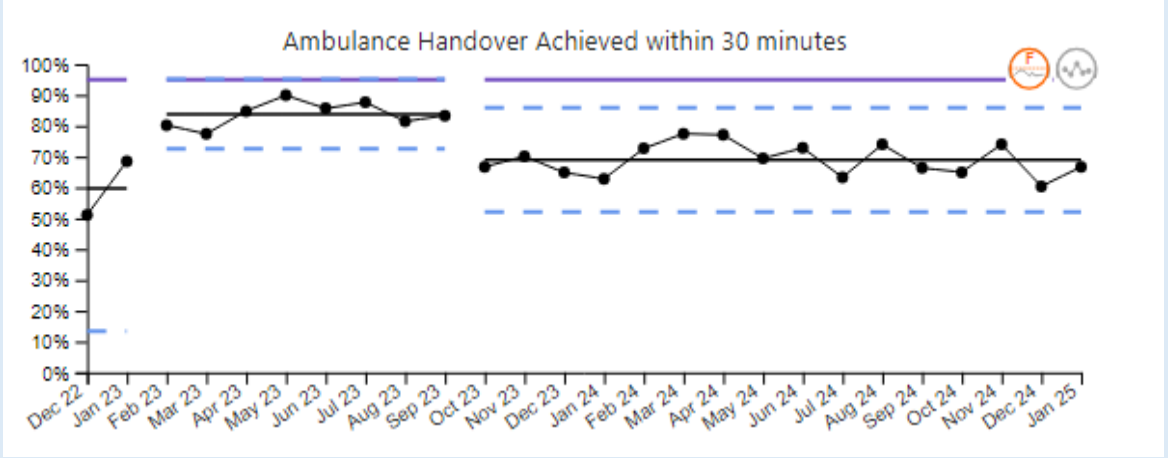
Source DBTH_IQPR_Dashboard_January 2025

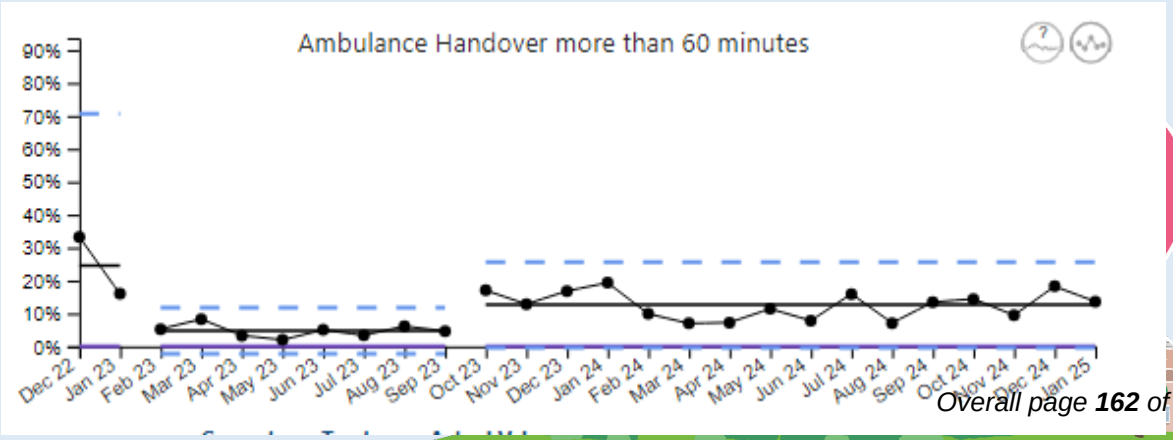
Assurance report

Ambulance Handover within 15/30/60 mins

Summary of challenges & risks	In January 2025, 33.8% of ambulance handovers took place within 15 minutes against the standard of 65%, 66.6% took place within 30 minutes against the standard of 95%, and 86.4% took place within 60 minutes against the standard of 100%. <u>Ambulance Handover 15 and 30 minutes</u> Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. <u>Ambulance Handover 60 minutes</u> Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits. Re-basing has taken place February 2023 as ESA was expanded and in October 2023 as the volume of ambulance arrivals increased
Actions to address risks, issues and emerging concerns relating to performance and forecast	Continued ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. This has been supported through a pilot, in conjunction with YAS, since December 2024 to provide additional support to reduce and redirect ambulance conveyance. Utilisation of the escalation area at times of peak demand to create additional capacity for handover Proactive capacity preparation to create capacity for forecast peaks in demand An increase in Early Senior Assessment at Bassetlaw will be in place from February 2025 following the opening of the Bassetlaw Emergency Village.
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



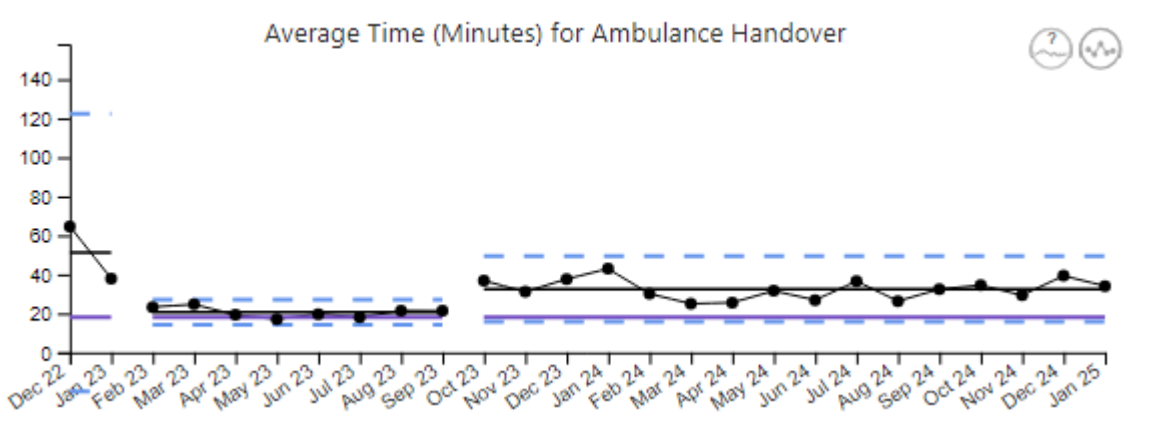




Assurance report

Average Ambulance Handover Times

Summary of challenges & risks	Average handover time for YAS in January 2025 was 34:08 compared to the trajectory of 30:00 Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits. Re-basing has taken place February 2023 as ESA was expanded and in October 2023 as the volume of ambulance arrivals increased
Actions to address risks, issues and emerging concerns relating to performance and forecast	Continued ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. This has been supported through a pilot, in conjunction with YAS, since December 2024 to provide additional support to reduce and redirect ambulance conveyance. Utilisation of the escalation area at times of peak demand to create additional capacity for handover Proactive capacity preparation to create capacity for forecast peaks in demand An increase in Early Senior Assessment at Bassetlaw will be in place from February 2025 following the opening of the Bassetlaw Emergency Village.
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

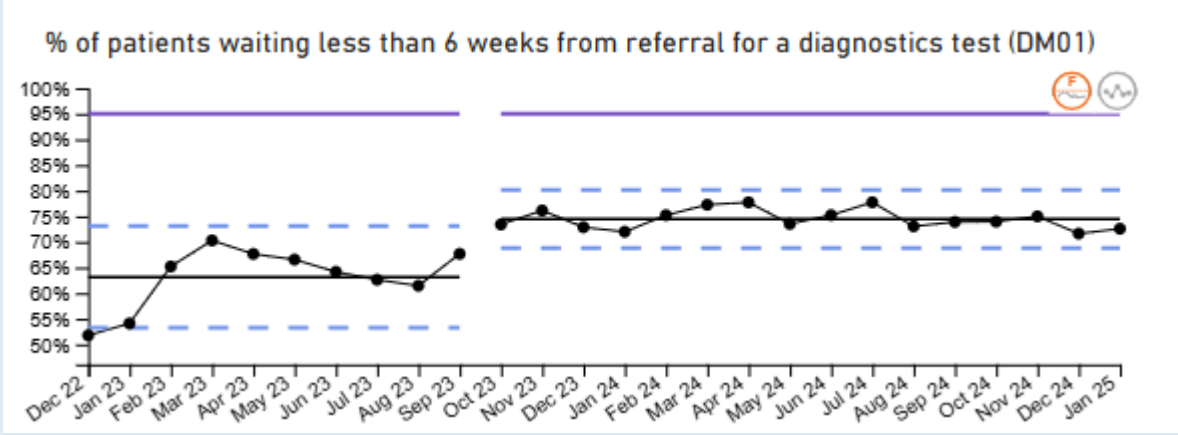


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

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

Summary of challenges & risks	In January 2025, 72.6% 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. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. Re-basing took place October 2023 at which point there was additional MRI & CT activity carried out to reduce waits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	**Audiology**: The Trust has a recovery plan in place and to date 400 adult patients awaiting hearing assessment have been outsourced to a third party provider. The Trust has procured a new clinical system and this is now in the implementation phase, with full roll out planned for June / July 2025. **MRI:** additional activity through insourcing has taken place since October 2024 and software changes have enabled a reduction in time to scan, therefore increasing productivity at Mexborough. These two actions have increased weekly activity from c. 471 per week to c. 524 per week. **Non obstetric ultrasound:** vacancies and long term sickness have resulted in reduced capacity through 2024/25. Additional capacity is being provided via insourcing to the end of 2024/25.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3434 Timely access to diagnostic services

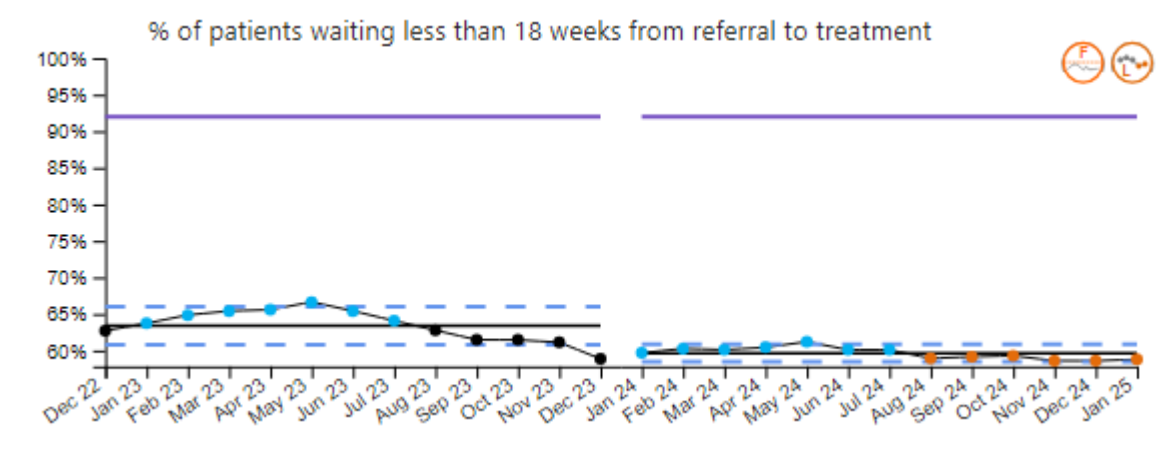


Source DBTH_IQPR_Dashboard_January_2025

Assurance report

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

Summary of challenges & risks	In January 2025 58.8% of the patients on the waiting list have been waiting for less than 18 weeks. Common cause variation, **NO SIGNIFICANT CHANGE.** This has changed from the previous Board Report. This process is not capable and will **FALL BELOW** the target without process redesign. Re-basing has taken place January 2024.
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

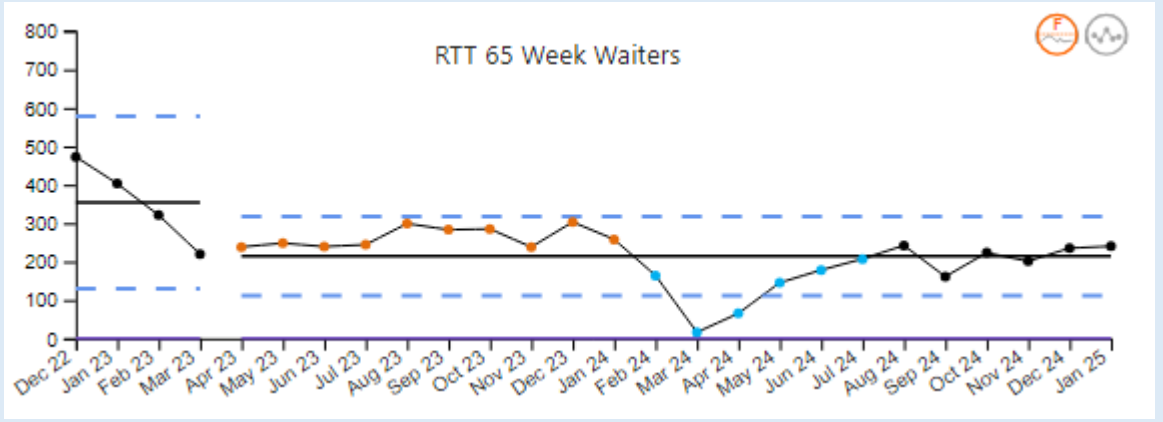


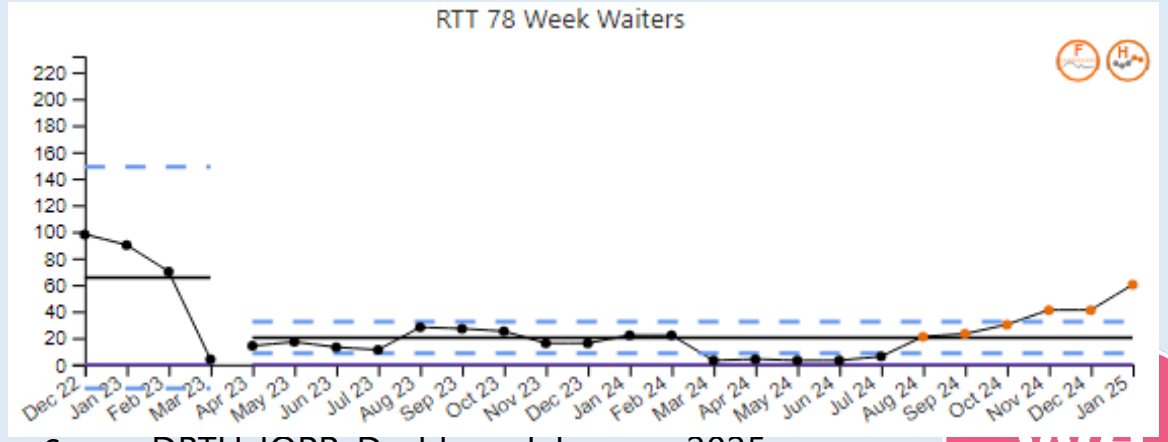
Source DBTH_IQPR_Dashboard_January 2025

Assurance report

RTT – 78+ / 65+ Week Waiters

Summary of challenges & risks	In January 2025, 60 patients were waiting > 78 weeks, against the trajectory of 0. In January 2025, there were 240 patients waiting > 65 weeks, against the trajectory of 0. <u>RTT 65 Weeks</u> Common cause variation. **NO SIGNIFCANT CHANGE.** This has changed from the previous Board Report. This process is not capable and will **FALL BELOW** the target without process redesign. <u>RTT 78 Weeks</u> Special cause variation of **CONCERNING** nature where the measure is significantly **LOWER.** This has changed from the previous Board Report. This process is not capable and will **FALL BELOW** the target without process redesign. Re-basing has taken place April 2023.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Prompt response when corneal transplant materials become available Options to address the Septorhinoplasty long waits are being discussed with the ICB and NHS England Additional weekend capacity is in place for ENT and T&O An Audiology recovery plan is in place
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



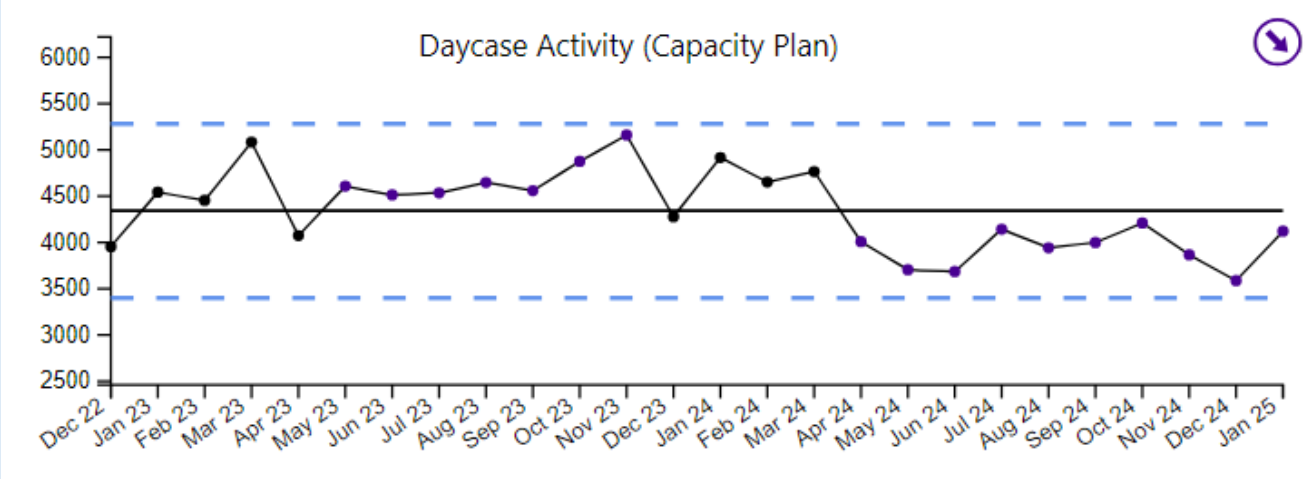


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Daycase Activity

Summary of challenges & risks	In January 2025, excluding MEOC, the Trust delivered 87.0% of the day case plan. YTD the Trust has delivered 88.1% of the day case plan. Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The following specialties are the key specialties driving the underperformance: General Surgery -2373 procedures YTD (79%) Trauma & Orthopaedics -890 procedures YTD (70%) Ophthalmology -509 procedures YTD (71%) Gastroenterology -2348 procedures YTD (80%) 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	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

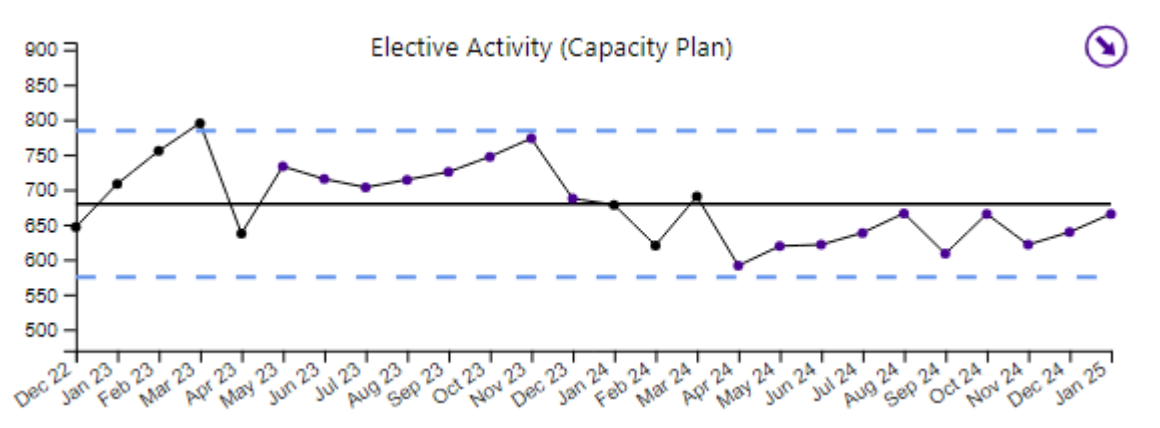


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Elective Activity

Summary of challenges & risks	In January 2025, excluding MEOC, the Trust delivered 97.9% of the elective plan. YTD the Trust has delivered 95.6% of the elective plan. Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In January, the Trust was 295 elective cases behind plan overall, with some specialties over performing. The key driver of the under performance is elective orthopaedics, which was 407 cases behind plan. 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	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

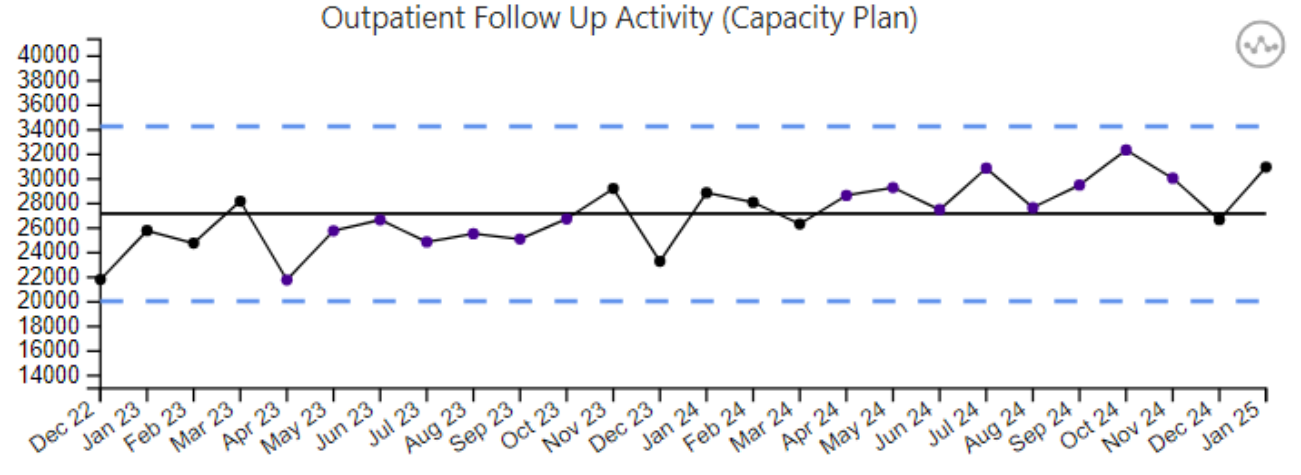


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Outpatient Follow Up Activity

Summary of challenges & risks	In January 2025, the Trust delivered 97.4% of plan for outpatient follow up appointments. Year to date the Trust has delivered 94.7% of the follow up outpatient plan Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In January, the Trust was 839 appointments behind plan overall, with a number of specialties over performing. Ophthalmology remains one of the key challenges at 429 appointment behind plan in January, workforce gaps being the main driver in the deficit. impacting on outpatient activity. Two Consultant vacancies have recently been recruited to. T&O is also behind plan at 412 appointments behind plan in January, with clinical capacity being prioritised for day case, elective and outpatient first appointments. The outpatient improvement programme continues to focus on utilisation of all clinic sessions and reducing the DNA rate. The DNA rate is now below pre-pandemic levels
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

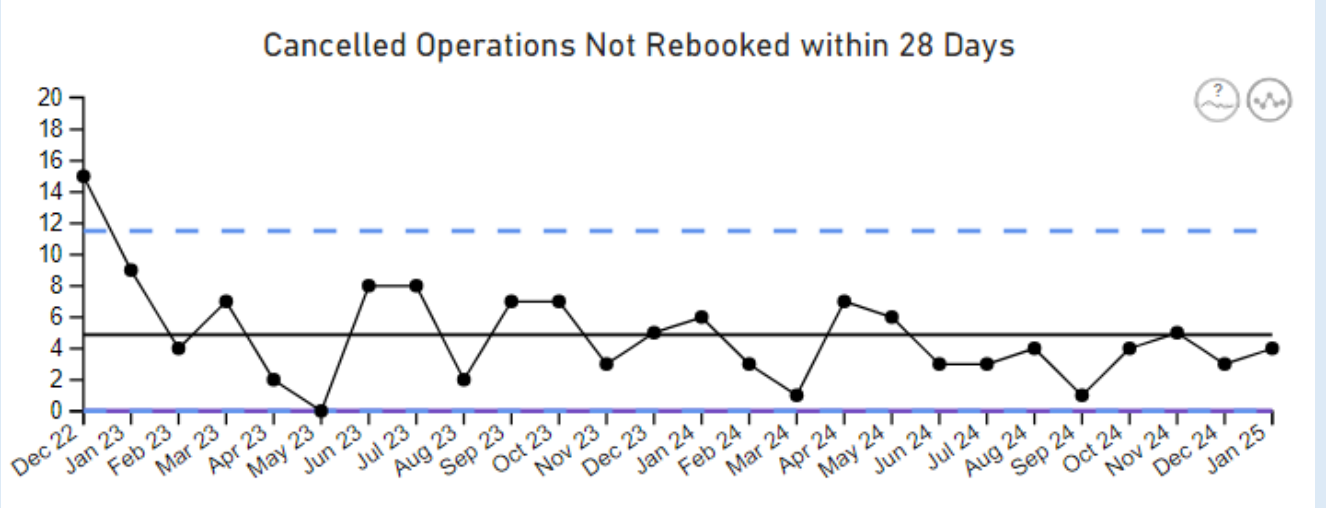


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Cancelled Operations Not Rebooked within 28 Days

Summary of challenges & risks	There were 4 breaches of the 28-day guarantee in January 2025 Common variation. **NO SIGNIFICANT CHANGE.** This has changed from the previous Board Report. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
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	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



Source DBTH_IQPR_Dashboard_January 2025

Assurance report

YTD distance from financial plan I&E

Summary of challenges & risks	**Note: The Trust's agreed financial target for 2024/25 has been amended following the receipt of additional funding from the ICB. The annual plan is now a £2.4m deficit against the original £26.2m deficit.** YTD variance - £2.4m adverse to budget and £3.3m adverse to forecast The Trust's reported deficit YTD at Month 10 was £4.4m, which was £2.2m adverse to budget and £3.3m adverse to forecast. The key drivers of this variance are elective activity underperformance, pay award funding pressures, premium costs for medical staffing and CIP underperformance.
Actions to address risks, issues and emerging concerns relating to performance and forecast	See actions on pay spend assurance and ERF position assurance. MEOC: MEOC Board focusing on improvements in filling the lists and improving productivity and case mix. Finance Challenge and Support Meetings are taking place with each Division led by the CFO with a number of actions taking place to reduce expenditure.
Action timescales and assurance group or committee	Ongoing
Risk register	16 - Failure to achieve compliance with Financial Performance and achieve Financial Plan.

M10 January 2025

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	(621,863)	(51,993)	(49,284)	2,709	A	(522,282)	(510,426)	11,857	A
Pay	394,787	32,198	31,403	(795)	F	329,696	331,258	1,562	A
Non Pay	220,914	18,965	17,321	(1,644)	F	187,380	177,091	(10,290)	F
Financing Costs	8,590	716	615	(101)	F	7,158	6,447	(711)	F
(Profit)/Loss on Asset Disposals	0	0	0	0	F	0	0	0	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**2,428**	**(113)**	**56**	**169**	**A**	**1,953**	**4,370**	**2,418**	**A**

Key

F = Favourable **A** = Adverse

Income			
Over-achieved	F	Under-achieved	A
Expenditure			
Underspent	F	Overspent	A

Assurance report

ERF position

Summary of challenges & risks	ERF is £5.4m behind plan YTD at month 10. This is mainly driven by Orthopaedics which is £7.7m behind plan (£4.5m core activity and £3.9m Independent Sector and MSK CAT's offsetting by £0.7m).
Actions to address risks, issues and emerging concerns relating to performance and forecast	Recovery plan is pending for elective activity, particularly for Orthopaedics. This is with the Operational Teams and the Chief Operating Officer. Additional sessions are taking place to reduce backlog in ENT.
Action timescales and assurance group or committee	The Surgery Division presented the T&O recovery plan to the Executive Team in January 2025. Discussions ongoing at E&E Committee
Risk register	16 - Failure to achieve compliance with Financial Performance and achieve Financial Plan.

Elective Recovery Fund (ERF) - Subset of Activity from Elective, Day Case and Outpatient Activity

ERF position by POD	M10 ERF Target	M10 ERF Actual	M10 variance to ERF Target	M9 variance to ERF Target
Daycase	(32,582)	(29,819)	2,763	2,137
Elective	(27,715)	(20,455)	7,260	6,267
Outpatient First	(23,317)	(23,377)	(60)	(77)
Outpatient Procedures	(14,185)	(15,044)	(860)	(832)
A&G / costing adjustment	0	(3,678)	(3,678)	(1,468)
Total	(97,799)	(92,374)	5,425	6,026

Assurance report

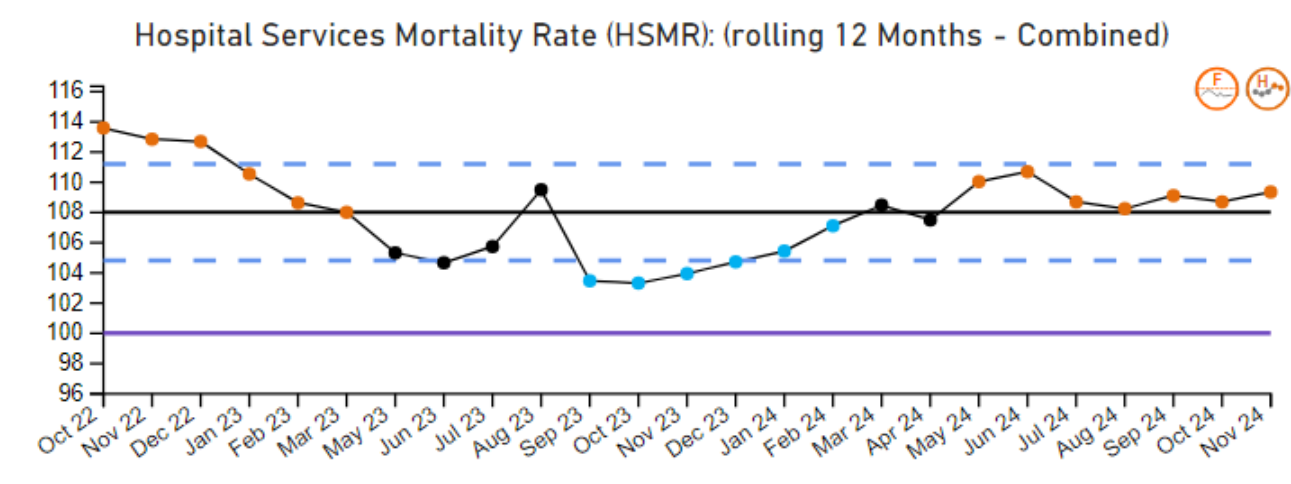
Pay spend against plan including substantive, additional sessions, bank and agency

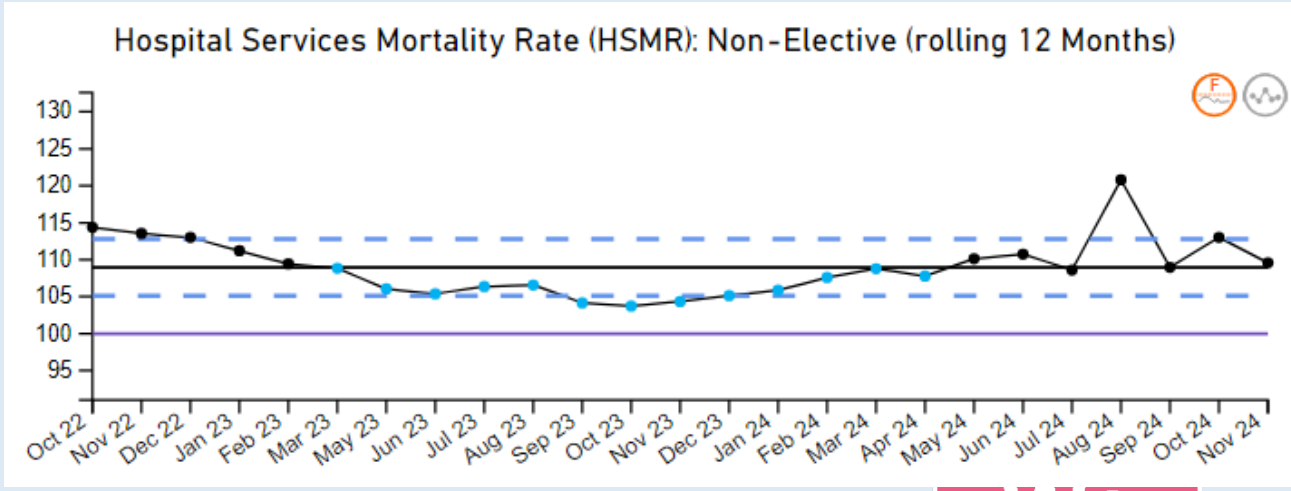
Summary of challenges & risks	Pay: £1.6m adverse to budget • MEOC is £2.1m favourable to budget, offsetting the lower income • CDC is £0.5m favourable to budget, offsetting the lower income • Pay CIP delivery is £1.5m favourable to plan • £1.4m as a one-off benefit identified from accruals and a review of accounting policies Offset by adverse variances mainly due to: • Pay award funding adverse £1.9m • Industrial Action costs of £0.5m, offset by clinical income • Continuing pressure on medics pay, agency expenditure and additional sessions covering sickness and vacancies £1.5m
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 Finance Challenge and Support meetings. Medical Director input into agency spend CIP workstreams. Nursing and Midwifery staff: Patients have more complexity requiring enhanced care driving the bank spend. Divisional Nurse review of Nursing and Midwifery spend at Finance Challenge and Support meetings. Director of Nursing input into the agency spend CIP workstreams. Allied Health Professionals: workforce plan being led by the Director of Nursing, progressing
Action timescales and assurance group or committee	Ongoing - being reviewed in CIP workstreams, Finance Challenge and Support meetings, PRM
Risk register	16 - Failure to achieve compliance with Financial Performance and achieve Financial Plan.

Assurance report

HSMR Rolling 12 months Combined

Summary of challenges & risks	The Trusts combined HSMR rolling 12-month rate is 109.4 against a target of 100 for November 2024. Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER.** This has changed from the previous Board Report. This may require a discussion regarding re-baselining. This process is not capable and will **FALL BELOW** the target without process redesign. The Trusts non-elective HSMR rolling 12-month rate is 109.6 against a target of 100 for November 2024. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Mortality Data Quality Assurance Improvement Group reconvened September 2024, with all actions monitored on Monday.com. Mortality dashboard developed to monitor SHMI performance and clinical coding/depth of coding, enabling early warning of any areas where prompt action to be taken. SJR process in place with monthly MDTs. SJRs being undertaken for all deaths recorded as sepsis, discussed in the sepsis action group. Opportunities for learning from deaths shared through governance meetings. Work continues to increase the number of senior medical staff undertaking mortality reviews. An update on the Trust's response to the findings and recommendations of the internal audit of mortality data quality assurance undertaken by 360 Assurance was reported to Audit and Risk Committee in February. All actions complete bar one which is in progress and on track to complete by 31 March 2025.
Action timescales and assurance group or committee	Due to the lag in SHMI performance reporting it will take time for improvements to be seen in the data. Assurance route is through governance framework to Quality Committee.
Risk register	



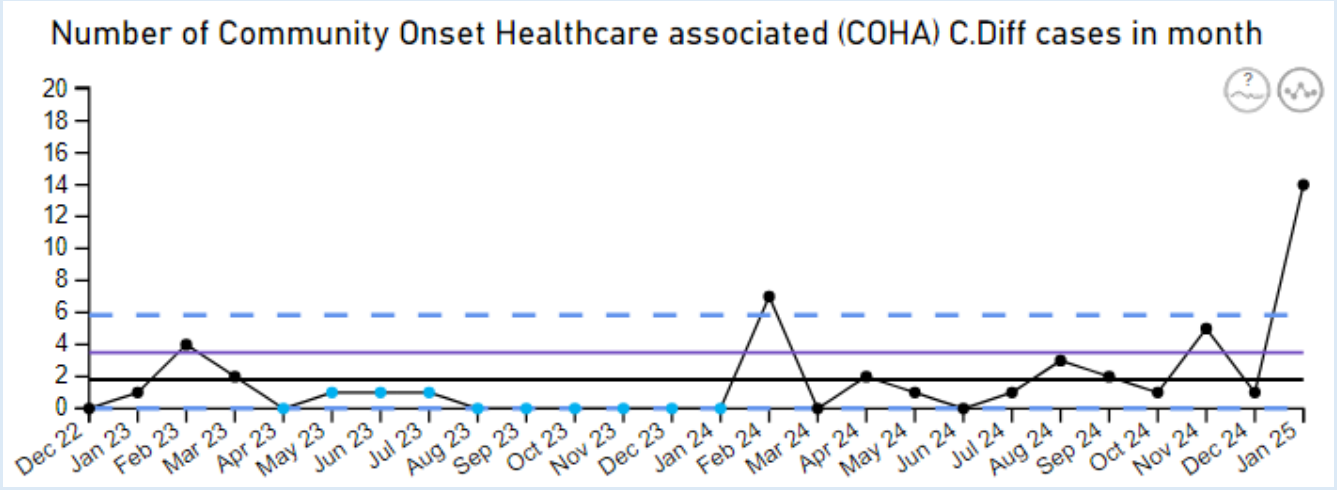


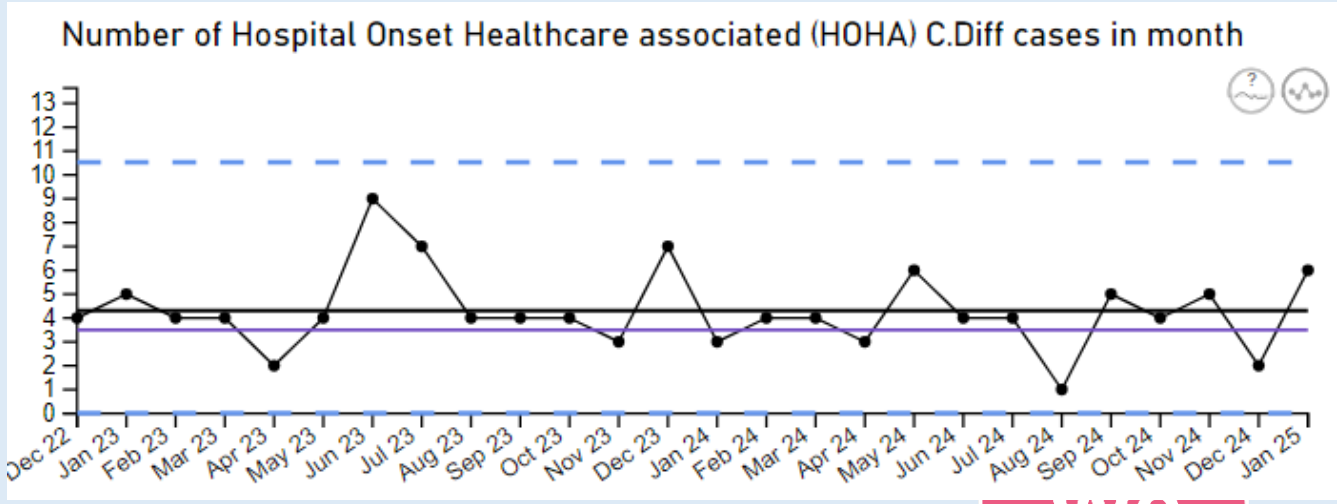
Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Cdiff Cases in month

Summary of challenges & risks	In January 2025 there were 20 cases of Hospital or Community Onset Healthcare associated C.Diff cases Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
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 pilot to educate upon stool sampling and stool charts • 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. • Antimicrobial nurse specialist commenced in post December 2024. • The DIPC & Lead IPC nurse now include the community cases in their weekly CDI ward round reviews.
Action timescales and assurance group or committee	Ongoing programme. Monitor as part of infection control operational group and Infection control strategic group
Risk register	Logged as risk ID - 3517



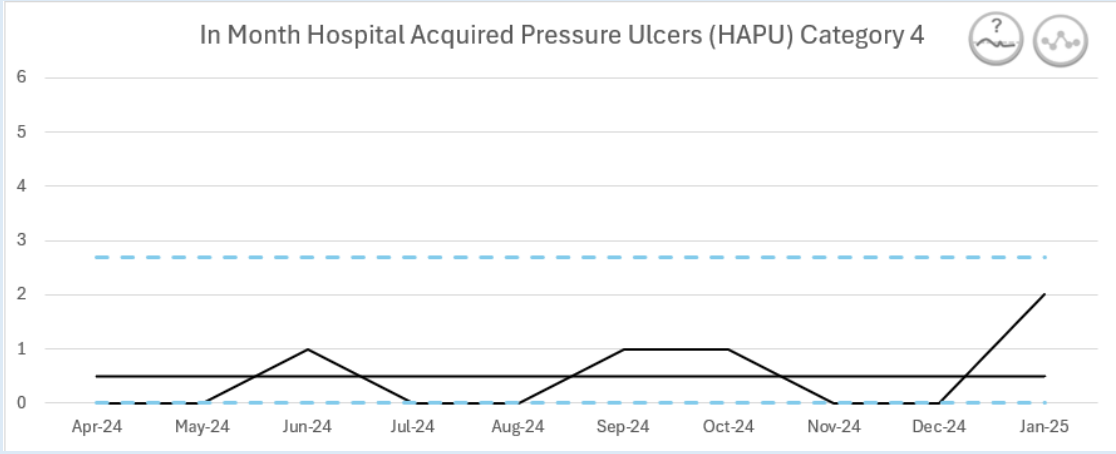


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Hospital Acquired Pressure Ulcers (HAPU) Cat 4

Summary of challenges & risks	There were 2 Hospital Acquired Pressure Ulcers (HAPU) Category 4 in January 2025. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Walk through analysis and hot debrief undertaken at time of verification by the skin integrity team. • AAR/PSII under taken by the ward manager and matron for all cases • Quality summits have been undertaken on all areas where the HAPU 4's were attributed to in line with chief nurse oversight framework. • Skin Integrity Pressure Ulcer Reduction Plan 2025 – 2028 being finalised to commence April 2025 which includes actions around enhancing the prevention techniques for Medical Device Related Pressure Ulcers (MDRPU), initial assessment and prevention in the Emergency Department, enhanced additional preventative equipment.
Action timescales and assurance group or committee	• Walk through analysis and hot debrief completed • AAR/PSII completed • Safety summits completed • Skin Integrity Pressure Ulcer Reduction Plan 2025-2028 to commence April 2025 – presented at the Chief Nurse Meeting February 2025.
Risk register	Risk ID 18897

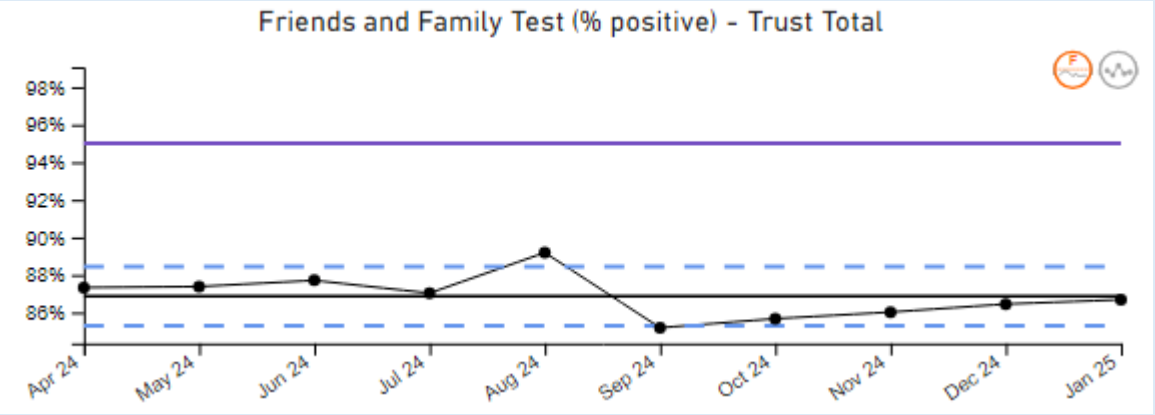


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Friends & Family Test (% positive) - Trust Total

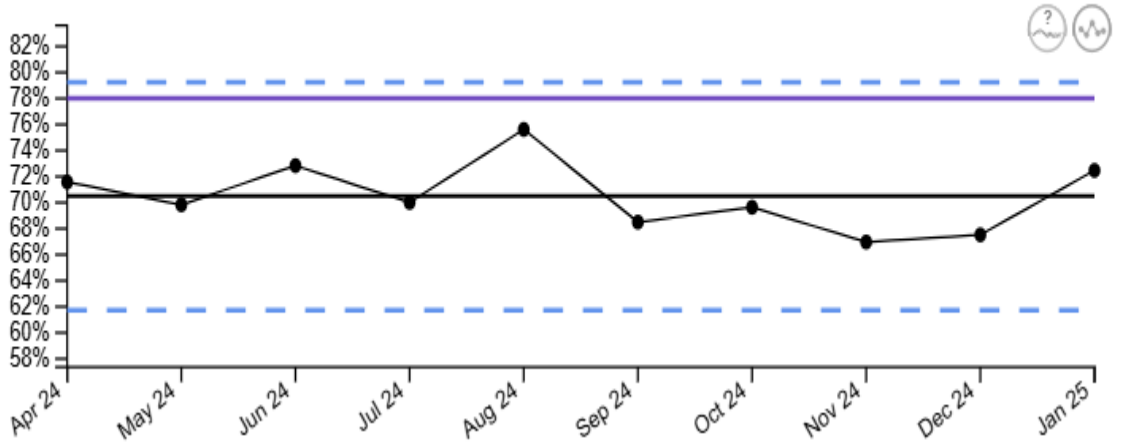
Summary of challenges & risks	Friends and family positive response rates fell below the standard of 95% in January 2025 for the Trust – 86.7% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Overall positive improvement trend seen, • Deep Dive planned into areas where positive rate was low • Identification of themes to be discussed via Patient Experience and Involvement Group
Action timescales and assurance group or committee	April 2025 – Patient Experience and Involvement Group
Risk register	N/A

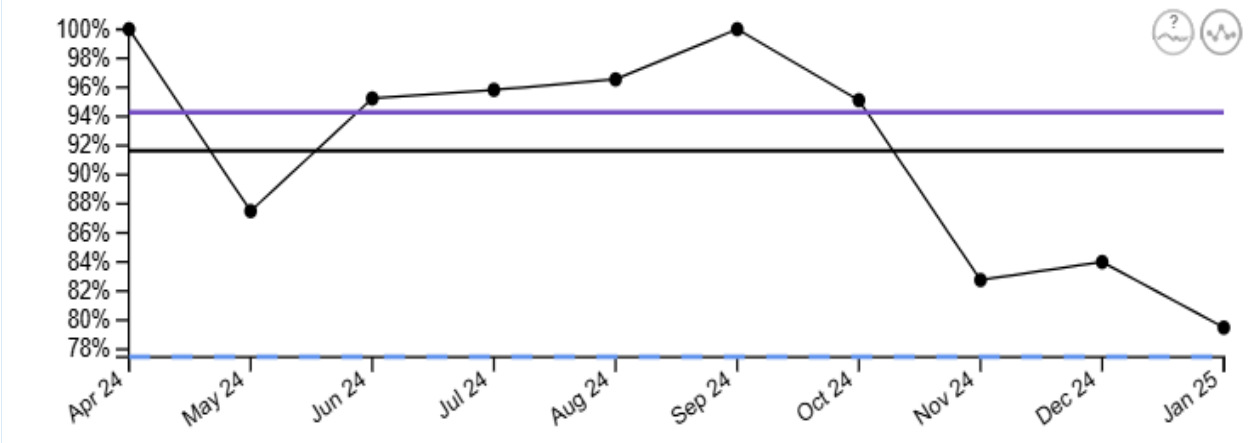


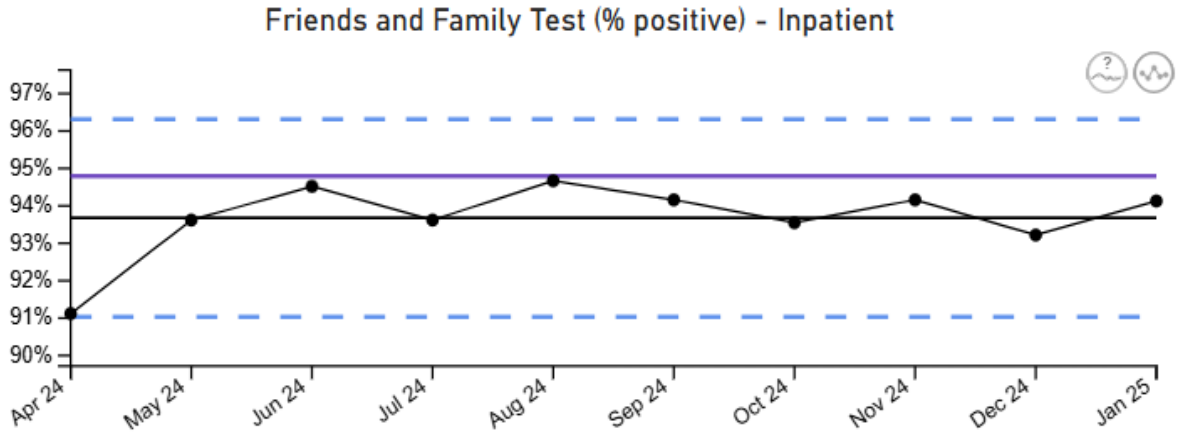
Source DBTH_IQPR_Dashboard_January 2025

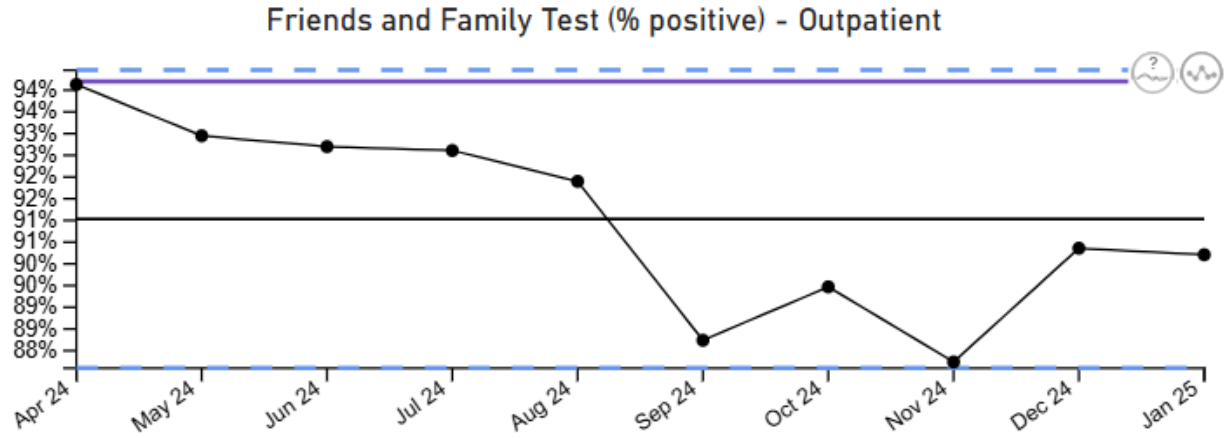
Assurance report

Friends & Family Test (% positive)







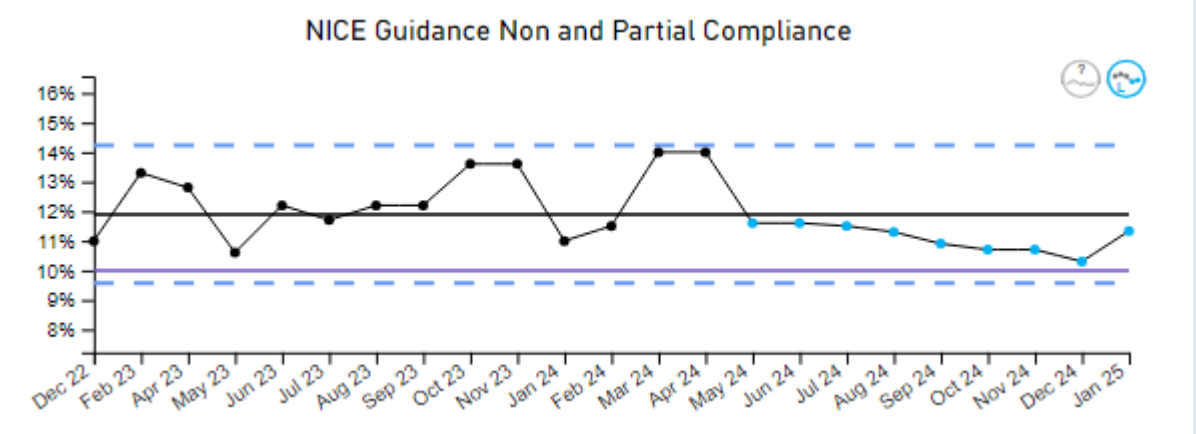


Source DBTH_IQPR_Dashboard_January_2025

Assurance report

NICE Guidance % Non & Partial Compliance

Summary of challenges & risks	In January 2025 compliance was 11.3%. Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign
Actions to address risks, issues and emerging concerns relating to performance and forecast	NICE guidance are distributed monthly to relevant Specialties/Divisions. Progress is monitored continuously via Monday.com and compliance is reported monthly at Divisional Governance Meetings and through the Trust's governance/assurance framework. Assurance for the NICE guidance sits within each Division and compliance is monitored as a continuous process to evidence Assurance. Of those NICE Guidance that are only partially or non compliant, these are: • waiting for drugs to be added to the formulary for use • undergoing audit to show compliance • re-audits to show compliance as standards were not achieved in initial audit. If compliance achieved these will move to compliant.
Action timescales and assurance group or committee	Timescales for actions are recorded in Monday.com with monthly reports produced for governance meetings and the assurance route is: • Audit & Effectiveness Forum • Effectiveness Committee • Quality Committee
Risk register	

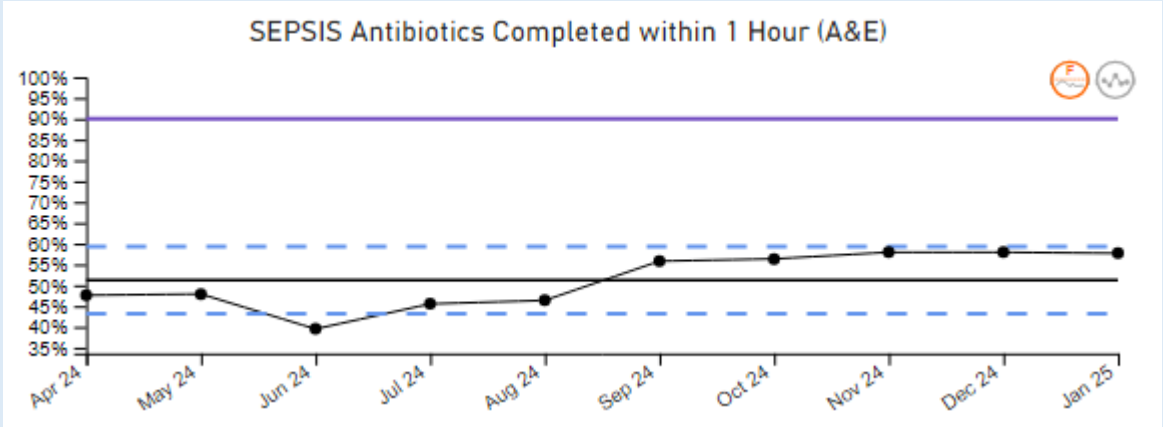


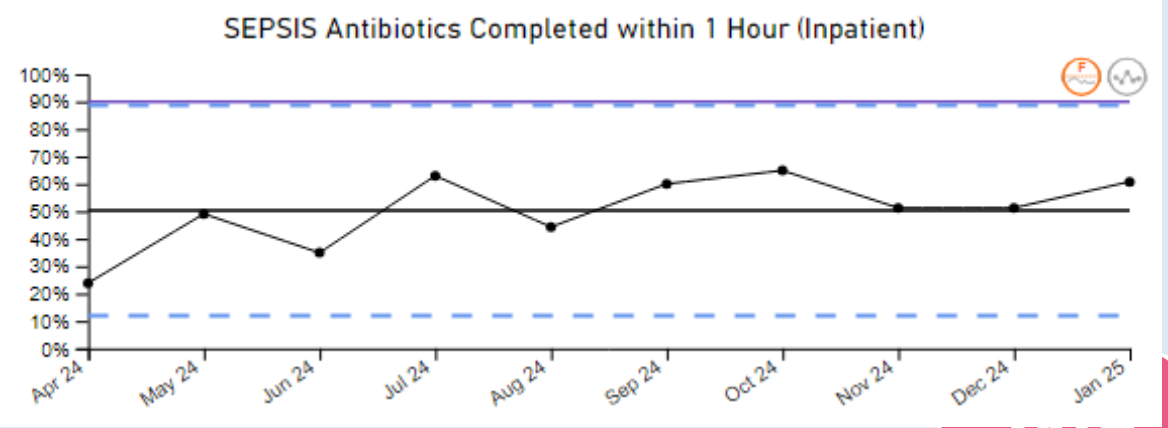
Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Sepsis Antibiotics Completed within 1 Hour

Summary of challenges & risks	For January 2025, 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 57.7% For January 2025, the Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 60.8% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign. This has changed from the previous Board Report.
Actions to address risks, issues and emerging concerns relating to performance and forecast	ED have several initiatives on blood cultures, antibiotics and education in the form of sepsis modules for all staff, these and the world sepsis day symposium have had a positive impact. All sepsis deaths are subject to Structured Judgement Reviews and reviewed in mortality governance group. Learning points to divisional leads for sepsis are fed back, particularly relating to blood cultures and antibiotics. There is a lead for sepsis in each division. They are overseeing QI projects to improve our response to sepsis. Ward based sepsis initiatives and education in small groups underway. Sepsis guidelines renewed to reflect NICE guidance. The move to EPR will improve our data collection on sepsis patients and also help compliance with out electronic sepsis and CAP bundles.
Action timescales and assurance group or committee	Sepsis Action Group submit an annual report to Patient Safety Committee
Risk register	



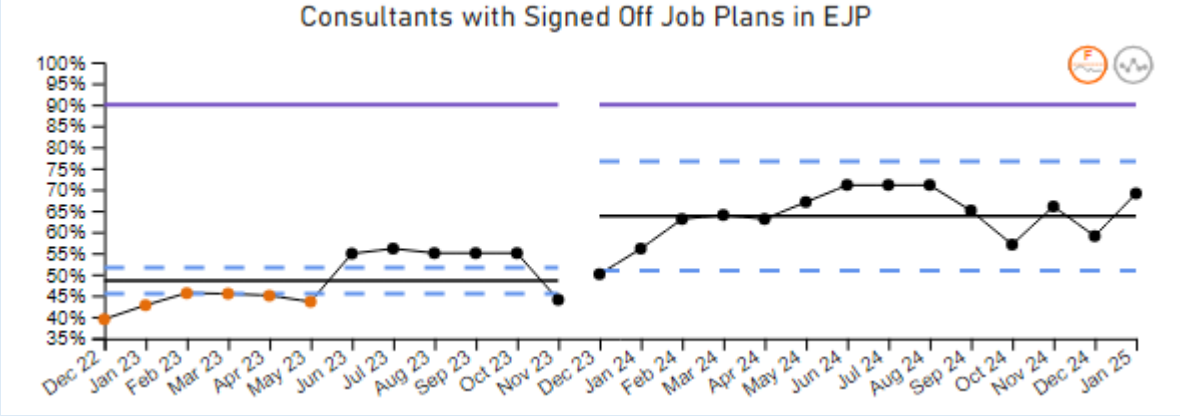


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Consultants with Signed Off Job Plans

Summary of challenges & risks	For January 2025 69% of Consultants had a signed off job plan Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign Re-basing has taken place December 2023 as job planning completion was linked to CEA programme
Actions to address risks, issues and emerging concerns relating to performance and forecast	National job planning target is 95% by 31/03/25, which is a stretch for all acute providers, but particularly challenging for the Trust following transition to L2P when performance dropped. The Associate Medical Director for Workforce is pro-actively managing this, along with the job planning admin team, supporting individuals and teams with the transition, re-building job plans in the new system and taking time to ensure job plans are accurate and high quality.
Action timescales and assurance group or committee	To achieve 95% of all job plans signed off by 31/03/2025.
Risk register	

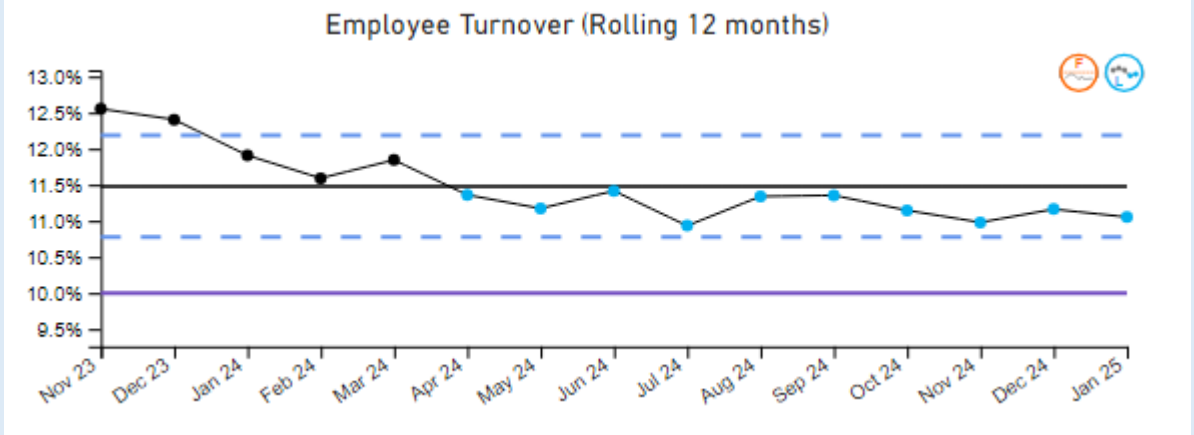


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Employee Turnover (Rolling 12 months)

Summary of challenges & risks	Employee turnover for January 2025 was 11.1% Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Work continues in relation to improving retention, toolkit for managers updated • Quality improvement approach being undertaken in relation to learning from leavers to improve the response rates of exit interviews and feedback from those leaving the Trust to enable improved thematic analysis • Draft Leavers Policy drafted • Improved appraisal process complemented by Scope for Growth conversations and succession planning discussions.
Action timescales and assurance group or committee	• Leavers policy due for approval at March 25 Policy Formulation Group meeting • Monitor improvements in relation to learning from leavers in Q4 and into 2025/26 – review at Workforce & Education Committee in February 25 • Scope for Growth and succession planning frameworks to be recommunicated in Q4 prior to 2025 appraisal season
Risk register	16, 2554

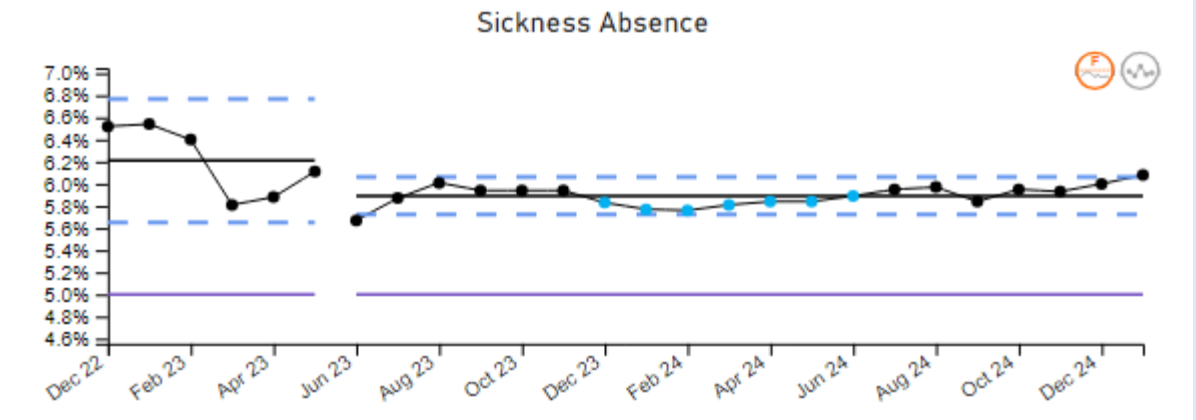


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Overall Sickness Absence

Summary of challenges & risks	For January 2025, the Trust sickness rate is 6.1% against a target for 5%. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. Re-basing has occurred June 2023 recognising the significant improvement following the review and implementation of the Sickness absence policy
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Concluding post implementation review (PIR) of the revised sickness absence policy • Effective management of long-term sickness absence cases including at the final stage of the process. Increase seen in short-term sickness absence related to seasonal variation. • Offer of additional support and training from the People Business Partner Teams • Focus and data analysis on specific groups - Health Care Assistants, Nursing • Identification of patterns of absence and appropriate actions that can be taken in line with the policy • Improvement work underway supporting absence management for medical colleagues with feedback, input and support from Clinical Directors
Action timescales and assurance group or committee	• Completion of the PIR in Q4 including incorporating feedback into practice • Actions to be identified following data analysis on nursing workforce absence in Q4, to be discussed at divisional performance review meetings • Medical workforce absence improvement work Q4 and into 2025/26 • Actions identified following a meeting held with another Trust to share learning on managing attendance
Risk register	2554

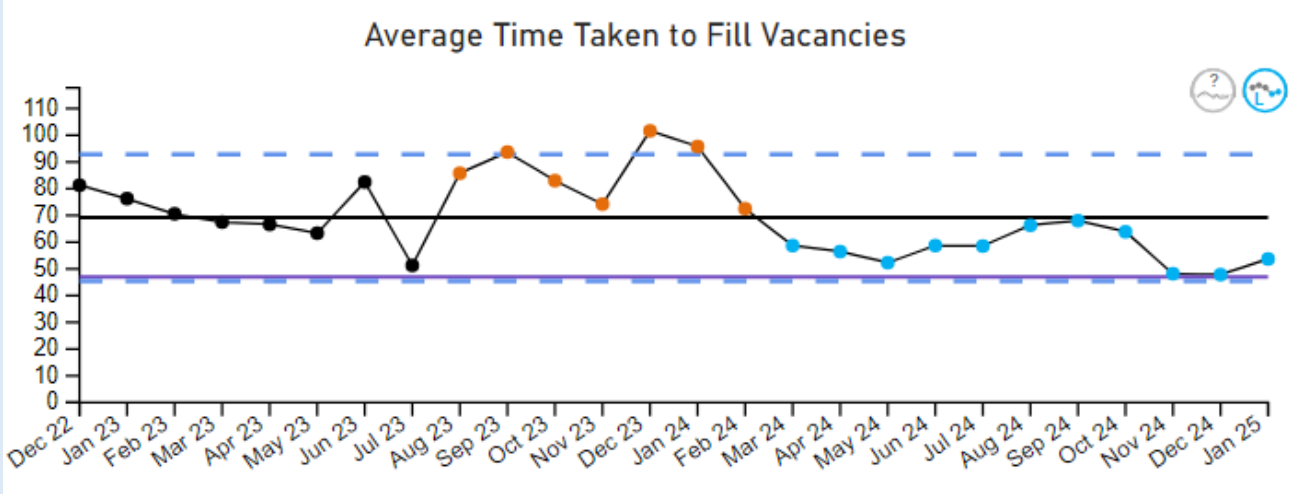


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Average Time Taken to Fill Vacancies

Summary of challenges & risks	The Trusts time to hire is 54 days for January 2025 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.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Further support to managers in managing campaigns within the identified KPIs • Additional training and support offered by the recruitment team • Improvements being made to the internal transfer register with plans to pilot the process for clinical admin and clerical roles in Q4 – anticipated to have a positive impact on reduction of number of vacancies • Collaborative work with system and regional trusts on improving time to hire continues
Action timescales and assurance group or committee	• Support actions and training offer are ongoing • Collaborative work is ongoing • Report update to Workforce & Education Committee in February 2025 • Internal transfer pilot work expected to begin by end March 25
Risk register	16 (linked)

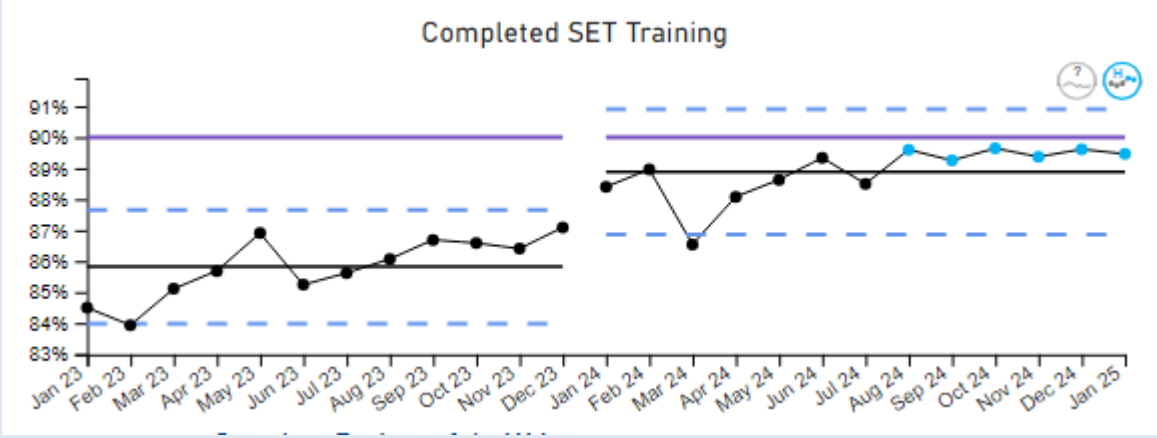


Source DBTH_IQPR_Dashboard_January 2025

Assurance report

Completed SET

Summary of challenges & risks	In January 2025 the Trust had a SET completion rate of 89% against a target of 90% Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER.** This has changed from the previous Board Report. This process will not consistently **HIT OR MISS** the target as the target lies between process limits. Re-basing has occurred January 2024 as there was a statistically significant improvement in compliance, attributed in part to the linkage between the CEA and appraisals processes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Over 89% compliance maintained for six consecutive months, including during operationally challenging winter period. SET training sessions continued during this time, for attendance where capacity allowed. • Education Team has undertaken analysis of compliance and identified some key areas where focused support will improve the position to achieve the 90% target. Three subjects have been identified as focus areas, where small improvements will lead to overall compliance to 90% - '3 steps to success' communications campaign • Work continues on NHSE national statutory and mandatory training project and is on track, the Trust is aligned on all SET topics • NHSE Memorandum of Understanding signed and returned in January 2025, to support future passporting between trusts of statutory and mandatory training
Action timescales and assurance group or committee	• Trust focus on '3 steps to success' on SET compliance continues throughout Q4 • NHSE project work in line with national timescales, Q4 and into 2025/26
Risk register	3005



Source DBTH_IQPR_Dashboard_January 2025

Metrics in development

- Medical Appraisals completed – *Back dated forms to be completed*
- Duty of Candour (failure to undertake in its entirety) *Awaiting changes to be made in Datix*
- Monthly SHMI measure – *to be built into 2025/26 Development Plan*
- Zero Tolerance Methicilin-resistant Staphylococcus aureus – *Data Source currently under investigation to scope out the development requirement.*
- Minimise rates of gram-negative bloodstream infections – *Data Source currently under investigation to scope out the development requirement.*
- Vacancies (specific staff groups) – *Additional data required in extracts provided. This is being investigated.*
- Severe harm falls per 1000 bed days – *Under testing*
- No urgent operation to be cancelled for a second time – *Further investigation required.*
- Proportion of all outpatient attendances that are for first appointments or Fus attracting a procedure tariff – *Development resource required to automate*
- Combining of COHA & HOHA – *In Test*
- Flu Vaccinations – *Development Resource Required*

- Clarification required on any changes (new metrics/removal of metrics for 2025/26)

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2503 - F2 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK REGISTER

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

Executive Directors
20 minutes

REFERENCES

Only PDFs are attached

F2 - Board Assurance Framework including Trust Risk Register.pdf

F2 - Appendix 1 Board Assurance Framework v3.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**F2**
Report Title:	**Board Assurance Framework (BAF) and Trust Risk Register**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance Tracy Evans-Phillips Trust Risk Manager		
Appendices:	Appendix 1 - BAF (risk 1-7) Appendix 2 – Risk Register report		

Report Summary

Purpose of the report

This report presents the Board Assurance Framework (BAF) for 2025/26 up to and including reviews into February 2025. The Board Assurance Framework and Trust Risk Register are 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's four priority areas – Patients, People, Partnerships and Pounds and the Trusts risk register to ensure any emerging risks, either internally or externally are effectively managed. It summarises the controls in place to mitigate / manage the risks and sets out the assurance, including three 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.

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 trusts 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.

The Partnership BAF risk will be discussed in depth within the confidential Board meeting. The results of any updates will be reflected in the May BAF that will come to the public board for assurance.

Updates

The BAF has been developed over the last 3 months, including with 2 specific board development sessions to ensure the template is effective for the Board and the executive team. All Board members have had the opportunity to review its content and feedback, which have then been included in this version.

The risks are very similar to the previous version, with some rewording to articulate some changes since 2024/25. Part of this process included transferring key controls / assurances and any outstanding actions into the new template before closing the older version. This has been monitored through the responsible committees. With the development of the new strategy, and clarity around the Trusts key ambitions, a further risk was identified for Digital and Cyber security, and this has been added as a further BAF risk

The Risks have been articulated as:
Risk 1: Patients; If there is a failure to embed the learning from incidents or listening to patients, Patients could experience avoidable harm, resulting in poor patient outcomes and possible regulatory action for DBTH.

Risk 2: People; If DBTH do not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way.

Risk 3: Patients; If we do not eliminate the Pandemic elective care backlog, improve efficiency and address the increased demand, we are unable to deliver timely access to care resulting in long waiting times and potential patient harm

Risk 4: Patients and People; If DBTH cannot maintain and improve care environment in a timely way, this will lead to a poor-quality or unsafe environment, impacting the quality of care experienced by patients, colleagues and / or regulatory actions.

Risk 5: Pounds; If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.

Risk 6: Partnerships; Due to insufficient resource, engagement, and governance arrangements, our partnerships do not deliver on the expected benefits, resulting in poor use of resources and inability to transform and enhance services.

Risk 7: Patients and People; If we fail to develop essential digital, data and technology that prioritises cyber resilience, we will prevent our people from delivering efficient, safe patient care and increase the risk of key system failure and disruption to services.

In line with the Trusts Risk management Policy – the BAF and Trust risk register will continue to be reviewed at every board and committee, with updates on the actions identified to close control and assurance gaps. As agreed, at the January Board of Directors meeting, the Partnership risk will be discussed within the confidential meetings and its updates brought to the May 2025 Board of Directors public meeting as part of the whole BAF assurance.

Once the internal audit plan is complete for 25/26, these audits will be provisionally added to the relevant BAF Risks, further supporting with planning and oversight of the nominated committee and to clearly track actions and recommendations.

Conclusion
The Trust continues to review, develop and implement enhancements of the BAF for 2025/26 in line with published guidance, internal audit suggestions and best practice benchmarking.

The 'clean version' of the Board Assurance Framework is enclosed in appendix 1 for Board review, discussion, and assurance. This has had all the tracked changes that were shared within the committee updated. To note, the Finance and Performance Committee had not yet taken place and so amendments to these risks will be reflected in the next iteration of the BAF to the Board of Directors in May 2025. The BAF will continue to mature in line with the developing strategy and identified milestones.

Operational 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. • **Discuss and Agree** the new BAF template, including its content and new BAF risk 7 Digital and Cyber resilience • Take **assurance** the 2025/26 BAF enables the Board to fulfil its duty to monitor its highest strategic risks. • **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** ***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
	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
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 Board development session 4 February 2025
Date:	Finance and Performance Committee - 27 February 2025 People Committee - 18 February 2025 Quality Committee - 11 February 2025
Any outcomes/next steps	N/A
Previously circulated reports to supplement this paper:	N/A

Board Assurance Framework and Trust Risk Register Review

Board Assurance Framework (Appendix 1)

BAF Summary of Changes:

- Assurance levels on actions and controls have been agreed by respective lead committees – see highlight reports from each committee.
- Risk 6 (Partnerships) will be reviewed by the Board of Directors within the confidential meeting as owners of this strategic risk, To note: it was discussed within the Board Development Session on 3 February 2025, that the Research and Innovation would be best placed within the Partnership BAF Risk which will be discussed within the confidential meeting as part of that risks review.
- The Board of Directors will review the whole BAF within its public meeting as per the Trust Risk Management Policy and take a decision on the recommendations made by the relevant committees. .
- A new Risk (7) has been proposed for Digital and Cyber security, this will have been discussed at the Finance and Performance Committee and a recommendation made to the Board of Directors on this.

Once the new templates and risks have been approved by the Board of Directors, all related documentation will be updated to reflect these changes – including the Trust Risk Register and Overarching Trust Risk Register.

Trust Risk Register (Appendix 2)

Introduction

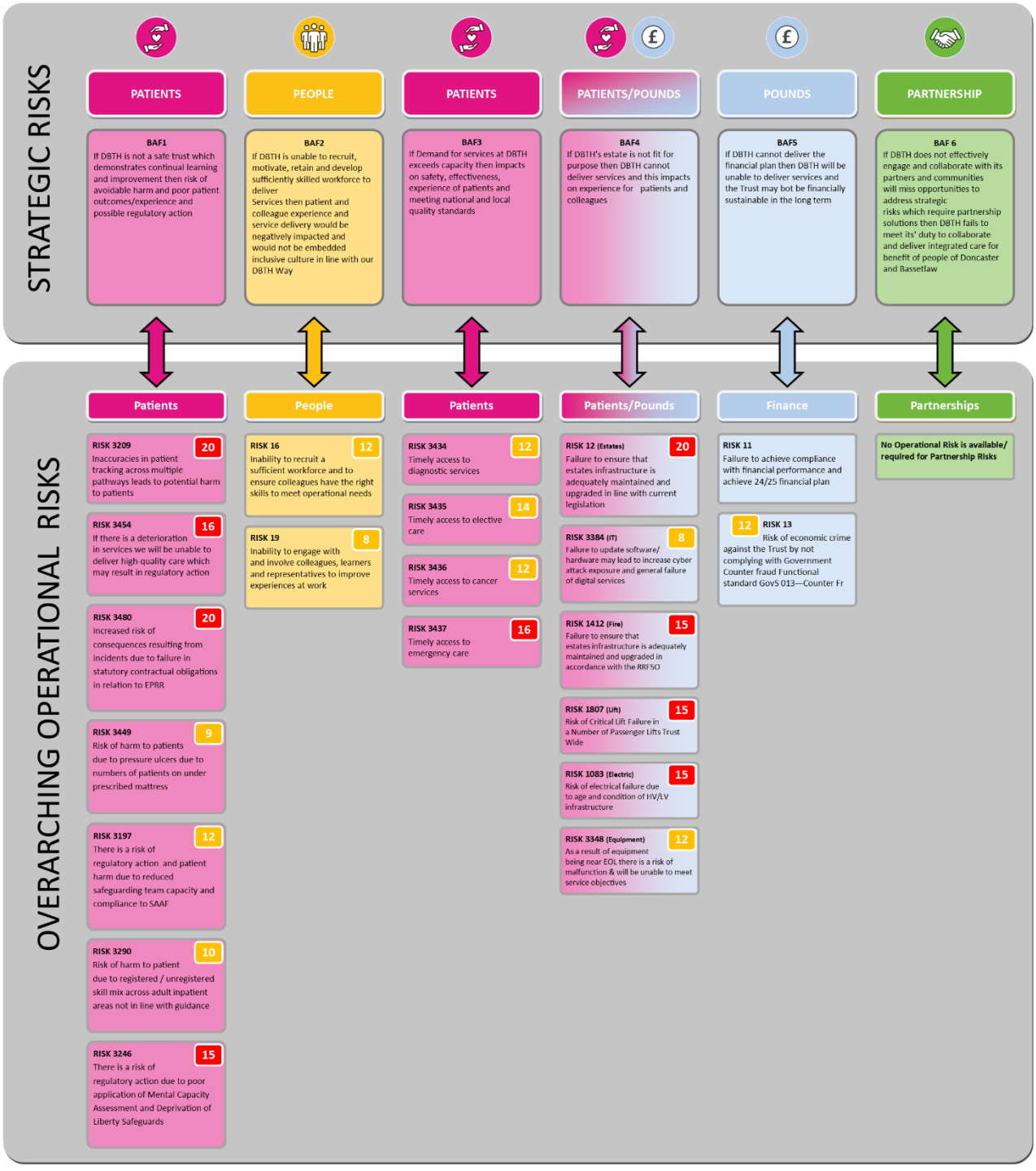
The following report provides an update to the Board of Directors following review of all risks on the Trust Risk Register. The risks contained within this report include overarching operational risks that directly relate to the strategic risks in the BAF, and any 15+ risks that are standalone. Each of the overarching operational risks identify any dependent 15+ risks – full details of which may be found on Datix. These risks have approval at Divisional / Directorate level and Risk Management Group*. A summary of the relationship between the Strategic Risks (BAF) and the Operational Risk is below. For the full Trust Risk Register see, Appendix 2. [* With the exception of new risks which have yet to be discussed at Risk Management Group].

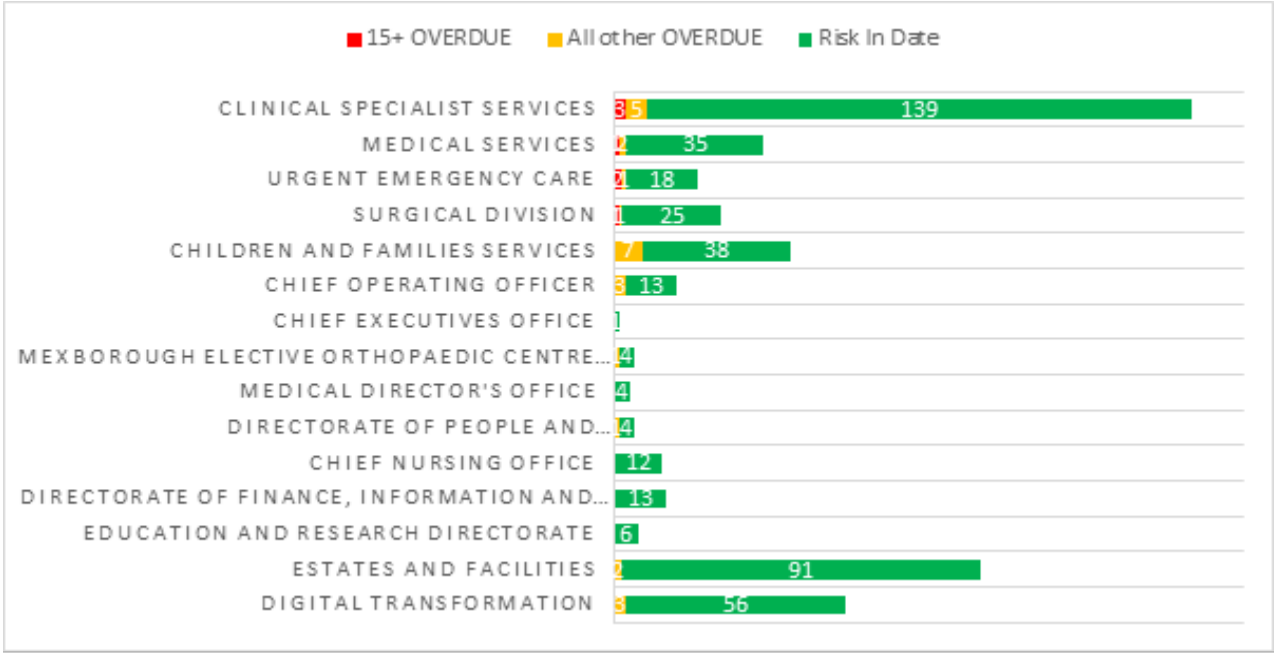
To Note: this information is based on the date these reports were collated and specific numbers will change throughout the month as these change.

Risk Review Dates

In terms of compliance with risk review dates, the chart below shows all risks in the Trust, including those with a risk score of over 15 (15+ risks) for each of the Divisions and Directorates. There are 33 overdue risks of which seven are extreme (15+) risks; the remainder are reviewed and compliant. The chart below provides an overview of compliance with review dates per Clinical and Corporate Division as of the 10 February 2025. The Clinical Divisions and Directorates are aware of the overdue risk, which is also been reported through the Performance Review Meeting (PRM).

Strategic and Overarching Operational Risk Relationship

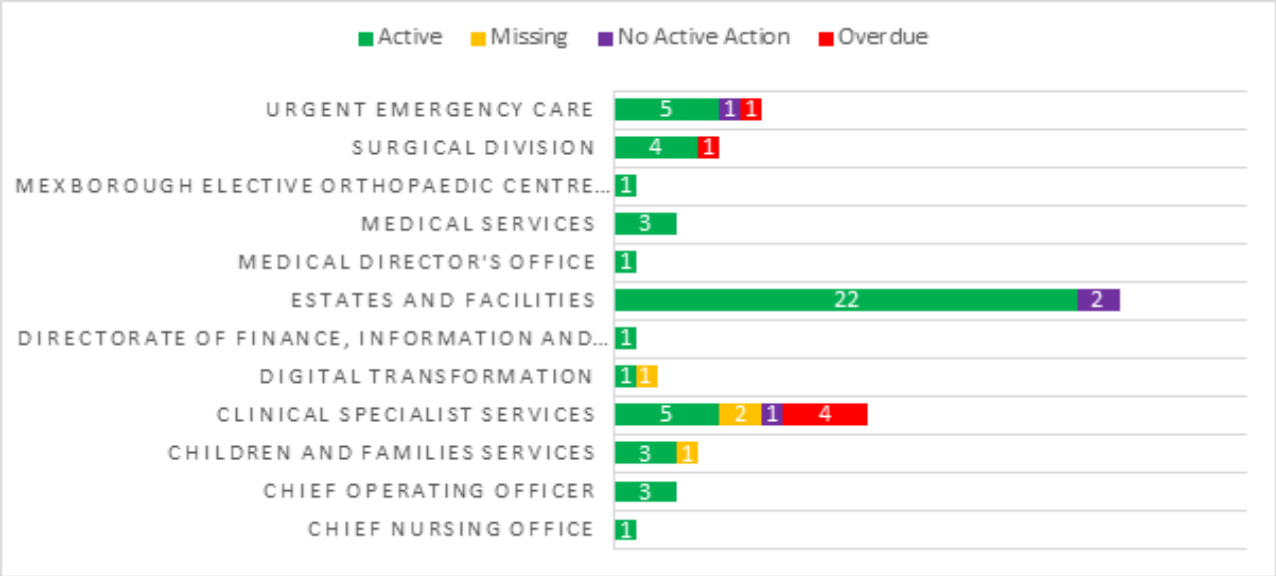




The above chart shows the 492 Trust Risks, which include 64 extreme risks [Data 10 February 25]

Risk Action Plans

All risks rated 15+ should contain remedial action plans to improve the management of the risk to the target risk score. The chart below shows the action plan status of each of the 15 + risks, by Division or Directorate identifying the active actions, those actions that are overdue or those that are missing from the Datix entry (but are available operationally). Some risks have had completed remedial action; however, this has not reduced the risk to the agreed target level and further mitigation action is thus required.



The above chart shows the action summary of 64 extreme risks as of 10 February 2025.

Risk Management Group review and discuss those with “no active action” to ascertain if further action is required outside of the risk location responsibility. There is a reduction in the number of risks requiring remedial action. The Risk Manager is working with the Divisions and Directorates to ensure that action plans are in place and to ensure good practice of this aspect of risk management.

Changes to Trust Risk Register

Following a further concentrated review of risks, ten risks were downgraded and no longer appear on the Trust Risk Register, one has been downgraded but remains an overarching operational risk, and twelve risks have been closed. Details below:

Risks Downgraded from a score of 15+, so no longer on Trust Risk Register

- **RISK 2873 Lack of flow in Emergency Department / Acute Medical Unit**
  Mitigation is in place to reduce the likelihood of occurrence
- **RISK 1209 Risk of reduced lighting following power failure**
  Mitigation is in place to reduce the likelihood of occurrence
- **RISK 3556 Acute trauma operative backlog**
  Trauma capacity status now green
- **RISK 3545 Standard 8 compliance with anomaly scans (20-week scans)**
  Improvement of compliance following last audit
- **RISK 3494 Community dietetic service in Bassetlaw area**
  Likelihood reduced due to smaller cohort of patients than expected
- **RISK 3199 Restricted refrigerator storage space in Pharmacy**
  Received two units of single doored fridges to store medication
- **RISK 1264 Ventilation - annual inspection and verification (Critical Systems)**
  Mitigation is in place to reduce the consequence should the risk occur
- **RISK 3101 Theatre slots for elective Caesarean Sections**
  Lower Segment Caesarean Section (LSCS) booked centrally for best utilisation of available slots
- **RISK 3553 Obstetric Ultrasound machine > 7 years old**
  Reduction in reported incidents so reduced likelihood
- **RISK 3544 Non-compliance with IR(ME)R amendment 2024 regulations**
  Staff aware of new regulations, department now compliant

Risks reduced but remain on the Trust Risk Register

- **RISK 11 Compliance with 24/25 financial plans**
  Targeted savings leading to improvement in forecast for year end

Risks closed.

- **RISK 3580 loss of escalation beds**
  Specific patient related risk, theme of risk incorporated into RISK 2287
- **RISK 3577 and RISK 3578 Radiographer support**
  Duplication of risk already in the system
- **RISK 3485 2024/25 – EPRR - Duty to Maintain Plans**
  Details covered by RISK 3480
- **RISK 3420 Paediatric Audiology - equipment and working practices**
  Duplication of other risks on the register
- **RISK 3398 Crowding / acuity in ambulatory Emergency pathways**
  Duplication of RISK 3410
- **RISK 3147 Failure of current ageing Echo machines**
  New equipment purchased and in use
- **RISK 3515 Consultant cover -long term sickness**
  Long-term sickness resolved
- **RISK 3473 Lack of Equipment to manage ROP screening**
  Duplicate of RISK 3219
- **RISK 3174 Failure to achieve compliance with financial performance and achieve financial plan**
  Duplication of RISK 11

- **RISK 3192 Ortho-geriatric cover for #NOF patients**
  Ortho-geriatrician is now in post
- **RISK 3579 out of hours urgent nephrostomy services**
  Period of reduced service shows no incidents or patient harm or requirement to utilise emergency theatre

New Risks

Six new risks have been added to Datix with a 15+ rating. None of these risks have been presented at Risk Management Group and are currently going through the divisional governance process before it is moderated in this forum.

- **RISK 3596 An increase in women not attending for routine ante-natal care due to being charged for care**
  Community midwives can advise and support. Overseas Team organising payment plans for the women
- **RISK 3589 Lack of glaucoma capacity**
  Vacancy Control Form completed for additional specialty doctor. Use of Advanced Nurse Practitioners and Glaucoma trained optician to reduce clinical demands
- **RISK 3601 Failure to communicate ATC name change to AMU**
  Alertive lead-time to change names on system is 2 – 4 weeks. Dissemination of change of name via Buzz, and regular email communications
- **RISK 3600 Ceiling tiles intermittently become water saturated**
  Estates asked to review if issues in plant room above affected area
- **RISK 3587 lack of trauma day case bed capacity**
  Ring-fenced elective workload affecting capacity, mutual aid from Theatre Admissions Unit where available
- **RISK 3359 increased patient demand on rheumatology nurse services**
  Increase in number of patients to service. Risk has been reviewed and moderated and subsequently reduced to a rating of 12

Appendix 2 Trust Risk Register

BAF	Risk ID	Risk Owner	Title	Review date	Rating (current)	Time at current risk rating (months)	Rating (Target)	Number of Dependent Extreme Risks	Risk score requires review	Actions requires review
BAF 1	1517	Wilson, Rachel	Risk of patient harm as a result of unavailability and supplies of medicines	08/04/2025	15	7 months	6	0	No	No
BAF 1	3197	Brown, Simon	There is a risk of regulatory action and patient harm due to reduced safeguarding team capacity and compliance to SAAF	03/03/2025	12	3 months	6	0	No	No
BAF 1	3209	Smith, Denise	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	10/03/2025	20	25 months	6	1	Yes	No
BAF 1	3246	Brown, Simon	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	11/03/2025	15	23 months	9	0	Yes	No
BAF 1	3290	Jessop, Karen	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	02/06/2025	10	21 months	6	0	Yes	No
BAF 1	3449	Brown, Simon	Risk of harm to patients due to pressure ulcers due to numbers of patients on under prescribed mattress	24/03/2025	9	3 months	6	0	No	No
BAF 1	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	13/03/2025	16	11 months	8	4	No	No
BAF 1	3480	Harvey, David	Increased risk of consequences resulting from incidents due to failure in statutory contractual obligations in relation to EPRR	31/03/2025	20	3 months	16	0	No	No
BAF 2	16	Lintin, Zoe	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	27/06/2025	12	8 months	9	4	No	No

BAF 2	19	Lintin, Zoe	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	25/04/2025	8	3 months	8	0	No	No
BAF 3	3434	Vasey, Ben	Timely access to diagnostic services - Demand, Capacity & Flow	30/04/2025	12	12 months	12	6	No	No
BAF 3	3435	Vasey, Ben	Timely access to elective care - Demand, Capacity & Flow	30/04/2025	12	12 months	12	0	No	No
BAF 3	3436	Barnett, Lesley	Timely access to cancer services - Demand, Capacity & Flow	30/04/2025	12	8 months	12	0	No	No
BAF 3	3437	Stubbs, Suzanne	Timely access to emergency care - Demand, Capacity & Flow	30/04/2025	16	11 months	12	5	No	No
BAF 4	12	Timms, Howard	Failure to ensure that estates infra-structure is adequately maintained and upgraded in line with current legislation	30/05/2025	20	105 months	10	14	Yes	No
BAF 4	1083	Gleadall, Mathew	Risk of electrical failure due to age and condition of HV/LV infrastructure	30/05/2025	15	79 months	5	1	Yes	No
BAF 4	1412	Timms, Howard	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	30/06/2025	15	47 months	10	5	Yes	No
BAF 4	1807	Gleadall, Mathew	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	30/06/2025	15	15 months	8	2	Yes	No
BAF 4	3348	Nicholas Mallaband	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	01/10/2025	12	4 months	10	3	No	No
BAF 4	3384	Howard, Dan	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	30/06/2025	8	3 months	8	3	No	No
BAF 5	11	Wilde, Sam	Failure to achieve compliance with financial performance and achieve 2024/25 financial plan	28/02/2025	12	1 month	8	2	No	No
BAF 5	13	Wilde, Sam	Risk of economic crime against the Trust by not complying with Government Counter Fraud Functional Std GovS 013	08/04/2025	12	15 months	8	0	Yes	Yes

Eight of the risks have been at the current risk rating for over 12 months and need further examination. Risk Management Group is undertaking a further review and moderation of all risks where the risk rating has not changed in over 12 months.

March 2025 Board of Directors Meeting. Board Assurance Framework

SUMMARY:

BAF Risk	Oversight Committee	Executive Oversight	Strategic Priorities	Strategic Risk Description (Cause – Event – Impact)	Target Score	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
1	Quality	Chief Nurse Medical Director	Patients	*If there is a failure to embed the learning from incidents or listening to patients, Patients could experience avoidable harm, resulting in poor patient outcomes and possible regulatory action for DBTH*	**12**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**		
2	People	Chief People Officer	People	*If DBTH do not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way*	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**		
3	Finance and Performance	Chief Operating Officer	Patients	*If we do not address the post-pandemic elective care backlog, improve efficiency and manage demand, we are unable to deliver timely access to care resulting in long waiting times and potential patient harm*	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**16**	**16**	**16**	**16**	**16**		
4	Finance and Performance	Chief Financial Officer	Patients People	*If DBTH cannot maintain and improve care environment in a timely way, this will lead to a poor-quality or unsafe environment, impacting the quality of care experienced by patients, colleagues and or regulatory actions.*	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**		
5	Finance and Performance	Chief Financial Officer	Pounds	*If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.*	**12**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**		
6	Confidential Board	Deputy Chief Executive Officer	Partnerships	*Due to insufficient resource, engagement, and governance arrangements, our partnerships do not deliver on the expected benefits, resulting in poor use of resources and inability to transform and enhance services*	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**		
7	Finance and Performance	Chief Financial Officer	Patients People	*If we fail to develop essential digital, data and technology that prioritises cyber resilience, we will prevent our people from delivering efficient, safe patient care and increase the risk of key system failure and disruption to services*	**12**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**		

Risk 1: Patient Care – Reviewed at Quality Committee 11 Feb 2025

Strategic Risk 1	*If there is a failure to embed the learning from incidents or listening to patients, Patients could experience avoidable harm, resulting in poor patient outcomes and possible regulatory action for DBTH.*						**Strategic Objective: Patients**	**We deliver safe, exceptional, person-centred care**
Lead Committee	Quality Committee	Risk Rating	Current Exposure	Tolerable	Target (March 26)	Risk Type	Strategic/ reputational	Links to Significant Risks on Risk Register
Executive Lead	Chief Nurse / Executive Medical Director	Likelihood	4		4	Risk Appetite	Quality: Cautious Regulatory: Minimal	3209; 3454; 3480; 3449; 3197; 3290; 3246
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Risks Last reviewed (by on behalf of Lead Director)	11 Feb 2025	Risk Rating	**16**		**12**			
Score Last Changed (By Lead Committee)	July 2023	Inherent Score	5x4=20					

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls and dates (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
Chief Nurse Oversight Framework – which includes ongoing monitoring of quality metrics, peer reviews, expert reviews, and the ward accreditation process.	**GC1** Quality Dashboard remains under development, ongoing issues with data quality and roll out of metrics	Year 1 progress report on NMAHPs Strategy to QC (Aug 24) (2) Divisional performance monitored at Performance Review Meetings with Exec oversight, (monthly) (1) CQC Action plan update to QC (Feb 24) (2) Tabletop CQC action plan progress review with "place" (Jan) (3) CQC Quarterly Engagement Meetings (3) CARE Accreditation Process review oversight at TLT (1) Maternity, Neonatal Quality and safety committee (1) IQPR (2)	**GA1 Unknown** impact of winter and the need to increase capacity to maintain patient safety.	**Significant Assurance**
Compliance with Developing workforce safeguards including use of Safer Nursing Care Tool and biannual workforce reviews (BR+ for Midwifery) Establishment changes via Chief Nurse approval.	**GC2** Nursing skill mix of RN/Non-RN is not in line with national guidance **GC3** Limited national guidance/decision support tools and reporting for Allied Health Professionals	Biannual establishment review reporting for Nursing and Midwifery to People Committee (Oct 24) (2) Trust wide safe staffing meetings (1) Established use of safe care (1) Evidence of escalation in incident reporting (1) Monthly compliance with safe staffing care hours per patient day reporting via unify (2)		**Significant Assurance**
Clinical Audit Programme and monitoring.		Report to Quality Committee (2) Monday.com dashboards reports into Audit and effectiveness forum (1)	**GA2** Clinical Audit oversight not consistent across all areas	**Significant Assurance**
Learning from deaths review process	**GC4** Insufficient structured judgement reviews (SJRs) completed to contribute to Learning From Deaths **GC5** No substantive Learning from Deaths manager in post **GC6** Lack of learning from Mortality reviews, needs governance review to embed learning	Humber LMNS review of still birth report (Oct 23) (3) Mortality (and DQ) report to Quality Committee (2) Compliance with Quarterly reporting of perinatal mortality review tool outcomes (2) SANDS review of bereavement care (3)		**Significant Assurance**

Clinical policies, processes and clinical guidelines	**GC7** Inconsistent use of complaints handling Policy **GC8** Application of the MCA not consistently applied across the Trust **GC9** High numbers of Clinical policies are out of date **GC10**: Antimicrobial Stewardship Procedures not consistently applied in all areas	Internal Audit Complaints Handling Policy (Oct 24) (3) (Limited Assurance) Infection Prevention Control Steering Group (1)	**GA3** Lack of visibility of resuscitation activity and RESPECT compliance	**Limited Assurance** **Moderate Assurance**
Patient safety incident response plan	**GC11** Trust wide safety improvement plans under development and not embedded	Never event and PSII tracker at internal meetings (1) Patient experience Annual reports to Trust Board (sept 24) (2) Never Event Exception report to QC (Oct 24) (2) Divisional and Trust LFPSE panels (1) Trust Executive Patient Safety Oversight Group (2)		**Significant Assurance**
Clinical Negligence Scheme for Trusts monitoring and oversight (maternity and neonates)		LMNS-Local maternity and neonatal Annual system check & challenge used to benchmark Trust performance (Feb 25) (3) CNST divisional oversight group highlight reports (1) Maternity, Neonatal Quality and safety committee (2) Maternity safety champions visits and meeting (2)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)

Actions	Timescale	Lead	Progress update
GA1) Winter planning and impact under review (utilising existing quality metrics, will include staff engagement post winter step down)	May 25	CN and COO	Plans reviewed at Board in November and monitored through Quality Committee, Finance and Performance Committee. Winter wards/capacity opened, staffing model in place, amended slightly due to availability of estate, monitoring continues
GA2) Review of Monday.com at Effectiveness Committee to check compliance with actions for clinical governance recommendations	March 26	EMD	Report on clinical governance completed actions to come to Quality Committee in Feb 25
GA3) Education Team working with EMD office to establish baseline for understanding required actions for RESPECT and resuscitation.	March 25	EMD	Audit review will come to Quality Committee once completed with next steps to address the gaps
GC1) Quality dashboard implemented with phase 1 & 2 development complete overseen by IT (information services) Phase 3 development is underway. Further iterations included in annual plan for consideration in business planning processes.	September 25	CFO	Team met to review and adjust relevant metrics and issues with the timing of data capture inaccurately impacting on compliance. Monitored through PRM and Exec group.
GC2) Business case under development to embed required skill mix based on quality risks	August 25	CN	Once developed BC will be reviewed through Business Planning 25/26
GC3) Work in progress to review AHP vulnerable services and produce staffing reporting where data available	May 25	CN	Significant work undertaken by AHP leads and Director of AHPs, drafts now being refined, plan to report via Executive team and then to People committee in March and April 2025
GC4) SJR plan in place to address current gaps	July 25	EMD	Phase 1 training complete, phase 2 including newly recruited consultants commencing. Review of Job plans to ensure sufficient time embedded.
GC5) Recruitment to Learning From Deaths Manager	April 25	EMD	Recruitment plan in place and mitigated currently with 1 day a week support through NHS
GC6) Mortality Governance Group Action Plan in place	Nov 25	EMD	Updated ToR, Membership review and workplan. Oversight of Mortality data assurance improvement plan and reporting into executive Team
GC7) Implement actions from IA complaints policy	May 25	CN	Report on actions to come to Quality Committee
GC8) MCA steering group established with associated work plan	September 25	CN	Reported via Strategic Safeguarding Group, MCA advisor posts now recruited to
GC9) Implement and embed processes to ensure Trust wide clinical policies are reviewed in a timely fashion	September 25	D CEO	Policies process established on Monday.com for monitoring, need to review processes/leadership etc. as part of governance review planned.

GC10) Continue with ongoing processes of antimicrobial ward rounds, embed role of antimicrobial stewardship nurse	September 25	CN	Role recently recruited to, plan to undergo induction and review of workplan utilising fresh eyes.
GC11) Monitoring of Trust wide safety improvement plans	July 25	CN	Skin integrity, Falls, infection prevention and control, recognition of deterioration all complete and in the process of being implemented. Access, admission, assessment and transfer of care (Coo office completing), recognising and responding to behaviours of concern (stakeholder group established) and documentation and communication under development.

Risk 2: People and Culture – Reviewed at People Committee 18 Feb 2025

Strategic Risk 2 (Cause – Event- impact)	*If DBTH do not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way.*						**Strategic Objective: People**	**We are supportive, positive and welcoming**
Lead Committee	People Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Strategic/ reputational	Links to Significant Risks on Risk Register
Executive Lead	Chief People Officer	**Likelihood**	4		4	Risk Appetite	People: Open Regulatory: Minimal	
Initial Date of Risk Assessment	July 2023	**Impact**	3		3	Risk Treatment Strategy	Manage	
Risks Last reviewed (by on behalf of Lead Director)	18 February 2025	**Risk Rating**	**12**		**12**			**16;19**
Score Last Changed (By Lead Committee)	October 2024	**Inherent Score (L x I)**	5x4=20					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates) (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
The People Strategy Delivery Plans	**GC1:** Additional actions identified to support return to work and reduce sickness absence.	Chief People Officer Senior Leadership meeting (1) Reports to every People Committee (2) IA Bank and Agency (3)(**Limited Assurance)** IA Pay and expenditure (3) **Significant Assurance** IQPR to Board	**GA1:** IA Bank and Agency recommendations **GA2:** IA Pay and Expenditure recommendations.	**Significant Assurance** **Significant Assurance** **Limited Assurance** **Significant Assurance**
HR policies and support resources including Health and wellbeing resources.	**GC2:** Identified gap of capturing information from exit interviews.	Policy Formulation Group (1) Operational Delivery Groups (1) Reports to People Committee (2)		**Significant Assurance**
Equality Diversity & Inclusion Improvement Plans		EDI Committee reports bimonthly (1) People Committee Biannually (2) WRES and WDES data reporting to Board (3)		**Significant Assurance**
Education Quality Framework		Operational Delivery Groups and Networks (1) People Committee reports (2) External Quality Visits (Various annual) (3) Learner Feedback and Surveys (various ongoing) (3)		**Significant Assurance**
People Engagement Strategic Approach		People Committee reports (2) Annual Staff Survey (3)		**Significant Assurance**
Speaking Up Process and Partnering Activities	**GC3:** Not all Staff Networks currently running as awaiting new volunteer Chair appointments.	Staff Networks (1) Operational Delivery Groups (1) Reports to EDI Committee (1) Reports to People Committee and Board (2)		**Significant Assurance**

Leadership Development Offer & Organisational Development Activities	**GC4:** Further work required to articulate the DBTH leadership framework for different levels of leadership role.	People Committee Report Annually (2) DBTH Way updates to People Committee (2)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	Timescale	Lead	Progress update
GA1: Implementation of IA Bank and Agency recommendations for people directorate	March 25	Chief People Officer	Update report to be provided at Feb 25 People Committee, report also reviewed at F&P Committee reference financial control recommendations
GA2: Implementation of IA Pay and Expenditure recommendations for people directorate	March 25	Chief People Officer	Update reported to be provided at Feb 25 People Committee, report also reviewed at F&P Committee reference financial control recommendations
GC1: The Workforce workstream reviewing identified actions for improvements, reporting to Efficiency & Effectiveness Committee	March 26	Chief People Officer	Policy implementation review of refreshed sickness absence policy due to be completed Feb 25, deep dive data analysis on different groups, contacted another trust to share learning
GC2: Learning from Leavers Project in place to capture information from and ensure consistency of approach to the exit interviews process	March 26	Chief People Officer	Monitoring and progress report to be presented at the Workforce and Education Committee in Feb 25
GC3: Network refresh and relaunch project	March 26	Chief People Officer	Progress monitoring and reporting will be through to EDI Committee. Work has commenced. Currently contacting other trusts in region and nationally to benchmark their approach to implementing and successfully maintaining effective staff networks, The results will feed into the relaunch of the networks
GC4: Design of holistic leadership development modules into an overarching leadership programme	March 27	Chief People Officer	Initial scoping work has commenced, update provided at CPO SLT in Jan 25

Risk 3: Access to Care - reviewed at Finance and Performance 27 February 2025

Strategic Risk 3 (Cause – Event- impact)	*If we do not address the post-pandemic elective care backlog, improve efficiency and manage demand, we are unable to deliver timely access to care resulting in long waiting times and potential patient harm.*						**Strategic Objective: Patients**	**We deliver safe, exceptional person-centred care**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Strategic / Financial	Links to Significant Risks on Trust Risk Register
Executive Lead	Chief Operating Officer	**Likelihood**	4		4	Risk Appetite	Quality: Cautious Regulatory: Minimal	**3434; 3435; 3436; 3437;**
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risks Last reviewed (by / on behalf of Lead Director)	February 2025	**Risk Rating**	**16**		**12**			
Score Last Changed (By Lead Committee)	November 2024	**Inherent Score (L x I)**	5x4=20					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) **RC**	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) **GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) **GA**	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
Waiting time standards Access Policy Cancer Access policy Capacity and flow policy Trust validation Programme Patient Tracking List management Cancer Patient Tracking List management Clinical Prioritisation	**GC1)** No Current Trust Access Group **GC2)** Inconsistent use of the Urgent Emergency Care (UEC) escalation process **GC3)** Trust Validation Process to be aligned to current national best practice **GC4)** Consistent application of clinical prioritisation coding **GC5)** Delivery of the Elective Care improvement programme	Performance Review Meetings monthly report (1) National Data Submission of Trust performance (2) Access Standards Reports to F&P Committee (2) IQPR report to Board (2) Doncaster Place UEC board (monthly) (3) NHSE / ICB/ Place Tier 2 meeting (fortnightly) (3) Acute Federation Elective oversight Group (monthly) (3) Acute Federation Diagnostic Oversight Group (monthly) (3) Model Health reporting system (3)	**GA1)** Operational Delivery Group (Monthly) to be set up **GA2)** Inconsistently applied Divisional Governance arrangements	**Partial Assurance**
Demand management Doncaster Place UEC improvement programme Patient initiated Follow-up (PIFU) policy Advice and Guidance policy Diagnostic improvement programme Virtual ward	**GC6)** Further develop SPA for ambulance crews to access **GC7)** A need to expand the use of PIFU **GC8)** A need to expand the use of Advice and Guidance **GC9)** Implement Urgent Treatment Centre First model **GC10)** Implement frailty and surgical SDEC	Performance Review Meetings monthly report (1 National Data Submission of Trust performance (2) Doncaster Place UEC board (monthly) (3) Outpatient improvement programme meeting (1) Diagnostic Improvement Programme meeting (1)	**GA3)** No current specific reporting on demand management	**Partial Assurance**
Efficiency GIRFT Programme Outpatient improvement programme Theatres improvement programme	**GC11)** Review of impact of current GIRFT programme	Performance Review Meetings monthly report (1 Doncaster Place UEC board (monthly) (3) Outpatient improvement programme meeting (1)	**GA4)** No current specific reporting on efficiency	**Partial Assurance**

Urgent Emergency Care improvement programme	**GC12)** Improved reporting of the improvement programmes, using SPC charts as the standard	Theatre improvement programme meeting (1) Model Health reporting system (3)		

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions: SMART Actions	**Timescale**	**Lead**	**Progress update**
GC1) Initiate and embed a Trust wide Access Group (executive led)	June 2025	COO	Discussed at executive group. Initial structure to be put in place
GC2) Embed consistent use of Urgent Emergency Care (UEC) escalation process	April 2025	COO	Escalation process documented, communication to be shared
GC3) Review Trust Validation Process with national best practice and initiate new process	September 2025	COO	Initial discussion with COO / CFO / CIO planned for March 2025
GC4) Clinical prioritisation coding action plan	August 2025	COO	Initial scoping underway
GC5) Elective Care improvement programme	June 2025	COO	Initial focus on validation, action plan for the wider programme to be finalised
GC6) UEC Improvement programme to address ambulance conveyance rates and provide a single point of access (SPA) for ambulance crews to access advice and alternatives to conveyance	August 2025	COO	Work underway across the whole system to review the YAS protocols and support with improvements to reduce the conveyancing to DBTH's ED. Partnership discussions underway through the Doncaster Place UEC Board
GC7) Expansion of Patient Initiated Follow ups across all specialities Action plan	October 2025	COO	Using existing successful implementations as a blueprint - Initial scoping underway for remaining services to produce action plan and time scales
GC8) Expansion of the use of Advice and Guidance action plan	October 2025	COO	Using existing successful implementations as a blueprint - Initial scoping underway for remaining services to produce action plan and time scales
GC9) Urgent Treatment Centre First model to be implemented at all sites	October 2026	COO	Initial scoping underway, initial meeting with FCMS taken place and working group planned from April 2025
GC10) frailty and surgical SDEC implementation plan	March 2026	COO	Initial scoping underway and further discussion at the UEC workshop in March 2025
GC11) Current GIRFT programme review	June 2025	COO	Links to GA4) as part of a fundamental strategic decision and review
GC12) SPC charts to be used as standard across all reporting for services	July 2025	COO	Working with Information team to scope what this will look like and how it can be used by managers
GA1) Operational Delivery Group (Monthly) Chaired by the COO	July 2025	COO	Initial timescales being scoped
GA2) Divisional Governance arrangements mapping exercise	June 2025	COO / DCEO	Part of a wider piece of work Trust wide. Currently led by the DCEO and Corporate Office
GA3) Demand management reporting plan	August 2025	COO	Working with Information team to scope what this will look like and how it can be used by managers
GA4) Efficiency reporting plan	June 2025	COO / EMD	Part of the wider Trust discussion on the GIRFT resources

Risk 4: The Care Environment - reviewed at Finance and Performance 27 February 2025

Strategic Risk 4 (Cause – Event- impact)	*If DBTH cannot maintain and improve care environment in a timely way, this will lead to a poor-quality or unsafe environment, impacting the quality of care experienced by patients, colleagues and / or regulatory actions.*						**Strategic Objective: Patients People**	***We deliver safe, exceptional person-centred care *We are supportive, positive and welcoming**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Quality / Financial	Links to Significant strategic Risks on Trust Risk Register
Executive Lead	Chief Financial Officer	**Likelihood**	5		4	Risk Appetite	Finance: Open Quality: Cautious Regulatory: Minimal	**12; 3384; 1412; 1807; 3348**
Initial Date of Risk Assessment	July 2023	**Impact**	4		4	Risk Treatment Strategy	Treat / manage	
Risk Last reviewed (by / on behalf of Lead Director)	January 2025	**Risk Rating**	**20**		**16**			
Score Last Changed (By Lead Committee)	July 2023	**Inherent Score (L x I)**	5x5=25					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates) (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
DRI Development Master Plan 2024 and long-term capital investment plan.		Review of incidents on Datix via Quality and Safety Group (1)		**Partial Assurance**
Planned Preventative Maintenance (PPM) program.	**GC1**: The Trust's current maintenance strategy focuses on statutory compliance and minimum essential maintenance requirements. An estates maintenance review indicates that circa £1m of additional resource (the majority at DRI) is required (£690kpay/£317k non-pay) to deliver an effective maintenance strategy that aims to improve preventative maintenance measures in line with industry guidance as a control against estates infrastructure risks.	Report to F&P Committee (2) Ongoing monitoring of maintenance reactive Programme of external audit for Authorising Engineers (AE) and enforcing authorities. (3) PAM Assurance Model self-Assessment (1)		**Significant Assurance**
Emergency Preparedness Resilience and Response (EPRR) planning process.	**GC2**: Work is currently in progress to establish effective site evacuation plans for DRI, supported by a regional response.	EPRR response approved by Board of Directors (2) Review through Capital Monitoring Committee (2) EPRR Self-Assessment extended review (1) Report to Audit and Risk Committee (2) Internal Audit Business Continuity **(limited assurance)**	**GA2:** Gaps in assurance in relation to EPRR core standards. **GA3)** implementation of the IA recommendations	**Partial Assurance** **Limited Assurance**

5 year Annual Capital Investment Programme CDEL – focus on backlog eradication Trust wide	**GC3:** Site Development Master Plans required for Bassetlaw and Montague sites. **GC4:** Annual CDEL investment alone is unable to keep up with level of backlog within the Trust, as evidenced in annual ERIC returns	Annual report to Board of Directors (2) ERIC return (3) Annual 6 facet surveys to monitor risk profile changes (1)		**Significant Assurance**
Policies and Standard operating procedures		Monitored through incident and risk in Datix at divisional management meetings (1) Health and Safety reports to F&P committee (2) HSE Audit Outcomes (3) ROSPA accreditation (3)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	**Timescale**	**Lead**	**Progress update**
GC1: Review of work program funding via Capital Investment Group for approval	June 2025	CFO	Business case went to CIG Dec 24, not approved with recommendation to include year 1 in 25/26 budget setting as a cost pressure. Awaiting further outcome by June 2025 to find out if this is approved or not
GC2: Complete site evacuation plans for DRI	May 2025	COO	Site evacuation plan, with action cards being drafted
GC3: Draft site development plans for BH and MH	March 2026	Director of Infrastructure	Ongoing annual investment plans for F&P
GC4: Review risk register and updated 6 facet survey data annually to inform capital planning process	March 2025	Director of Infrastructure	Annual investment plans for F&P to be brought to committee and reviewed ahead of the following year
GA2: Address any outstanding gaps in compliance with EPRR core standards	November 2025	COO	Part of a wider piece of work regarding meeting EPRR core standards, directly monitored through the Audit and Risk Committee and Board.
GA3) Implementation of Internal Audit Recommendations for Business continuity	June 2025	COO	Business continuity managed through the EPRR steering group, chaired by the COO and reported through to Audit and Risk Committee

Risk 5: Financial Sustainability - reviewed at Finance and Performance 27 February 2025

Strategic Risk 5 (Cause – Event- impact)	*If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.*						**Strategic Objective: Pounds**	**We are efficient and spend public money wisely**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Reputational / Financial	Links to Significant Risks on Risk Register
Executive Lead	Chief Financial Officer	**Likelihood**	4		4	Risk Appetite	Finance: Open Regulatory: Minimal	**11,3175,3177,3178, 3179, 3181, 3017,3018,3361,3017,3018,3361 13**
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risk Last reviewed (by / on behalf of Lead Director)	January 2025	**Risk Rating**	**16**		**12**			
Score Last Changed (By Lead Committee)		**Inherent Score (L x I)**	4x5=20					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates) (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
Annual , Medium- & Long-Term Planning	**GC1:** Medium Term Finance Plan requires review and updating	Annual Plan reviewed by the F&P Committee (2) Trust Board Approve the Annual Plan (2)		**Partial Assurance**
Cost Improvement Plans	**GC2**: Don't currently have a rolling 3-year CIP programme	CIP reported to F&P committee (2) HFMA Checklist Action Plan complete in April 2023. (3) CIP plans reviewed at Performance Review Meetings at divisional level monthly (2)	**GA1**: HFMA checklist compliance check is now out of date	**Partial Assurance**
BAU Financial Operating policies, procedures	**GC3:** Outstanding actions from IA of Bank and Agency spend **GC4:** Outstanding actions from IA of Cash flow and Treasury management **GC5**: Embedding of Medical rostering	Internal Audit Bank and Agency Spend (3) (Limited Assurance) Internal Audit cash flow and treasury management (3) (Significant Assurance) Reports to Audit and Risk Committee (2) Counter fraud reports (2), Internal Audit work plan (3) NHSE monthly finance and workforce submissions (3) External Auditors Annual Audit Letter (Clean Opinion)		**Limited Assurance** **Significant Assurance**
Specific Financial expenditure control measures: • Executive vacancy approval Panel Weekly (1) • Capital Investment Group and linked operational Control environments • DCN review of Nursing Agency and temp • Off framework protocol • Nursing rosters review	**GC6:** Specific control measures not having the impact in all areas / divisions	Reports to Executive team (1) Reports to F&P Committee (2) Confirm and Support meetings with each division (1)		**Partial Assurance**

• Weekly Non-pay review				

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions SMART (specific, measurable, achievable, relevant, and time-bound) actions.	**Timescale**	**Lead**	**Progress update**
GC1: Medium Term Finance Plan will be refreshed, reviewed by new CFO, aligned to capital plans and allocation of resources.	July 2025	CFO	24/25 underlying exit rate estimated at £45.5M deficit at January 2025. Plans being scoped for future reporting
GC2: Dashboard metrics of actual V target CIPs to be used within the PRM setting to track achievement earlier.	April 2025	CFO	Part of the reset of financial management framework at beginning of the new financial year
GC3: Implementation of all Internal Audit recommendations for Bank and Agency spend	March 2025	CPO	Implementation of action plan following Internal Audit in progress, working with the CPO teams and monitored through the People Committee
GC4: Implementation of all Internal Audit recommendations for cash flow and Treasury management	November 2024	CFO	Completion of all Audit actions being checked.
GC5: Medical rostering project, measured via reduction in locum medical use and expenditure	September 2025	CFO / MD	Key project for 2025/26, initial project being scoped
GC6: Development of dashboard for PRM metrics enable targeted support approach to areas struggling to hit these.	July 2025	CFO	Working with the information and performance teams. Part of the reset of financial management framework at beginning of the new financial year
GA1: Review of current compliance against the HFMA checklist	June 2025	CFO	Refreshed assessment to be made by new CFO and Deputy Director of Finance

Risk 6: Partnerships (to be reviewed in Confidential Board of Directors meeting 4 March 2025)

Strategic Risk 6	*Due to insufficient resource, engagement, and governance arrangements, our partnerships do not deliver on the expected benefits, resulting in poor use of resources and inability to transform and enhance services*						**Strategic Objective: Partnerships**	**We work together to enhance our services with clear goals for our communities**
Lead Committee	Board of Directors - Confidential	Risk Rating	Current Exposure	Tolerable	Target	Risk Type	Strategic/ reputational	Links to Significant Risks on Risk Register
Executive Lead	Deputy Chief Executive Officer	Likelihood	2		2	Risk Appetite	Open	
Initial Date of Risk Assessment	July 2023	Impact	3		3	Risk Treatment Strategy	Manage	
Risk Last reviewed (by on behalf of Lead Director)	February 2025	Risk Rating	**6**		**6**			
Score Last Changed (By Lead Committee)	July 2023	Inherent Score	3x4=12					

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates) (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
CEO Is partner member of South Yorkshire Integrated Care Board. Chair and DCEO attendance at key South Yorkshire and Nottinghamshire strategic forums.	**GC1:**Collaborative Opportunities and impact on DBTH not yet assessed	Reporting through to each Board on activities from the CEO report (1) The DGH Collaboration Opportunities Report(3)		**Partial Assurance**
Executive attendance at South Yorkshire Acute Federation professional groups, leading on key services and pathways.	**GC2:** Traction on some of the key identified workstreams has yet to be demonstrated	DBTH involvement with Acute Federation Clinical Sustainability Review report. (2)		**Partial Assurance**
Health Inequalities Strategy at Trust and Place level.		Health Inequalities reported through to Finance and Performance Committee on progress(2) Internal Audit of Partnership arrangements due in April 2025 (3)		**Significant Assurance**
Partnership governance arrangements for Acute Federation		Professional Partnerships Company Secretary Network reviews governance arrangements including ToR review.(2) Acute Federation Commissioned Audit of Partnership arrangements due in 2025 (3)	**GA1** Reporting arrangements through the individual organisations are not fully embedded.	**Partial Assurance**
Strategic Partnership Teaching Hospital Forum	**GC3:** Full Partner engagement on some of the key identified workstreams to achieve University Teaching Hospital status.	Reports to People Committee (2) Updates to DBTH Board (2)		**Significant Assurance**
Research Innovation Strategy delivery plans		Reports to People Committee (2) Updates to DBTH Board (2)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)

Actions	**Timescale**	**Lead**	**Progress update**

GC1: Assessment of the Opportunities / risks for DBTH as part of this report's conclusions.	March 25	CEO	Work commissioned and final report on the opportunities still being compiled.
GC2: Engagement in Acute Federation workstreams to drive change and improvements.	March 26	DCEO as Lead exec	Clinical Sustainability Review workstreams established. Outcomes to be delivered by defined timescales in programme mandates.
GC3: Increased Partnership engagement around University Hospital Status	March 27	CPO	Refreshed Terms of Reference and membership of the Strategic Partnership Teaching Hospital Forum.
GA1: Mapping of the partnership governance arrangements. 360 Assurance reviewing partnership arrangements across the ICB, will feed into these recommendations	June 25	DCEO	DBTH will review any recommendations

Risk 7 – Digital And Cyber Resilience – reviewed at Finance and Performance 27 February 2025 (post board paper submission)

Strategic Risk 7 (Cause – Event- impact)	*If we fail to develop essential digital, data and technology that prioritises cyber resilience, we will prevent our people from delivering efficient, safe patient care and increase the risk of key system failure and disruption to services*						**Strategic Objective: Patients People**	***We deliver safe, exceptional, person-centred care. *We are supportive, positive and welcoming**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 28)**	**Risk Type**	Reputational / Quality	Links to Significant Risks on Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	3		3	Risk Appetite	Regulatory: Minimal Quality: Cautious	1410 3384, 2727 3184 3352; 1663 1667; 3474; 3056;2736
Initial Date of Risk Assessment	January 2025	**Impact**	5		4	Risk Treatment Strategy	Treat	
Last reviewed (by / on behalf of Lead Director)	February 2025	**Risk Rating**	**15**		**12**			
Last Changed (By Lead Committee)		**Inherent Score (L x I)**	4 x 5 = 20		3 x 5 = 15			

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of Assurance relating to effectiveness of the controls and associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
Digital Strategy (including Analytics) Digital Business Plan (versions to be updated)	**GC1**: 24/25 funding confirmed. Agreement of funding for all routine business as usual priority areas for 25/26 and onwards. **GC2**: Universal digital performance reporting not yet fully in place (such as system monitoring and desktop support tickets) **GC3:** New Digital Strategy and Delivery Plan not yet completed	Report to F&P Committee (2) Digital Data and Technology (DDaT) Meeting(1) Report to Trust Leadership team (a regular digital update is preferred) (1)		**For review**
Electronic Patient Record (EPR) Programme Board, overseeing EPR FBC and programme delivery.	**GC4:** Frontline Digitisation funding approval for EPR not yet secured	DSPT Audit reports, external cyber security assessments such as penetration testing, ad testing of information sharing agreements. (3)		**For review**
Digital policies and procedures and Standard Operating Policies and Procedures for all digital activities	**GC5:** Unsupported end user hardware (such as Windows 10 which is end of life mid-October 25)	Data Security and Protection Toolkit assessment (achieved standards met assessment in 24/25) and	**GA1**: DSPT Action Plan	**For review**
Data quality improvement plan.	**GC6:** Unsupported and out of data core systems or systems running unsupported versions of Microsoft Server	Digital Maturity Assessment (3)		**For review**
Cyber security monitoring (monitoring, penetration testing, awareness campaigns, software/hardware),		NHS Cyber Assurance Framework results(3) Results of business continuity / EPRR testing (1) Reporting into DDaT (1) Report to Audit and Risk Committee (2) Data Security and Protection Toolkit (3) Audit plan (internal audit) (3) Counter Fraud arrangements (3)	**GA2**: Cyber Assurance Framework Action Plan	**For review**

EPRR and business continuity arrangements	**GC7**: Check resilience of EPRR disaster recovery and business continuity plans	Reported to Audit and Risk Committee (2)		**For review**
Information Asset Management Framework		Reviewed by IG committee and SIRO (1)		**For review**

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	**Timescale**	**Lead**	**Progress update**
GC1: Agree Digital Delivery plan for 25/26	March 25	CIO	Proposed 25/26 digital plan has been shared. Subject to review and agreement as part of Trust business planning cycle and on target to be approved by March 25. Plan subject to onward review by F&P.
GC2: Universal digital performance reporting action plan	August 2025	CIO	Draft KPIs in place and are being reported on at the next Digital Performance Group (March 25)
GC3: Agree Digital Strategy 2025-2030	August 25	CIO	Early planning has started and draft themes shared. Workshop sessions to build digital strategy to be set up. To be approved by relevant committee and Trust Board in due course.
GC4:NHSE Frontline Digitisation approval of the full business case for EPR	June 25	CIO	Draft FBC was reviewed by F&P in February 2025. Final FBC will be reviewed by F&P in Feb, Trust Board in March 2025 and then onwards to regional and national approval, including Cabinet Office.
GC5: Replace all end of Windows 10 life desktop hardware (desktops, laptops)	September 25	CIO	Not confirmed. Subject to agreeing funding.
GC6: Core System review project	September 25	CIO	Terms of reference and scope agreed.
GC7: Complete Digital Disaster Recovery and Business Continuity review	August 25	CIO	On track for completion by end of July 25. Actions will be monitored thereafter and progress reviewed by relevant committee.
GA1: DSPT Action plan recommendations	March 25	CIO	Progress update to be shared with IG Committee in Feb 25
GA2: Agree Cyber Assurance Framework Action Plan and complete actions	May 25	CIO	Monitored by Audit and Risk Committee. On track for completion by end of May 25.

2503 - F3 DELIVERY UPDATE 2024/25 STRATEGIC PRIORITIES SUCCESS MEASURES

Discussion Item | Zara Jones, Deputy Chief Executive | 12:00

10 minutes

REFERENCES

Only PDFs are attached

F3 - Delivery Update 2024-25 Strategic Priorities Success Measures.pdf

F3 - Appendix 1 2024-25 Delivery Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	4 March 2025	**Agenda Reference:**	**F3**
Report Title:	**Delivery Update 2024/25 Strategic Priorities Success Measures**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Angela O'Mara, Deputy Company Secretary		
Appendices:	Appendix 1 – 2024/25 Delivery Update		

Report Summary

Purpose of the report & Executive Summary

Progress against the success measures supporting delivery of the Trust's strategic priorities is presented in appendix 1 of the report; with changes to personnel and executive directors' portfolios reflected in the accountability and governance framework.

As part of routine reporting, aligned to work plans and terms of reference, the Board and its assurance committees have oversight of progress throughout the year, including areas of required improvement and risks to delivery of the Trusts strategic priorities. The iterative development of the Board Assurance Framework and associated thinking will enable improved scrutiny of the risks to delivery, plans to close the gaps in controls and actions to drive performance and achievement of standards.

The Board is asked to note the progress made, in the context of local and national operational and financial pressures, and the ongoing system work related to the procurement of an Electronic Patient Record.

A paper articulating 2025/26 success measures will be brought to the Board of Directors in May 2025, with updates against delivery to be provided in September 2025 and March 2026.

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

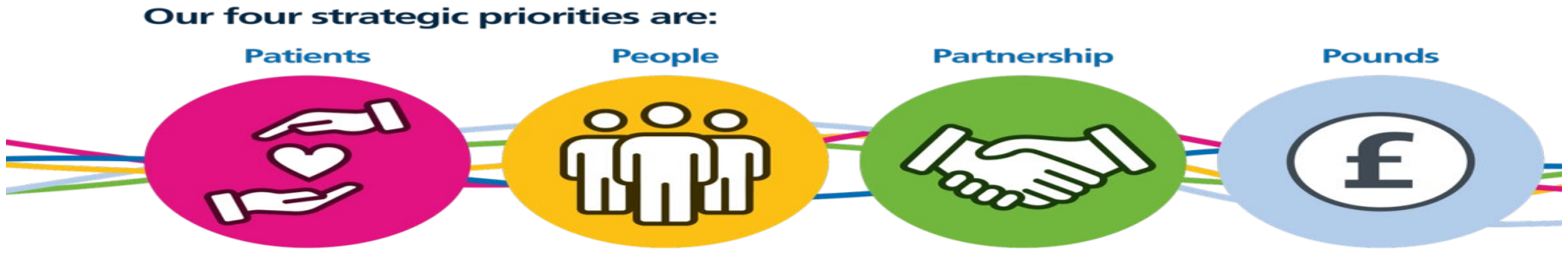
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend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

Implications

	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

Relationship to Board assurance framework:	**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:			
Resources:	N/A		
Assurance Route			
Previously considered by:		Board of Directors & Board Development Sessions	
Date:	2 July & 3 September 2024 and 3 December 2024 & 4 February 2025 respectively		
Any outcomes / next steps	2025/26 success measures to be determined and reported to the Board of Directors meeting in May 2025, with a mid-year and year-end position reported in September 2025 and March 2026.		
Previously circulated reports to supplement this paper:	Trust Vision Refresh & 2024/25 Priorities Framework - May 2024 Board of Directors Strategic Priorities – Measuring Success – July & September 2024 Board of Directors		

4 P Delivery Framework



Success measures	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
Creation of our Trust Strategy	✓	✓	✓	✓
Delivery of year 2 of the People enabling strategy	✓	✓	✓	✓
Delivery of year 1 of Research & Innovation enabling strategy	✓	✓	✓	✓
Delivery of year 1 of Nursing Midwifery and Allied Health Professionals (NMAHPS) Quality enabling strategy	✓	✓		
Delivery of Year 2 of the Three year delivery plan for maternity and neonatal services	✓	✓		
Ensure clinically effective and efficient services through delivering strong performance against national standards and benchmarks	✓	✓		✓
Deliver our operational plan for 2024/25 to ensure our access and activity plans are achieved	✓	✓	✓	✓
Demonstrating progress in becoming a digitally enabled organisation through delivery of our digital enabling strategy	✓	✓	✓	✓
Delivery of year 2 of the Health Inequalities enabling strategy	✓	✓	✓	
Deliver our financial plan for 2024/25				✓

Accountability and Governance

Success measures	Lead Executive Director	Lead Board Committee
Creation of our Trust Strategy	Zara Jones, Deputy Chief Executive	Board of Directors*
Delivery of year 2 of the People enabling strategy	Zoe Lintin, Chief People Officer	People Committee
Delivery of year 1 of Research & Innovation enabling strategy	Zoe Lintin, Chief People Officer	People Committee
Delivery of year 1 of Nursing Midwifery and Allied Health Professionals (NMAHPS) Quality enabling strategy	Karen Jessop, Chief Nurse	Quality Committee
Delivery of Year 2 of the Three year delivery plan for maternity and neonatal services	Karen Jessop, Chief Nurse	Quality Committee
Ensure clinically effective and efficient services through delivering strong performance against national standards and benchmarks	Nick Mallaband, Acting Executive Medical Director	Quality Committee
Deliver our operational plan for 2024/25 to ensure our access and activity plans are achieved	Denise Smith, Chief Operating Officer	Finance and Performance Committee
Demonstrating progress in becoming a digitally enabled organisation through delivery of our digital enabling strategy	Sam Wilde, Chief Financial Officer	Board of Directors*
Delivery of year 2 of the Health Inequalities enabling strategy	Zara Jones, Deputy Chief Executive	Board of Directors*
Deliver our financial plan for 2024/25	Sam Wilde, Chief Financial Officer	Finance and Performance Committee

*Governance will be across multiple committees of the Board and specific milestones and deliverables will be set for different committees to oversee.

2024/25 Delivery Update

Not started	R
Off track	A
On track	G
Complete	B

Success Measures	Lead Director Progress Update	Next Steps & Milestones	RAG

Creation of our Trust Strategy	• Engagement sessions held with governors
	• Engagement sessions held with senior leaders through the Trust Leadership Team
	• Feedback received from engagement events
	• 2 x Board Development Sessions held
	• Read across with ICB and national priorities
	• Ambitions now agreed with senior leadership teams, Board and Council of Governors
	• Strategy on a page developed
		• The Ambitions have been agreed that sit across the strategic framework of the 4P's; Patients, People, Partnership and Pounds
		• Ambitions agreed:
		  • Best Care environment
		  • Becoming Digitally Mature
		  • Tackling Health Inequalities
		  • Becoming a centre of excellence for research and education
		• Align existing enabling strategies / plans to each of these ambitions and collate the measures that will enable us to monitor progress for each of these
		• Confirm the governance arrangements by which each ambition and any associated risks are managed and monitored
		• Programme for Board Development Sessions to review strategic ambitions and associated risks in place for 2025/26	

Success Measures	Lead Director Progress Update	Next Steps & Milestones	RAG
Delivery of year 2 of the People enabling strategy	• People Strategy assurance reports presented at each People Committee meeting in Q3/4 with full/significant assurance reported. Delivery plans on track at mid year point in year 2. Committee agreed new format for future reporting at the February meeting recognising that detailed delivery plans, success measures and KPIs are in place. Committee work plan has been refreshed to fully map to all aspects of the People Strategy, with regular focused reports received at the Committee covering all strategy pillars. • Good progress made on Anti-racism workstream including engagement with EDI Committee/networks and development session held with senior leaders. Doncaster Place Anti-racism Steering Group established with a commitment from partners to work together to focus on three areas in 2025 – consistent message, training, inclusive recruitment practices. During Race Equality Week in February, Doncaster partners collaborated one poster across the organisations to demonstrate this shared commitment.	• Actions continue as outlined in detailed delivery plans against the four pillars of the strategy: Looking after our people, Belonging in Team DBTH, Growing for the future, New ways of working and delivering care. • Planning for and launch of Appraisal Season 2025 in April, alongside refreshed communication of the Scope for Growth and succession planning frameworks to support talent management and career conversations. • Staff survey engagement sessions to be held in teams across all divisions/directorates in Q1, following national publication of the results. • DBTH Leadership Conference planned for April. • Working groups supporting the Doncaster Anti-racism work to start identifying recommended communications, changes in practices and training options in Q1/2. Cohorts 4 of DBTH Reciprocal Mentoring Programme and Board Development Delegate Programme to commence in March/April.	

Success Measures	Lead Director Progress Update	Next Steps & Milestones	RAG
Delivery of year 1 of Research & Innovation enabling strategy	• Review of year 1 to date of Research & Innovation Strategy presented to People Committee in February. Delivery plan on track. Key achievements include increasing commercial research activity in stroke, rheumatology and renal; growing innovation. opportunities, working with industry and university partners. Committee reported significant assurance. • Refresh of Teaching Hospital Strategic Partnership Forum in Q4, as a key mechanism to engage with external partners.	• Q4 and into Q1 2025/26 – completion and consideration of full business case to support Research & Innovation strategic priorities, aligned with University Teaching Hospital ambition. • Clinical research space identified at DRI and refurbishment expected to be completed in Q1 2025/26, to support the aim to grow clinical research capabilities.	
Delivery of year 1 of Nursing Midwifery and Allied Health Professionals (NMAHPS) Quality enabling strategy	• Year 1 objectives data for success measures complete and reported against. Work plans in place for each strategic theme. Discussed via quality steering group.	• Continue with plan and collection of data for success measures. • Continue to deliver year 1 objectives. Year 2 priorities identified and success measures being worked through	
Delivery of Year 2 of the Three-year delivery plan for maternity and neonatal services	• Steady progress is being made on the Three-year plan, with oversight from the LMNS. There are no areas of concern at present.	• Continue with plan, oversight via the Maternity Safety and Quality Group chaired by the Chief Nurse, reporting via Director of Midwifery to Trust Board.	

Success Measures	Lead Director Progress Update	Next Steps & Milestones	RAG
Ensure clinically effective and efficient services through delivering strong performance against national standards and benchmarks (cont'd)	• All medical appraisals due by the end of March 2025 are being monitored to ensure meetings scheduled between appraisees and appraisers by year end. It is anticipated that 2024-25 performance will exceed the national and local 95% KPI. • National job planning target is 95% by 31/03/25, which is a stretch for all acute Trusts, but particularly challenging following transition to L2P when performance dropped. Associate Medical Director is pro-actively managing this, along with the admin team, supporting individuals/teams with the transition and re-building job plans in the new system. • Mortality Data Quality Assurance Improvement Group reconvened September 2024, with all actions monitored on Monday.com. • Mortality dashboard developed to monitor SHMI performance and clinical coding/depth of coding, enabling early warning of any areas where prompt action to be taken. • SJR process in place with monthly MDTs. SJRs being undertaken for all deaths recorded as sepsis, discussed in the sepsis action group. Opportunities for learning from deaths shared through governance meetings. Work continues to increase the number of senior medical staff undertaking mortality reviews.	• Current position around 90%. Will continue to focus on scheduled appraisals, on track to exceed the 95% target for 2024/25. • Current position around 70%. Will continue to encourage Divisional Directors and Clinical Directors to work with their medical teams to update job plans to sign-off to achieve as close to the 95% target as possible. • Continue to work on actions to ensure mortality performance improves in line with peers and national benchmark. Move to SHMI for mortality reporting, which is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. • Further developments ongoing to improve the dashboard, data quality and analysis. • Increase number of SJRs being allocated to medical colleagues, aligned to job plans within manageable PA allowance. Expected standard of 15-20% of deaths having a review using SJR methodology.	

Success Measures	Lead Director Progress Update	Next Steps & Milestones	RAG
Ensure clinically effective and efficient services through delivering strong performance against national standards and benchmarks	• Findings and recommendations of the internal audit of mortality data quality assurance reported to Audit and Risk Committee in February. Actions complete bar one which will be closed by 31 March 2025. • Divisional and specialty level GIRFT sessions ongoing, with national deep dives being undertaken in breast surgery, orthopaedics, paediatrics and pancreatic cancer. • DBTH is part of the national GIRFT Further Faster 20 programme which is targeted at areas for rapid transformation to reduce waits and enable working age population to return to work asap. Two areas of focus locally, MSK pathway and ENT with plans for additional activity being developed utilising non-recurrent funding. • Process in place for clinical validation and clinical harm reviews, monitored through monthly reports.	• Draft Mortality Governance work plan developed and will be presented to March's meeting for review and sign off. This will complete the recommendations and actions from the internal audit. • Plans being developed to utilise non-recurrent GIRFT FF20 funding to reduce waiting times. • Ongoing monitoring to ensure patients are clinically reviewed, through clinical governance process.	

Success measures	Lead director progress update	Next steps and milestones	RAG
Deliver our operational plan for 2024/25 to ensure our access and activity plans are achieved	Although the Trust remains behind trajectory against the 4 hour standard, performance in January 2025 (69.9%) improved compared to January 2024 (61.74%). During the same period, a significant improvement was seen at Doncaster, with 4 hour performance of 63.46% in January 2025, compared to 48.76% in January 2024. The proportion of patient spending > 12 hours in ED has also reduced in January 2025 (4.9%) compared to January 2024 (8.2%). Whole system discharge work continues and the Trust is seeing a reduction in the proportion of patients remaining in hospital when there is no criteria to reside. The Trust is on plan for outpatient new activity and diagnostic activity. The Trust remains behind plan (YTD) for day case and elective activity, although Mexborough Elective Orthopaedic Centre activity is above plan. The Trust has seen a reduction in 'did not attend rates' and these are now below pre-pandemic levels. The Trust continues to deliver the Cancer Faster Diagnosis Standard and 31 day diagnosis to treatment standards and is above trajectory for the 62 day cancer standard.	Q4: reduce the number and proportion of patients spending > 12 hours in ED and improve the non-admitted 4 hour performance through an improvement in waiting times for initial assessment. Q4: Continue to reduce the outpatient DNA rates and improve outpatient booked / actual utilisation. Improve theatres booked / capped utilisation and reduce on the day cancellations. Increase delivery of elective and day case activity. Q3: Maintain delivery of the FDS and 31 day cancer waiting time standards and continue to improve the 62 day cancer waiting time standard	
Demonstrating progress in becoming a digitally enabled organisation through delivery of our digital enabling strategy	The Trust is finalising the Full Business Case for an EPR solution which converges with system partners. Very significant capital funding is on offer from NHS England although the phasing of that might not match the expenditure requirements. The Board need to take a view on the Full Business Case including all aspects of its deliverability, which includes but is not limited to financial aspects.	• Consideration of the final version of the EPR Full Business Case at March Board	

Success measures	Lead director progress update	Next steps and milestones	RAG
Delivery of year 2 of the Health Inequalities enabling strategy	• **Training & Education:** We've trained 139 staff on the Change Initiators course with positive feedback. We have also launched Health Inequalities in SET+ and are developed a Health Inequalities Advocate Training module using the ECHO platform. We are also working to coproduce training with the QII team focusing on tackle health inequalities within Quality Improvement methodologies. • **Data & Research:** We're developing a Health Inequalities Dashboard for robust reporting on disparities across patient populations. Dr. Kelly Mackenzie's research includes an 18-month study on perinatal mental health inequalities in Sheffield and Doncaster, and a shortlisted grant proposal focused on increasing vaccination uptake in underserved communities. • **Service Development & Impact:** We are aligning our strategy with the NHS England's "Reforming Elective Care for Patients" framework and the Darzi report. A project assessing inclusion health groups' access and outcomes in Emergency Departments is underway, with a workshop scheduled for March. We're also collaborating with maternity and paediatric teams to provide specialist Health Inequalities support. • **Engagement & Communications:** We held an Executive Team session on tackling Health Inequalities and have a communications plan in place, including a web space on The Hive and a Teams platform. We're partnering with the People Focused Group (PFG) to integrate lived experiences into decision-making.	**Strengthening Board Engagement & Decision-Making:** We will review how Health Inequalities (HI) are incorporated into decision-making, using the Board self-assessment tool. Actions from the Executive Board development session will focus on data, leadership, governance, and specific initiatives. **Enhancing Data Capabilities & Reporting:** We'll complete and deploy the Health Inequalities Dashboard to support data-driven decision-making. Additionally, an Equity Index will help prioritise interventions based on disparities and DBTH's influence. **Scaling Training & Workforce Development:** Training will continue with the introduction of Practitioner-level training and the launch of Health Inequalities Advocate Training. We are also exploring external training opportunities and embedding HI awareness into other Trust training programs. **Targeted Service Improvements:** Post-March workshop, we'll implement solutions to improve Emergency Department outcomes for vulnerable groups. We are exploring initiatives to support economically active patients awaiting elective care and enhancing maternity and paediatric engagement for better HI integration. **Research & Innovation Expansion:** We are advancing perinatal mental health research and a maternity inequalities study, alongside pursuing new grant opportunities, particularly around vaccination uptake and preventative care. **Community Engagement & Patient Centred Approaches:** We'll increase the use of lived experience insights in service development and strengthen partnerships with local voluntary organizations to improve accessibility and outcomes.	

Success measures	Lead director progress update	Next steps and milestones	RAG
Deliver our financial plan for 2024/25	The Trust is behind plan at the end of Month 10 with a deficit of £4.4m (this being £2.4m adverse to budget). However, the *most likely* scenario in the month 10 full-year forecast would see the Trust deliver the £2.4M deficit originally planned.	• Continued implementation of recovery actions • Monitoring via Efficiency & Effectiveness and Finance & Performance Committees.	

2503 - F4 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Bailey, Non-executive Director | 12:10

5 minutes

REFERENCES

Only PDFs are attached

F4 - Chair's Assurance Log - Finance and Performance Committee - January 2025.pdf

F4 - Chair's Assurance Log - Finance & Performance Committee - February 2025.pdf

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: March 2025**
Prepared By:	Mark Bailey - Committee Chair & Non-Executive Director	
Approved By:	Finance & Performance Committee Members	
Presented By:	Mark Bailey - Committee Chair & Non-Executive Director	
Purpose	The paper summaries the **key highlights** from the Finance and Performance Committee meeting held on 28th January 2025	

Matters of Concern/Escalation Items (with Partial or No Assurance)	Major Actions Commissioned / Work Underway
2024/25 Financial Performance and Forecast Outturn (partial assurance) Period 9 financials show a deterioration in the deficit position; adverse to both budget and forecast. Elective activity and CIP underperformance, pay award funding pressures and premium costs for medical staffing drive the adverse variances. Re-forecast of outturn using current operational performance and improvements realisable in the remaining periods of the financial year conclude that the delivery of the committed plan is at risk. Further risks and potential mitigations additional to operational improvements have been identified. Potential scenarios have been modelled based on these. The 'most likely' scenario shows a deficit in line with plan. This will be reviewed again at Period 10 close. **Access Standards (partial assurance)** Continued attention to improvement work internal to DBTH and with partners however significant challenges are evident in meeting the expected standards for urgent and emergency care. Ambulance handovers and UEC demand is highlighted with the latter driving over-spends on pay with the need for escalation beds. **Elective Activity (partial assurance)** – recovery of elective surgery is behind plan in several specialities and is a contributory factor to the long waiters not reducing in line with expectations. **Doncaster Place - Urgent & Emergency Care Improvement Plan (partial assurance)** The plan is recognised as not fully addressing all challenges seen across the system. Priority areas have been agreed which focus on management of the winter period and an evaluation of their individual and combined impact will be necessary. Areas include improved co-ordination between ED and Yorkshire Ambulance on pre-hospital arrival; service specification for urgent treatment centre care; Same Day Emergency Care to reduce in-patient admissions; virtual ward expansion and community discharge capacity.	**Electronic Patient Record (EPR)** Development of the Full Business Case (FBC) presenting the case for DBTH to invest in an Electronic Patient Record (EPR) system by utilising the EPR being implemented at Sheffield Teaching Hospitals (Oracle Health Millennium). Noting that the strategic intent is for this system to be part of a convergence of EPR across Acute Trusts within South Yorkshire. **Digital and Data Quality** "Kitemark" work to improve the quality of data to ensure accuracy and alignment to national definitions. Full assessment by September 2025. Confirmation of executive governance and resourcing plan to deliver and sustain the improvement requested. **Getting it Right First Time (GIRFT)** Programme of benchmarking and adoption / standardisation of best practice. Priority focus on theatre utilisation, DNA rates, complex procedures for cataracts and joints, day case rates and RTT +52 weeks. Assurance sought by the Committee around resolution of patchy divisional engagement which can slow or lose productivity improvement and the connection to financial and operational planning. **Demand & Capacity planning** Future F&P will seek further assurance on the demand vs capacity planning for services in 2025/26. As part of this assurance, it is requested that a high-level overview of the current and projected capability for key service lines is included.

Significant or Full Assurances	Decisions Made
Health & Safety - biannual report - period April – September 2024 (**significant assurance**) Comprehensive report providing evidence of arrangements for compliance with all relevant Health and Safety, Fire Safety Legislation, Approved Codes of Practice, Guidance and Standards.	**Pharmacy Robot Business Case** Approved by the Trust with Chair's action prior to this committee due to tight procurement deadlines. Confirmation of support to the business case and adherence to tendering protocols. **Workplan** February & March Committees to prioritise time to provide assurance on: - 2024/5 Financial Outturn Forecast - Electronic Patient Record (EPR) Full Business Case - Service demand & capacity planning for 2025/6

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.

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: March 2025**
Prepared By:	Mark Bailey, Committee Chair & Non-Executive Director	
Approved By:	Finance and Performance Committee Members	
Presented By:	Kath Smart, Non-Executive Director	
Purpose	The paper summaries the **key highlights** from the Finance and Performance Committee meeting held on 27th February 2025	

Matters of Concern/Escalation Items (with Partial or No Assurance)	**Major Actions Commissioned / Work Underway**
2024/25 Financial Performance and Forecast Outturn (partial assurance) Period 10 financials show an improvement in the level of deficit although the cumulative position remains adverse to both budget and forecast. Elective activity, CIP performance, pay award funding and medical staffing costs drive the adverse variances. The full year outturn forecast using current operational performance with an overlay of risks and mitigation actions concludes that with further close monitoring of risks the 'most likely' deficit will be £2.4m and in line with the committed plan. **Access Standards & Elective Activity (partial assurance)** Meeting the urgent and emergency care access standards remains a significant challenge. Improvements are noted but more action is recognised as being required. Elective activity is behind plan and is a significant contributor to patient wait times and income.	**Financial Plan 2025/6** An interim headline plan has been submitted to the ICB. Further Divisional and Corporate confirm, and challenge and cross cutting cost improvement programme definition is underway. Final submission to NHSE is due on 27th March. **Access Standards** Specific intervention actions are planned, for example co-ordination between ED and Yorkshire Ambulance on pre-hospital arrival, revisions to existing operational and clinical decision-making practices, changes to the urgent treatment centre models, frailty and surgical same day emergency care improvements. It is agreed that greater assurance confidence will be aided by a 'holistic picture' of how the interventions contribute to performance and productivity improvement trajectories individually or collectively. **Estates & Facilities** Updated planned preventative maintenance strategy to be revisited as part of 2025/6 budget process with implications for risk management to be clearly identified. **Electronic Patient Record (EPR)** The Full Business Case (FBC) for an Electronic Patient Record (EPR) system utilising the EPR being implemented at Sheffield Teaching Hospitals (Oracle Health Millennium) is planned for submission to a DBTH Board in March. Outcomes from further clinical / operational team consultations and experience gathered from peer hospital trusts is to be added to the case. If approved, this investment will deliver the strategic intent for EPR convergence in South Yorkshire.

Significant or Full Assurances to Provide	Decisions Made
Estates & Facilities – quarter 3 performance report (significant assurance) Comprehensive monitor and assessment of current performance for estates, cleaning, portering and security. Outsourced sterile services highlighted as delivering high quality processing but with challenges on some delivery times, confirmation of 'no impact' to theatre productivity is to be provided. Contract discussions planned. Noted: Actions in place and planned with respect to the HSE Inspections letter to NHS Trusts on Management of Workplace risk from Musculoskeletal disorders and Violence & Aggression.	**The Village Building, Waterdale Shopping Centre, Doncaster** The Board is recommended to approve the lease agreement for the Village Building subject in the first instance to satisfactory VAT treatment and resolution of a value for money gap. With this, the Committee supports this case as part of a strategic 'health to the high street' move. This is conditional on further assurance evidence being presented to confirm a) that consideration had been given to alternative locations b) there is a high-level programme for service transfers in line with the lease activation and c) any residual 'value for money gap' can be put in context of a wider operational cost benefit from release of estate capacity at the DRI site. **Master Vendor Contract** Noted the process and outcome of procurement activity for the Collaborative Locum Doctors Master Vendor Contract. The Board is recommended to approve the award of the contract to the successful supplier. **Board Assurance Framework (BAF)** Assurance ratings agreed for the key risks with strengthened action planning to address gaps in control for BAF Risk 3: Access to Care; Risk 4: Best Care environment; Risk 5: Financial Sustainability. Preliminary assurance ratings for new Risk 7: Digital & Cyber Security.

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.

2503 - F5 CHAIR'S ASSURANCE LOG - QUALITY COMMITTEE

Discussion Item | Jo Gander, Non-executive Director | 12:15

5 minutes

REFERENCES

Only PDFs are attached

F5 - Chair's Assurance Log - Quality Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Quality Committee Meeting - Chair's Highlight Report to Trust Board		
Subject:	Quality Committee	**Board Date: March 2025**
Prepared By:	Jo Gander, Committee Chair & Non-executive Director	
Approved By:	Quality Committee Members	
Presented By:	Jo Gander, Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on 11th February 2025	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
	Business case development in progress to support resource challenges as part of Infected Blood enquiry workload. Acting Executive Medical Director to enquire regarding potential availability of National Framework for licence procurements for digital software licences with NHSE National Digital team.
Significant or Full Assurances	**Decisions Made**
• Maternity Single Delivery Plan **Significant Assurance** • CQC Update Reports/action plan **Significant Assurance** • PSIRF Progress and Outcomes report **Significant Assurance** • Clinical Audit progress against annual plan and outcomes including NICE compliance **Significant Assurance** • Learning from deaths and Structured Judgement Reviews **Significant Assurance** • Mortality Surveillance System and process compliance **Significant Assurance** • Infected Blood Enquiry **Significant Assurance** • Board Assurance Framework **Significant Assurance**	The committee reflected on the changes to the Board Assurance Framework document and how this mapped across to the previous version. Feedback included that this was an easier template to understand and to triangulate the assurance and that action plans were clearly articulated. The committee would continue to review the BAF and Risk register details at each committee and were significantly assured to recommend this to the Board of Directors for approval.

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.
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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.

2503 - F6 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

Discussion Item | Lucy Nickson, Non-executive Director | 12:20

5 minutes

REFERENCES

Only PDFs are attached

F6 - Chair's Assurance Log - People Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board

Subject:	**People Committee Meeting**	**Board Date: March 2025**
Prepared By:	Lucy Nickson, Committee Chair & Non-Executive Director	
Approved By:	People Committee Members	
Presented By:	Lucy Nickson, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 18th February 2025	

Matters of Concern
(Moderate, Limited or No Assurance)

There were no items in which moderate, limited or no assurance was given

Work Underway / Major actions commissions

Safe Staffing and Skill Mix
Development of business case to support changing skill mix in nursing workforce, to be progressed though usual Trust channels.

Workforce Supply & Demand
Annual workforce planning and business planning processes to be concluded for submission in line with national guidance and deadlines.

Research & Innovation
Ongoing development of business case to support future years of the Research & Innovation Strategy, to be progressed through usual Trust channels.

Significant Assurances

People Strategy: Significant Assurance
Update provided on revised reporting for the People Strategy. Going forward there will be a retrospective annual deep dive into the work contained within the people strategy, it's ongoing implementation and performance. Additionally there will be regular assurance given via PC on other relevant topics related to the strategy and finally we were assured that we will continue to see reporting on the People Strategy metrics through the IQPR and staff survey metrics.

Engagement & Leadership: Significant Assurance
Continued evidence of review of current practices and future ambitions/ways of continuing to develop the very well received engagement and recognition work. National staff survey embargo to be lifted/results released 13th March, with results being presented again to Board by IQVIA at the May Board.

Decisions Made

E-Rostering internal Audit
AOB – following discussion at recent ARC, it was agreed that a fuller update on the actions following internal audit on e-rostering will be brought to People Committee in April

Rapid Access to Treatment for NHS employees
This item came up as an AOB following a discussion at board development about supporting strategies for NHS staff to return to work (RTW) from sickness absence, there is a need to assess the Trust's position in relation to the national policy. It was agreed that this is not a People Committee item as access to treatment sits within the COOs portfolio and clearly relates to clinical decision making. However, It was agreed that the Chief People Officer, Zoe Lintin would take this item to a wider Exec team discussion.

Education: **Significant Assurance**

Statutory compliance – report shows the Trust continuing to hold on to a slightly above 89% of the 90% target, which is to be commended particularly given the additional operational challenges and pressures. There is a re-launch of '3 steps to success' for the first 3-4 months of this year on key SET topics to help improve the target further. Additional work is also taking place to look in more detail at the data sitting behind compliance to ensure comprehensive understanding and prioritisation of SET training. Apprenticeship completions remain strong.

Safe Staffing and Skill Mix: **Significant Assurance**

Comprehensive report giving evidence of processes and outcomes / actions taken to monitor and ensure safe staffing against national care quality standards. Strong evidence of practices which are in place to support the daily operational aspects of this, as well as the planning related aspects. There is clearly work still to do but progress is being made towards achieving establishment staffing levels with continued progress on agency usage reduction. The triangulation between safer staffer and skill mix was well articulated and there is strong evidence of the systems being used to support the work around skill mix, as well as other relevant aspects such as cultural aspects of changing roles for qualified nurses as the reduction of HCA posts shifts over time. Current target for skill mix changes to increase qualified nursing posts is to get to 60% across divisions in a phased way, with additional 60 qualified nurses being recruited by September 2025. Some of the skill mix improvements have already been achieved in budget in Medicine but this is proving harder within the surgical division and as such the committee was asked to support the proposal for business case development through the usual route which will set out the funding required to enable achievement of a 60% and 72% ideal target over time. The committee commented on the evident balance of quality being taken into account in this work despite immense operational and financial pressures.

Workforce Supply & Demand: **Significant Assurance**

Structured approach to workforce planning component of the 2025/26 business planning was further articulated, highlighting some of the difference being made to the planning process this year. Clearly expectations regarding performance are challenging in relation to reduced bank and agency expenditure and sickness absence management but there is good evidence of earlier planning, utilisation of systems and triangulation of impact of such systems and worth noting is the improving visibility and impact of job planning processes. Specific work is also underway to further explore how the sickness absence position can be improved, although some improvements already being seen. Overall, there is a sense of an improve planning process and greater grip and control through divisional structures and meetings which is really helping.

Board Assurance Framework

The Committee proposed delivery of the research and innovation strategy be incorporated in strategic risk six (Partnerships). Reflective of the importance of partnership working in securing the Trust's ambition to be a centre of excellence and university teaching hospital. As the Board has oversight of strategic risk six, this recommendation will be considered at the confidential Board of Directors meeting in March 2025.

Equality, Diversity & Inclusion (EDI): Significant Assurance The annual gender pay gap report was presented and the committee took assurance from the actions in place whilst acknowledging the longitudinal nature of change in this area, given the wider societal context. The committee noted and took assurance from the 'Achieving' rating resulting from the peer review assessment of the EDS 2022 framework. Both reports to be submitted and reported on the website. **Research & Innovation bi-annual report: Significant Assurance** Report with supporting detailed delivery plans outlining year 1 of the Research & Innovation Strategy and progress against KPIs. The committee welcomed the allocation of clinical research space at DRI. **Board Assurance Framework (BAF):- Significant Assurance** The Committee agreed the refresh of the BAF People risks and a move to the strategic risk being articulated more widely as relating to culture.	

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.

2503 - F7 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 12:25

5 minutes

REFERENCES

Only PDFs are attached

F7 - Chairs Assurance Log - Audit & Risk Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Audit & Risk Committee Meeting	**Board Date: March 2025**
Prepared By:	Kath Smart, Committee Chair & Non-executive Director	
Approved By:	Audit & Risk Committee Members	
Presented By:	Kath Smart, Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 13 February 2025	

Matters of Concern (with moderate, partial, limited or weak assurance)	**Work Underway / Major Actions Commissioned**
a) Audit Reports issued from 360 Assurance i) Risk Management Follow-up Audit – Limited Assurance - This audit followed up on the 2023 work & recommendations, and demonstrated there are still areas for improvement in the process, with 1 medium risk recommendation agreed by management relating to ensuring there is a SMART action plan to address known weaknesses in the risk system, including risk management training, and risk moderation processes. This will come to the April ARC. Positive feedback was given on areas which have improved and these were noted by ARC. ii) Complaints Audit - Moderate Assurance – This audit showed there were opportunities for improvements to the Complaints Handling Policy; the Annual Patient Experience Report; evidencing the timeliness & quality of compliant responses; and evidencing the learning from Complaints using the new Datix module. Verbal update from the Chief Nurse confirmed that all actions were on track for delivery on or before the due dates at the end of February. iii) E-Roster audit – Moderate (Nursing & Midwifery)/ Limited (other Trust areas using e-Roster); The split opinion reflected the use of e-Roster was more effective in N&M areas, and there are opportunities to embed processes for other areas across the Trust, including compliance with the Trust Policy; developing a roadmap and monitoring / reporting KPI's. Five recommendations have been agreed (incl 4 med and 1 low risk) iv) Board Assurance Framework audit – Moderate – The BAF review confirmed that there were inconsistencies in the Trusts compliance with its policy which was outlined at the last ARC, and that the Policy itself needs some work to be clear about the Trust requirements. 6 Actions (5 medium & 1 low) have been agreed and work has started on the new BAF. b) Updates on previous audit reports i) Mortality Data Quality Assurance – This was originally a limited assurance audit outcome. Information provided by the Acting Medical Director in relation to closed	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery b) Review of Board Assurance Framework and Trust Risk register – This work carried on from the BAF Board Development session on 4th February to fully populate the newly refreshed template and for Committees to review their portion of the BAF. Committee Chairs were asked to ensure the refreshed BAF is reviewed at Committee meetings for further feedback and population of the templates.

recommendations was encouraging and the evidence was being assessed by Internal Audit. It was reported that 5/6 medium recommendations were being closed and the remaining action was underway. Good progress has been made, and assurance was moved to partial assurance. ii) Business Continuity arrangements / EPRR Progress – This was originally a limited assurance audit outcome & the COO gave an update on work to improve compliance with the Trusts EPRR arrangements, which has been bolstered with a new key member of the team starting in December 2024. Assessment is currently underway of the audit evidence for one of the Business continuity high risk actions, and the other action has an extended deadline. The decision was taken to remain with the current assurance level until the status of the high risk action was clear. iii) Cyber Security information – Partial Assurance - The Data Security & protection toolkit outcome was originally a Substantial assurance outcome. However, this is the first in-depth review of the Cyber Security arrangements in place (previously ARC considered the DSPT). The information confirmed some good assurances in place from external (third line) assurers, including annual penetration testing. Outcomes from recent CAF audit are awaited, as is improvements to meet the new DCB0129 Clinical risk standard. There was judged to be a good improvement plan in place, alongside a comprehensive risk register. c) <u>Key risks to escalate</u> None	
Significant or Full Assurances to Provide	**Decisions Made**
a) Local Counter fraud arrangements - Significant – There was a comprehensive written update on fraud prevention, training, compliance with national standards, fraud cases and action taken and Trust proactive work. There will be a future change to the Trusts long standing LCFs and this is being carefully managed. b) **Single Tender Waivers** – Significant assurance that the Trusts SFI/ SO process had been followed c) **Losses and Compensations** – Significant assurance that the Trusts SFI/ SO process has been followed	

2503 - G INFORMATION

2503 - G1 BOARD OF DIRECTORS WORK PLAN

Information Item

Rebecca Allen, Associate Director Strategy, Partnerships & Governance

REFERENCES

Only PDFs are attached

G1- Board Work Plan (4Ps).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	06/05/2025	01/07/2025	02/09/2025	04/11/2025
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			Staff Survey			
PATIENTS													
Maternity & Neonatal Update	Director of Midwifery	Every Meeting	Mar-25										
Learning from Deaths	Executive Medical Director	Quarterly	Mar-25		verbal								
Patient Experience Annual Report	Chief Nurse	Annual	Nov-25										
Winter Plan	Chief Operating Officer	Annual	Sep-25										
Quality Accounts	Chief Nurse	Annual	Jul-25										
Safeguarding Annual Report	Chief Nurse	Annual	Sep-25										
Clinical Audit Plan	Executive Medical Director	Annual	Sep-25										
PEOPLE													
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Mar-25										
Workforce Race Equality Standards	Chief People Officer	Annual	Jul-25										
Workforce Disability Equality Standards	Chief People Officer	Annual	Jul-25										
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	May-25										
Staff Survey Results	Chief People Officer	Annual	May-25										
Maternity Workforce	Director of Midwifery	Bi-annual	Jul-25										
Research & Innovation Case Study	Chief People Officer	Annual	Jul-25										
PARTNERSHIP													
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	Mar-25										
POUNDS													
Financial Position	Chief Financial Officer	Every Meeting	Every Meeting										
Financial Plan	Chief Financial Officer	Annual	May-25										
Going Concern	Chief Financial Officer	Annual	Mar-25										
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Jul-25										
Annual Business Plan	Chief Financial Officer	Annual	Mar-25										
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-25										
ASSURANCE & GOVERNANCE													
Integrated Quality & Performance Report	COO/CN/EMD/CPO	Every Meeting	Every Meeting										
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	May-25										
Board Risk Appetite	Deputy Chief Executive	Annual	May-25										
Review of Strategic Risks	Deputy Chief Executive	Annual	May-25										
2024/2025 Strategic Priorities Success Measures	Deputy Chief Executive	Annual	May-25										
Delivery Update 2024/25 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	Mar-25										
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-25										
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-25										
Chair's Assurance Log - Finance & Performance Committee	F&P Chair	Post Committee	Mar-25		verbal								
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Mar-25										
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Mar-25										
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Mar-25										
Chair's Assurance Log - Charitable Funds Committee	CFC Chair	Post Committee	May-25										
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	May-25										
Annual Report - Chartable Funds Committee	Chair of CFC	Annual	Jan-25										
Board Work Plan (approval)	AD of Strategy, Partnerships & G	Annual	May-25										
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annual	Nov-25										
Trust Seal	AD of Strategy, Partnerships &	As Req'd	Mar-25										
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships & G	Annual	May-25										
Board Effectiveness	AD of Strategy, Partnerships & G	Annual	Mar-25										
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships & G	Annual	May-25										
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships & G	Annual	May-25										
Terms of Reference - People Committee	AD of Strategy, Partnerships & G	Annual	May-25										
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships & G	Annual	May-25										
Partnership Updates (details TBC)	Deputy Chief Executive	TBC	TBC										
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Executive	TBC	TBC										
ENABLING STRATEGIES													
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, Innovation & Transformation		2028										
TRUST POLICIES													
CORP/FIN 1 - A Standing Orders - Board of Directors	AD of Governance	Annual	Jul-25										
CORP/FIN 1 - B Standing Financial Instructions	AD of Governance	Annual	Jul-25										
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	Jul-25										
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 & G	3 yearly	Sep-25										
CORP/COMM 11 - Management of Reviews, Visits, Inspections and Accreditations Policy	AD of Strategy, Partnerships & G	2 yearly	Dec-25										
CORP/COMM 25 - Establishment and Administration of Committees Policy	AD of Strategy, Partnerships & G	3 yearly	Feb-26										
CORP/FIN 4 - Standards of Business Conduct and Employees Declarations of Interest Policy	AD of Strategy, Partnerships & G	3 yearly	Jun-26										
CORP/RISK 30 - Risk Identification, Assessment, and Management Policy	AD of Strategy, Partnerships & G	3 yearly	Oct-26										
CORP/COMM 1 - Approved Procedural Documents (APDs) Development and Management Policy	AD of Strategy, Partnerships & G	3 yearly	Mar-27										
INFORMATION													
Work Plan	AD of Strategy, Partnerships & G	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.*

2503 - H CLOSING ITEMS

2503 - H1 MINUTES OF THE MEETING HELD ON 7 JANUARY 2025

Decision Item | Suzy Brain England OBE, Chair of the Board | 12:30

5 minutes

REFERENCES

Only PDFs are attached

H1 - Draft Public Board of Directors Minutes - 7 January 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 7 January 2025 at 09:30 via MS Teams

Present:
Mark Bailey - Non-executive Director
Suzy Brain England OBE - Chair of the Board (Chair)
Hazel Brand - Non-executive Director
Jo Gander - Non-executive Director
Karen Jessop - Chief Nurse
Dr Emyr Jones - Non-executive Director
Zara Jones - Deputy Chief Executive
Zoe Lintin - Chief People Officer
Dr Nick Mallaband - Acting Executive Medical Director
Lucy Nickson - Non-executive Director
Jon Sargeant - Chief Financial Officer
Kath Smart - Non-executive Director
Denise Smith - Chief Operating Officer
Sam Wilde - Chief Financial Officer Designate

In attendance:
Rebecca Allen - Associate Director of Strategy, Partnerships & Governance
Lois Mellor - Director of Midwifery
Angela O'Mara - Deputy Company Secretary (minutes)
Emma Shaheen - Director of Communications & Engagement

Public in attendance:
Rob Allen - Public Governor
Denise Carr - Public Governor
Lynne Logan - Public Governor
Joseph Money - Staff Governor
Marjie Moores - Doncaster & Bassetlaw Teaching Hospitals
Vivek Panikkar - Staff Governor
Lynne Schuller - Public Governor
Mandy Tyrrell - Staff Governor
Sheila Walsh - Public Governor

Apologies:
Mark Day - Non-executive Director
Richard Parker OBE - Chief Executive

P25/01/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

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

P25/01/A2 **Actions from Previous Meetings**

Action 1 and 2 were closed.

Action 3 – **Strategic Risk 2 - Board Assurance Framework** - an update to reflect the discussion at November's Board meeting had been considered by the People Committee and was included in the updated Board Assurance Framework at agenda item C4. Action to be closed.

Action 4 - **Emergency Preparedness, Resilience & Response Compliance against the National Core Standards** - following a peer review by South Yorkshire Integrated Care Board there was no change to the Trust's self-assessment of compliance. Work against the core standards would continue, with progress reported through the relevant governance route. The Audit & Risk Committee received the compliance self-assessment, prior to submission and a mid-year review of progress against actions. Action to be closed.

P25/01/A3 **Chair's Report (Enclosure A3)**

The Chair's report provided an overview of activities, visits, and key events in the Trust calendar since the last Board of Directors meeting.

The Board:

- ***Noted the Chair's Report***

P25/01/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 provision of overnight and extended stays in the Children's Assessment Unit at Bassetlaw Hospital was a welcomed addition and following the recent handover from the contractors more news was expected regarding the opening of the Bassetlaw Emergency Village in due course.

The Board:

- ***Noted the Chief Executive's Report***

P25/01/B1 **Trust Strategy Update Report (Enclosure B1)**

The Deputy Chief Executive reflected on the ongoing work to refresh the Trust's strategy, through engagement with stakeholders. A set of priorities had been agreed in principle, with a focus on health inequalities, digital maturity, a fit for the future estate, and the development of the Trust's education and research activity to support its ambition to be a university teaching hospital.

These proposed priorities aligned to the national direction of travel for the NHS and would be further explored at the Board of Directors development session in early February 2025.

There would be a need to consider these alongside the awaited 2025/26 planning guidance and the reforming elective care for patients plan issued yesterday.

Non-executive Director, Lucy Nickson enquired if the reference to working in partnership with the independent sector in the reforming elective care plan impacted upon the Trust's strategy. The Chief Operating Officer confirmed the Trust was well placed to progress future conversations in light of its established relationships with a number of independent sector providers. There would be the potential to further develop Community Diagnostic Centre (CDC) activity, with partnership working already in place across South Yorkshire.

In respect of the impact of devolution, there may be wider opportunities through devolved decision making which supports different ways of working.

Non-executive Director, Kath Smart expressed the need to articulate the risks to delivery of the strategy and enquired if the support of the Trust's internal auditors would be beneficial. Along with the support of internal audit partners, best practice and wider colleague contribution would ensure the correct risks were captured and the definitions and controls for mitigating actions strengthened.

In response to a question from Non-executive Director, Hazel Brand regarding the challenges and risks in delivering a 12 hour a day service, 7 days a week detailed in the reforming elective care plan. The Chief Operating Officer confirmed not all elective services were routinely offered seven days a week, and in due course an assessment would be made on a service by service basis.

The Board:

- ***Noted and took assurance from the Trust Strategy Report***

P24/01/C1 **Integrated Quality & Performance Report (IQPR) (Enclosure C1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for October and remaining access, quality, and workforce standards for November 2024. Where a local or national standard was not met an assurance report provided supporting commentary of the challenges, actions and emerging concerns.

The Deputy Chief Executive acknowledged the reforming elective care plan had only been received yesterday and the detail would need to be worked through. The focus on patient care and patient experience whilst waiting for treatment was noted, alongside waiting times which currently fell short of constitutional standards. It was clear that milestone improvements would be required over a multi-year approach. The focus on health inequalities and digital in the plan aligned with the Trust's strategic ambitions and in terms of elective activity, opportunities existed through the Community Diagnostic Centre, Elective Orthopaedic Centre, and the emergency care pathway at Bassetlaw Hospital.

The data within the IQPR reflected the mid-winter position and respective pressures which had continued into December. Safe, quality care had continued to be provided, however, there had been an impact on elective recovery with high levels of influenza affecting bed occupancy.

The executive directors summarised their respective key performance indicators.

Reflecting on the reforming elective care plan and improved access to diagnostic testing via general practice, Non-executive Director, Emyr Jones questioned the impact on consultant time and the capacity to support a potential increase in diagnostic tests. The Acting Executive Medical Director did not expect to see a reduction in consultant time, however, there was the potential to see an increase in incidental findings which could impact positively on population health. The Chief Operating Officer recognised the ambition of the reforming elective care plan and confirmed time was required to understand the impact, as the advice and guidance service required consultant time.

In response to a question from Non-executive Director, Hazel Brand regarding a reduction in outpatient activity due to patient initiated follow-up (PIFU), the Chief Operating Officer confirmed that whilst the Trust benchmarked well in some specialities, there remained scope to expand PIFU.

In response to a question from Non-executive Director, Kath Smart regarding the implementation of the Trust's winter plans. The Chief Operating Officer confirmed that all plans had been enacted to manage the impact of seasonal illnesses, minimising elective cancellations and prioritising clinically urgent and cancer surgery.

The Chair of the Board encouraged colleagues and members of the public to take the opportunity to be vaccinated against influenza.

In terms of eliminating 65+ week elective waits, the Chief Operating Officer confirmed that an action plan was in place, with weekly monitoring and reporting arrangements in place for ENT. An element of patient choice was noted in respect of some wait times.

Non-executive Director, Kath Smart reported a difficulty in assessing performance where a local target was not provided and suggested this be considered for future reporting.

Non-executive Director, Lucy Nickson noted the high volume of Emergency Department attendances, the Chief Operating Officer confirmed that a series of actions were in place to consider alternatives to conveyance, including the use of the Same Day Emergency Care Centre and primary care. The Acting Executive Medical Director highlighted industrial action in general practice had been limited locally, and cautioned that should the nationally recommended daily patient contact be adopted by general practice there was the potential for an increase in the number of referrals to the Emergency Department. This was recognised to be a national issue.

Non-executive Director, Jo Gander welcomed the work with partners to improve the conveyance rate. Considering the number of patients who were discharged from the department without the need for diagnostic tests or treatment the Chief Operating Officer confirmed a high level of confidence in the focus of the work. A higher acuity had been seen during the winter, with a significant increase in the provision of same day emergency care or admission.

Non-executive Director, Mark Bailey reflected on the efforts to date to drive improvements and encouraged a post-winter service redesign, considering the potential use of diagnostic centres and advice and guidance.

The Board:

- ***Noted and took assurance from the Integrated Quality & Performance Board***

P25/01/C2 **Financial Position (Enclosure C2)**

The Chair of the Board welcomed the Chief Financial Officer to his last Board meeting, ahead of his retirement at the end of January. The Board was informed that Jon would continue to work at Place in the coming months to progress a range of patient and community projects.

The Chief Financial Officer reported a month eight deficit of £1.6m, £0.5m adverse to budget and £0.9m adverse to forecast. The year to date deficit of £2.3m was £1.2m adverse to budget and £2m adverse to forecast. The year to date position was mainly driven by elective recovery fund (ERF) underperformance, with ERF income £5.8m adverse to budget, mainly related to underperformance in Trauma and Orthopaedics.

The total year to date capital spend, excluding donated assets and charitable funds, was £12m, against a year to date budget of £12.3m.

The cash balance at month eight was £41m and would require careful management over the remainder of the financial year.

In month, the Trust had delivered £1.4m of savings against a plan of £2.2m, £8.9m of savings had been delivered year to date, against a plan of £10.7m.

Further scrutiny would be carried out by the Board's Finance & Performance Committee, with improvements of c£3m anticipated during the remainder of the financial year.

The Chief Financial Officer confirmed that approval of the cash support for the capital plan was awaited and there may be a need to seek approval of business cases via Chair's actions in order to meet the lead time for orders.

Non-executive Director, Lucy Nickson recognised the financial impact of operational performance and enquired of the level of confidence in actions taken to address inconsistencies. The Chief Financial Officer acknowledged good progress had been made during the summer months in respect of rota management and the subsequent reduction in the use of temporary workforce. There remained a need to address productivity, particularly in Orthopaedics where activity was significantly behind plan, however, during the winter months the priority had been on maintaining a safe service.

The Chief Operating Officer confirmed capacity was always utilised to see and treat the most clinically urgent patients, followed by the length of wait.

The Deputy Chief Executive acknowledged the tensions between cost improvements linked to bed management and winter pressures and the importance of delivering transformational change through partnership work.

The Chief Operating Officer acknowledged the delivery of length of stay cost improvements was challenging due to the inability to reduce the bed base and required staffing. Fully utilising capacity and the management and reduction of on the day

cancellations and did not attend (DNA) rates was critical and the Chair of the Board implored patients to notify the hospital of non-attendances in order that those waiting could be seen and efficiencies improved.

Non-executive Director, Emyr Jones reflected on the activity and associated financials of the Mexborough Elective Orthopaedic Centre. The Chief Operating Officers across the three partner organisations continued to work together to explore opportunities to increase activity, an additional orthopaedic surgeon had been recruited by a partner organisation and a proposal was being developed to explore the opportunity to increase the number of sessions, operating on a cost per case basis.

The Chair of the Board recognised the outgoing Chief Financial Officer's contribution and extended her best wishes on his retirement. A warm welcome was extended to Sam Wilde.

The Board:

- ***Noted the financial position update***

P25/01/C3 **Audiology Service Update (Enclosure C3)**

Further to the audiology service update at November 2024's Board of Directors meeting, the Deputy Chief Executive advised that the outcomes of 13 paediatric assessments had now been received, which identified three incidents of moderate harm and two of low level harm.

Personally, and on behalf of the Trust, the Deputy Chief Executive offered her sincere apologies to the affected children and their families and provided assurance of the actions taken to ensure the future delivery of a high quality, safe service. Where further care and support was identified, this would be offered in a timely and appropriate manner. Low level harm would be monitored to ensure the impact was not sustained and duty of candour had commenced in all cases.

In respect of wider service recovery plans, the Trust had procured a fit for purpose, integrated IT system, used nationally in high performing audiology services. Updated paediatric audiology facilities were planned at Doncaster Royal Infirmary (DRI) and Bassetlaw Hospital in March and April 2025, respectively; with improvements to DRI's ENT outpatient department scheduled for April 2025. Equipment to support the reinstatement of services had been purchased and comprehensive colleague training arranged, facilitated by Nottingham University Hospitals.

Despite offering a limited service since October 2024, the Trust had carried out in excess of 2,500 repairs, to replace hearing aid batteries and tubes with the support of community partners.

A further update would be shared at the next Board of Directors' meeting on 4 March 2025. **ZJ**

In response to a question from Non-executive Director, Lucy Nickson in respect of the duty of candour requirements, the Chief Nurse confirmed that the Trust maintained close contact with the families, providing an appropriate link to Sheffield Children's Hospital as the organisation supporting the paediatric pathway assessments.

Non-executive Director, Kath Smart acknowledged the difficult outcomes and ongoing communication with the families and enquired of the Trust's internal communication plan. The Deputy Chief Executive confirmed that the service was briefed on a weekly basis, with executive directors remaining close to the work, driving forward improvements and offering support, recognising the potential impact on colleagues health and wellbeing.

The Board:

- ***Noted the Audiology Service Update***

P25/01/C4 **Board Assurance Framework & Trust Risk Register (Enclosure C4)**

The Board Assurance Framework (BAF) continued to be iteratively developed, alongside the ongoing improvement of Trust wide risk management, through the work of the Risk Management Group.

There was no overall change to the scoring of the strategic risks. Strategic risk four, relating to the Trust's estate, represented the greatest risk, with a score of 20.
The BAFs had been refreshed and reviewed by the relevant Board Committee assigned oversight. In respect of strategic risk six, relating to partnership working, the Board would be the risk owner and this would be considered as part of February's Board development session.

The refreshed BAF for strategic risk one had been reviewed by the Quality Committee in December 2024, due to a formatting error the enclosure did not include a complete picture of the gaps in assurance and this was corrected post meeting.

Following feedback at November's Board of Directors meeting, the Chief People Officer had updated strategic risk two to reflect the risk and associated action plans in respect of sickness absence rates, which although reducing were above the target rate. A planned review of the BAF would take place with the support of the Associate Director of Strategy, Partnerships & Governance.

The Chief Operating Officer had refreshed the BAF for strategic risk three, which had been considered by the Board's Finance & Performance Committee. The refreshed actions to close gaps were highlighted for ease of reference and included refined arrangements for the oversight of the patient tracking list and delivery of the elective recovery plan.

Non-executive Director, Kath Smart welcomed the progress made in respect of risk review dates and noted the 23 overdue risks had now been assessed and all were compliant. Where risks were not fully mitigated they would be subject to further discussion at the Risk Management Group.

In respect of progress towards the target scores for strategic risks one, three and five it was noted there was some way to go and this would form part of discussions at February's Board development session, recognising this may not be delivered in year. The Deputy Chief Executive suggested it may also be helpful to reflect the risk to delivery of the financial plan and if this should be adjusted over time.

The Board:

- ***Noted and took assurance from the Board Assurance Framework & Trust Risk Register***

P25/01/C5 **Chair's Assurance Log – Finance & Performance Committee (Enclosure C5)**

The Board received the Finance & Performance Committee Chair's assurance log which provided an overview of assurance, areas of major works, areas of focus and decisions made by the Committee.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P25/01/C6 **Chair's Assurance Log – Quality Committee (Enclosure C6)**

The Board received the Quality Committee Chair's assurance log which summarised the assurance, areas of major works, areas of focus and decisions made by the Committee.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P25/01/C7 **Chair's Assurance Log – People Committee (Enclosure C7)**

The Board received the People Committee Chair's assurance log which provided an overview of the assurance, areas of major works, areas of focus and decisions made.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P25/01/C8 **Chair's Assurance Log – Charitable Funds Committee (Enclosure D11)**

The Board received the Charitable Funds Committee Chair's assurance log, which provided an overview of the assurance, areas of major works, areas of focus and decisions made by the Committee.

Since writing the report, the Charity's lottery had been launched and initial interest had exceeded expectations.

A review of the management and operation of the Charity would be progressed with the support of the Deputy Chief Executive and Chief Financial Officer for consideration at the next Committee meeting in March 2025.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P25/01/C9 **Standing Financial Instructions, Standing Orders & Reservation of Powers to the Board & Delegation of Powers (Enclosure C9)**

The Board received the refreshed policies for approval following consideration by the Audit & Risk Committee.

The Chief Operating Officer requested delegated matter 28b (*temporary change to bed allocation and use, excluding critical care*) in CORP/FIN 1C Reservation of Powers to the Board and Delegation of Powers be amended as follows:

- in hours - Chief Operating Officer, with Head of Patient Flow advice
- out of hours - executive on call with Clinical Site Manager advice

The Board:

- ***Approved the Standing Financial Instructions, Standing Orders & Reservation of Powers to the Board & Delegation of Powers (Enclosure C9) subject to the above amendment***

P25/01/C10 **The Insightful Provider Board & DBTH Reporting (Enclosure E1)**

The Deputy Chief Executive brought the Board's attention to NHSE's recently published guidance which considered the information available to boards to support improved decision making, productivity and outcomes.

The Trust's operational data flow and reporting was considered against the guidance, including the Integrated Quality and Performance Report received by the Board. Reflections on effective governance arrangements and the impact of organisational culture provided a helpful perspective.

The Board:

- ***Noted the Insightful Provider Board & DBTH Reporting***

P25/01/D1 **Maternity & Neonatal Update (Enclosure D1)**

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). This included the review and learning from patient safety events, perinatal mortality reviews and patient safety investigations. There had been no Maternity & Newborn Safety Investigations (MNSI) referrals in October and November 2024, the ongoing investigation of two cases was noted. One maternity Patient Safety Incident Investigation (PSII) was underway, which spanned a number of providers and was subject to review by the Local Maternity and Neonatal System (LMNS). Quarter 2 2024/25 Perinatal Mortality Reviews Summary report provided an insight into reviews during 1 July to 30 September 2024, utilising the national Perinatal Mortality Review Tool (PMRT). The Board was asked to review and approve the PMRT report.

The Single Delivery Plan was on track and the Board was informed that greater than 90% training compliance had been achieved in November 2024.

The perinatal quadrumvirate leadership team had met with the Board Safety Champion and non-executive Maternity Safety Champions on 28 November 2024. In the absence of a Maternity & Neonatal Voices Partnership Chair, the Maternity and Neonatal Partnership Strategic Lead had joined the meeting and agreed to support the service on an interim basis. The Board Safety Champion continued to work closely with the perinatal quadrumvirate leadership team to develop and sustain improvements in culture in maternity services.

The Trust had achieved nine of the ten Maternity Incentive Scheme safety actions.

Since writing the report, the Director of Midwifery confirmed that there were only two vacancies in midwifery staffing. In respect of the neonatal nursing and medical workforce, the Trust was not compliant with the British Association of Perinatal Medicine (BAPM) national standards and an action plan was in place to address this. The Board was asked to review and approve the neonatal medical workforce progress update. The Director of Midwifery advised there had been a change in BAPM guidance in year and the implications of this, particularly for medical staffing, were being worked through.

Non-executive Director, Kath Smart recognised the achievement of greater than 90% training compliance in November 2024 and enquired if there was a sustainable approach that could be replicated throughout the year. The Director of Midwifery confirmed that training time was allocated in advance, however, this was subject to change.

In response to a question regarding neonatal staffing, the Director of Midwifery confirmed there were no adverse incidents related to staffing levels. This would remain under review and should there be any concerns, the risk would be assessed and added to the risk register, if required.

The Chief Operating Officer confirmed there had been no blanket cancellation of training due to winter pressures, and divisional colleagues' judgement was trusted to support completion during the winter months.

Non-executive Director, Mark Bailey recognised the significant success in maternity services in relation to the recruitment and retention of colleagues and enquired of opportunities taken to reflect this positive performance. The Director of Midwifery reflected on the time invested in developing recruitment and retention strategies, including a structured preceptorship programme and pastoral care. This good news story had been shared with the support of the Communications & Engagement team.

In his capacity as non-executive Maternity Safety Champion, Emyr Jones reflected on the positive and insightful engagement visits and discussions as part of this role, including the monitoring of the ongoing cultural work supporting multi-disciplinary working.

The Chief Nurse shared her appreciation of the Board of Directors' ongoing support to maintain safe staffing levels and shared an opportunity to bring the success of maternity services to the attention of the Chief Midwifery Officer during a recent visit. Despite the progress made, the team were not complacent and remained focused on improvements, noting the importance of the ongoing cultural work.

The Chair of the Board thanked the Chief Nurse and Director of Midwifery for their leadership.

The Board:

- ***Noted and took assurance from the Maternity & Neonatal Update***
- ***Reviewed and approved Q2 PMRT***
- ***Reviewed and approved the neonatal medical workforce progress update***
- ***Noted the number of Maternity and Newborn Safety Investigation (MNSI) / Early Notification Scheme (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 the bi-monthly Board Safety Champion meetings with the perinatal leadership team and any support required of the Trust board has been identified and is being implemented***
- ***Noted 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***

P25/01/D1 **Bi-annual Midwifery Workforce Report (Enclosure D1)**

The bi-annual midwifery workforce report provided an overview of planning and monitoring in place to support safe midwifery staffing levels during Q1/2 2024/25, in accordance with Birthrate Plus® recommendations. The paper included the midwife to birth ratio and provision of one to one care, which was supported 100% of the time across Doncaster and Bassetlaw sites.

The Director of Midwifery highlighted an improving vacancy position in Q3 2024/25 and the number of specialist midwife posts now in place, which included those externally funded by NHS England and the LMNS to support delivery of the Single Delivery Plan.

The current Birthrate Plus® assessment was completed in 2022 and was expected to be repeated in Summer 2025.

The Board:

- ***Noted and took assurance from the Bi-annual Midwifery Workforce Report***

P25/01/D2 **Year 6 Clinical Negligence Scheme for Trusts' Board Declaration (Enclosure D2)**

The Director of Midwifery reported the current and planned submission position in respect of compliance with the Year 6 Clinical Negligence Scheme for Trusts' standards ahead of the submission deadline of 3 March 2025.

The Trust would declare compliance with nine of the ten maternity safety actions. Safety action one (requirement three) related to use of the national Perinatal Mortality Review Tool and was non-compliant due to an incomplete data capture in two cases. The Chief

Nurse clarified that all of the required actions had been completed with the family and the issue related to an incomplete electronic record.

Compliance had been subject to review by the Local Maternity & Neonatal System (LMNS) and discussed with the LMNS Collaborative Board. The Trust had brought the matter to the attention of NHS Resolution and MBRACCE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and this would be submitted for an early assessment as part of the external validation process. It was hoped this would result in an upgraded assessment.

Progress was reported on the implementation of version three of the Saving Babies Lives Care Bundle, however, the risk to full implementation was noted and in particular the challenge in providing a diabetic clinic.

The Chief Nurse recognised the volume of evidence required to confirm compliance and acknowledged the significant efforts of the Director of Midwifery and wider team. This was echoed by the Chair of the Board.

The Board:

- ***confirmed it was satisfied with the evidence provided to achieve the nine maternity safety actions***
- ***delegated authority to the Chief Executive to sign-off the Board Declaration, prior to submission to NHS Resolution on 3 March 2025***
- ***noted that the Chief Executive would appraise the Integrated Care Board's Accountable Officer (ICB Executive Chief Nurse, Cathy Winfeld) of the Maternity Incentive Scheme (MIS) safety actions***

P25/01/E1 **Board of Directors Work Plan (Enclosure E1)**

The Board received the Board of Directors work plan, the structure of which would be revised to align with the Trust's strategic priorities.

The Board:

- ***Received the Board of Directors Work Plan for information***

P25/01/F1 **Minutes of the meeting held on 5 November 2024 (Enclosure F1)**

The Board:

- ***Approved the minutes of the meeting held on 5 November 2024***

P25/01/F2 **Pre-submitted Governor Questions regarding the business of the meeting (verbal)**

The following governor question had been received:

"I have concerns regarding the waiting times for cancer patients in gynaecology in Sheffield. Since gynaecological cancer patients from Doncaster are referred to Sheffield, I have observed significant delays in appointments, with some cases exceeding target wait times. Could we obtain detailed information regarding the waiting times for the first outpatients appointment and then the time period before they are operated on/receive treatment".

The Chief Operating Officer had agreed to provide a response outside of the meeting. This would be captured on the governor question and answer database, available via the governor portal.

P25/01/F3 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

P25/01/F4 **Date and time of next meeting (Verbal)**

Date: Tuesday 4 March 2025
Time: 9:30
Venue: MS Teams

P25/01/F5 **Withdrawal of Press and Public (Verbal)**

The Board:

- ***Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

P25/01/G **Close of meeting (Verbal)**

The meeting closed at 12.12

2503 - H2 PRE-SUBMITTED GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:35

10 minutes

2503 - H3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:45

10 minutes

2503 - H4 DATE AND TIME OF THE NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 12:55

Date: Tuesday 6 May 2025
Time: 09:30
Venue: MS Teams

2503- H5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Suzy Brain England OBE, Chair of the Board | 12:55

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.