Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

1 July 2025

09:30 GMT+1 Europe/London

Boardroom, Bassetlaw Hospital Kilton Hill, Worksop S81 0BD

AGENDA

2507 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 1 July 2025 v3.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 1 July 2025 at 09:30
Boardroom, Bassetlaw Hospital

		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*			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
	BOARD LEARNING & REFLECTION			**09:55**
A5	Research & Innovation Update *Zoe Lintin, Chief People Officer,* *Professor Sam Debbage, Director of Education & Research* *Dr Jane Fearnside, Head of Research*	*Note*		15
B	**PATIENTS**			**10:10**
B1	Audiology Service Update *Zara Jones, Deputy Chief Executive*	*Review*		10
B2	Maternity & Neonatal Update *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery*	*Approve / Assurance*		10
B3	Bi-annual Midwifery Workforce Report *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery*	*Assurance*		10

C	**PEOPLE**			**10:40**
C1	Guardian of Safe Working Quarterly Report *Zoe Lintin, Chief People Officer* *Mohammad Khan, Guardian of Safe Working*	*Assurance*		10
C2	Workforce Race & Disability Equality Standards *Zoe Lintin, Chief People Officer*	*Note*		5
BREAK 10:55 – 11:10				
D	**PARTNERSHIP**			**11:10**
D1	Doncaster & Bassetlaw Healthcare Services Update *Sam Wilde, Chief Finance Officer*	*Assurance*		5
D2	Trust Strategy and 2025/26 Strategic Priorities Success Measures *Zara Jones, Deputy Chief Executive*	*Approve*		10
E	**POUNDS**			**11:25**
E1	Financial & Activity Report – Month 2 *Sam Wilde, Chief Finance Officer*	*Note*		10
E2	Estates Return Information Collection 2024/25 *Sam Wilde, Chief Finance Officer*	*Approve*		10
F	**ASSURANCE & GOVERNANCE**			**11:45**
F1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
F2	Board Assurance Framework including Trust Risk Register *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Approve*		20
F3	2024/25 Annual Report & Accounts, including Annual Governance Statement *Richard Parker, Chief Executive*	*Note*		5
F4	Chair's Assurance Log – Finance & Performance Committee *Mark Bailey, 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

F8	Audit & Risk Committee Annual Report *Kath Smart, Non-executive Director*	*Assurance*		5
G	**INFORMATION**			**12:55**
G1	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-
H	**CLOSING ITEMS**			**12:55**
H1	Minutes of the meeting held on 6 May 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 2 September 2025 **Time:** 9:30 **Venue:** MS Teams	*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**			**13:20**

*Governor Questions

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

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

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

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

Suzy Brain England OBE
Chair of the Board

2507 - 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 governors are there as observers only

REFERENCES

Only PDFs are attached

A1 - Register of Interests & FPP (24.6.2025).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

Hazel Brand, Non-Executive Director
Councillor, Bassetlaw District Council (independent) - member of the Council's Appointments and Licencsing Committees in this role
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

(as at 24 June 2025)

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)

Nick Mallaband, Acting Executive Medical Director
Director - Doncaster and Bassetlaw Healthcare Services Ltd

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

(as at 24 June 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 24 June 2025)

2507 - A2 ACTIONS FROM PREVIOUS MEETING

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

5 minutes

REFERENCES

Only PDFs are attached

A2 - BoD Action Log - 6 May 2025.pdf

Action notes prepared by: Angela O'Mara
Updated: 17 June 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	6 May 2025

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P25/03/D2**	**Trust Strategy** To be received for approval by the Board.	**ZJ**	~~**May**~~ **July 2025**	Deferred to July 2025's Board of Directors meeting **Update** – included on the agenda @ D2
2.	**P25/03/F1**	**Community Diagnostic Centre Staffing** To clarify with the Head of Medical Imaging any recruitment challenges.	**KJ**	**May 2025**	**Update 24/4/2025** – The Head of Medical Imaging has confirmed full recruitment of an increased establishment, including all relevant professions, administration colleagues and increased trainee posts via the universities. **Update 6/5/2025 – action closed**
3.	**P25/03/F3**	**2025/2026 Success Measures** To be received by the Board.	**ZJ**	~~**May**~~ **July 2025**	Deferred to July 2025's Board of Directors meeting **Update** – included on the agenda @ D2

Action notes prepared by: Angela O'Mara
Updated: 17 June 2025

No.	Minute No.	Action	Responsibility	Target Date	Update
4.	**P25/05/B1**	**<u>Audiology Subject Matter Expert Visit</u>** Feedback from the planned visit on 27 May 2025 to be shared with the Board's Quality Committee.	**ZJ/NM**		**Update 6/5/2025** – transferred to the Quality Committee work plan. Board action to be closed.
5.	**P25/05/E2**	**<u>Review of Strategic Risk Two Target Risk Rating</u>** Chief People Officer to consider target risk, Board Assurance Framework to be considered at June's People Committee, ahead of July's Board of Directors meeting.	**ZL**	**July 2025**	**Update 17/06/2025 –** discussion and agreement reached at June's People Committee to retain the target risk rating of 12. The Board Assurance Framework is included on the agenda @ F2 for review and approval by the Board.

2507 - 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 Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Chair's Report**			
Executive Sponsor:	Suzy Brain England OBE, Chair of the Board			
Authors:	Katie Michel, PA to the Chief Executive and Chair			
Appendices:				
Purpose of the report	Assurance	Decision required	**Information**	Discussion
Impacts on Strategic Risks (BAF 1-7)	BAF 4, 6 & 7			

Executive Summary – Key messages and Issues
The report provides an insight into the Chair's activities since the last Board report in May 2025, including visits, duties and areas of interest as Chair of the Board and Council of Governors.

Recommendations
The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	This report highlights the commitment to support patients in a setting to best suit their healthcare needs.
People	This report highlights the Trust's commitment to support its people and develop an inclusive and diverse workforce.
Partnerships	This report identifies how the Trust interacts with its partners at a Place, system and national level.
Pounds	This reports highlights the national focus on financial sustainability, efficiency and productivity, discussed at the HSJ Provider Summit.
Health Inequalities	This report does not have any impact on health inequalities.
Legal/ Regulation:	This report does not identify any legal or regulatory impact.
Partner ICB strategies	This report does not impact on the strategies of our partner ICBs.

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

President's Lunch – Celebrate our Achievements

As part of my role on the Doncaster Chamber of Commerce Board, I was invited to its annual President's Lunch in May, bringing together local business leaders, policymakers, and community stakeholders for an afternoon of networking and strategic dialogue. Held in London, the event featured a keynote address by the Chamber President, who highlighted the region's economic growth, upcoming initiatives, and the importance of collaboration between the public and private sectors. Special guest speakers shared insights on innovation, sustainability, and workforce development. The lunch fostered meaningful connections and reinforced the Chamber's commitment to supporting business excellence.

Northern Greener NHS Week

During Northern Greener NHS Week (2 - 6 June 2025), the Trust highlighted the fantastic work happening across DBTH to make our services more environmentally sustainable. Each day, there was a focus on a different green initiative that highlights how our teams are reducing waste, improving efficiency, and helping us move towards a Net Zero NHS. From greener theatres and digital innovation to reducing food waste and enhancing our green spaces, colleagues across the Trust are proving that sustainability can become integrated into every area.

I also visited the Rainbow Garden at Doncaster Royal Infirmary during Northern Greener Week to film a short piece on our gardens across the Trust which can be viewed here - Pride in our gardens at DBTH - Doncaster and Bassetlaw Teaching Hospitals

Board Development Session

Last month's Board development session opened with a focused discussion on the Trust Strategy, which will be received for approval by the Board at this meeting. Consideration was given to the ongoing plans being developed by the executive team, to deliver a breakeven financial position in 2025/26, including a significant cost improvement programme of £31.4m, which if delivered, would be the highest ever savings made by the trust in-year. Finally, governance and fund raising arrangements were considered relating to the Trust's Charity.

NHS ConfedExpo 2025

In June I attended the annual NHS ConfedExpo 2025, in Manchester, which brought together over 5,000 health and care leaders for the UK's largest health and care conference, co-hosted by NHS England and the NHS Confederation. The event featured more than 150 sessions focused on key themes such as innovation,

workforce, health inequalities, integrated care, and digital transformation. Keynote speeches from NHS Confederation Chief Executive Matthew Taylor and Health Secretary Wes Streeting addressed the future of NHS care, funding challenges, and a forthcoming 10-Year Plan. We explored cutting-edge health technologies through exhibitions and live demonstrations hosted by Innovate UK, while also engaging in CPD-accredited workshops and valuable networking opportunities. ConfedExpo 2025 reinforced a shared commitment to collaboration, transformation, and sustainability in the future of health and care delivery.

Doncaster College Student Celebration Awards

I had the pleasure of attending this event as the Trust had been nominated for an award. The celebration honoured outstanding student achievements across a wide range of academic and vocational paths. Nominations recognised excellence in areas like employability, innovation, and course-specific success. The awards included categories such as Employer of the Year and Employability Award, underscoring strong partnerships and standout student performance. The ceremony celebrated both individual learners and organisational collaborators in education and training. I am incredibly proud to say that the Trust was awarded Employer of the Year: Employability. This accolade acknowledges the Trust's passion in providing T level student with a high-quality, inclusive experience that prepares learners for the world of work. A special thank you to everyone involved in arranging and supporting the T level placements, I agree with the sentiments of Doncaster College, the Trust is a shining example of what outstanding employer support looks like!

Non-Executive Director Vacancies

We have been out to advert for two NED vacancies for the Trust. As a Non-Executive Director, the successful candidate will contribute to shaping the future of DBTH by working alongside the executive team to review performance, guide long-term plans, and ensure the Trust remains financially sustainable. They will also support high standards of care, champion patient needs, and help strengthen relationships with system partners.

The shortlisting process has begun and interviews will be taking place over the coming weeks.

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 chaired the monthly South Yorkshire and Bassetlaw (SY&B) Acute Federation Board meeting and chaired and contributed to discussions at the SY&B Acute Federation Governor Event. Governors heard from a range of speakers on topics including improved access to surgery through perioperative care, the paediatric dental hub and learning from the pilot of paediatric virtual wards. Cathy Hassell, Managing Director of SY&B Acute Federation, shared highlights from the 2024/25 Annual Report and Lee Outhwaite, Chief Financial Officer of South Yorkshire's Integrated Care Board explained how the Acute Federation could support the system's financial stability.

Non-executive Director (NED) Champion Roles & Activity

Hazel Brand
In keeping with her role as NED Freedom to Speak Up (FTSU) Champion, Hazel Brand has attended a quarterly meeting with the Chief People Officer and FTSU Guardian. She has also sat on the interview panel to recruit to the Head of Charity post.
Hazel has represented the Trust at a number of Nottingham & Nottinghamshire Integrated Care Board meetings, informing members of developments at DBTH and also attended the SY&B Acute Federation governor event.

Kath Smart
Since the last report Kath has chaired the Board of Directors and Council of Governors meetings held in person at Doncaster Royal Infirmary. She has met with her executive buddy, Denise Smith, Chief Operating Officer and the Chair of the Board for her 2024/25 annual appraisal.

As part of her role as Audit Chair, and in preparation for the year-end meeting she has met with both the internal and external auditors on a number of occasions, to be informed of progress. There has also been a session on the Trust accounts, led by finance colleagues, which was attended by the Chair of the Board, Kath and fellow non-executive colleagues. Finally, alongside other Board members she has met with The Value Circle as part of the ongoing Well Led review.

Lucy Nickson
In her capacity as the Senior Independent Director (SID), Non-Executive Director, Lucy Nickson, has undertook the Chair's annual appraisal during the month of June.

Emyr Jones
Since the last Board meeting Emyr has chaired two interview panels, which successfully appointed two Consultant Paediatricians, with a special interest in neonatology and respiratory medicine and a Consultant Physician, with a special interest in elderly medicine.

The pre-meet for the Teaching Hospital Strategic Partnership Form took place, however, due to a number of apologies the meeting did not go ahead as planned.

Emyr also took the opportunity to join the Trust's doctors at the General Medical Council's Freedom to Speak Up training session and the Health Tech News Conference which explored digital opportunities to support elective recovery, analogue to digital programmes and digital and data strategy.

Jo Gander
During May and June, Jo has chaired interview panels for a Consultant Endoscopist and Interventional Radiologist and heard an appeal hearing. In her capacity as a non-executive Maternity Champion, she attended the regular Maternity Safety meeting.

Mark Bailey
Mark has participated in South Yorkshire ICB's Chief Finance Officer non-executive briefing with counterpart Finance & Performance Chairs, held to provide clarity on regional and individual trust level commitments for 2025/26.

As Chair of the Finance & Performance Committee Mark contributed to the Integrated Care Board and NHSE 'deep dive' event, looking at the Trust's operational and financial planning for 2025/26.

2507 - 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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Chief Executive's Report**			
Executive Sponsor:	Richard Parker OBE, Chief Executive			
Authors:	Emma Shaheen, Director of Communication & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1 - 7			

Executive Summary – Key messages and Issues
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.

Recommendations
The Board of Directors is asked to note the content of the report.

Healthier together – delivering exceptional care for all	
Patients	This report highlights the actions taken by the Trust to ensure patient experience is assessed and refreshed to ensure the delivery of safe, exceptional person-centred care.
People	A positive, engaged and supported workforce contributes to the delivery of good patient care.
Partnerships	The Trust works with partners and local community groups to support improvements in service delivery.
Pounds	To ensure efficient use of resources, spending public money wisely, whilst safe care remains a priority.
Health Inequalities	The Trust considers its activities, including clinical research, through the health inequalities lens and engages with patient and community groups to ensure mitigating actions limit variation in access.
Legal/ Regulation:	This report does not identify any legal or regulatory impact.
Partner ICB strategies	The Trust continues to work closely with partner Integrated Care Board in respect of financial management and service provision.

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Chief Executive Board Paper

July 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

This report presents updates categorised under our four strategic priorities.

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

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

AI stroke software helps to save lives

A year after its introduction at Doncaster and Bassetlaw Teaching Hospitals (DBTH), new stroke imaging software is helping to change the way patients are diagnosed and treated.

The system, called Rapid CTP, uses artificial intelligence to analyse brain scans in real time, helping specialists to identify which areas of the brain may be saved following a stroke.

The technology extends the treatment window from four and a half hours to up to 24 – giving more patients the chance to receive life-saving care.

Over the past 12 months, Rapid CTP has made a real difference to how DBTH diagnose and treat strokes, helping teams deliver faster, more accurate care.

The technology enhances clinical expertise giving our stroke specialists immediate insights that help them make confident, informed decisions when every second counts.

Audiology Services update

A comprehensive paper detailing the Audiology Recovery Programme and the progress which is being made is included within the Board pack. The paper outlines the significant work undertaken to improve services and the progress being made to date.

We are extremely sorry that the service has had not met our communities needs and we remain fully committed to learning from this to ensure the highest standards of care moving forward.

Diabetic eye screening pop-up clinic

A recent pop-up diabetic eye screening clinic at Bentley Pavilion demonstrates the Trust's commitment to reducing health inequalities and improving access to care within local communities.

Delivered in partnership with local GP practices and community organisations, the clinic targeted patients at higher risk of missing routine screenings, many of whom had not attended in several years, providing vital sight-saving checks close to home.

The initiative supported 36 residents and successfully screened for diabetic retinopathy.

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

DBTH Way in Action launched

A planned independent review of what it feels like to work at DBTH was launched in June – The DBTH Way in Action. The independent team from the *Valuecircle* are hoping to hear from as many colleagues as possible.

Colleagues can get involved by filling in a survey, sending information direct through a dedicated email, or taking part in planned, and in location, focus groups.

Continuing our journey towards Anti-Racism at DBTH

As a Trust, we remain steadfast in our commitment to tackling racism and fostering an inclusive and respectful environment for all.

Earlier this year, during Race Equality Week, we proudly joined other local organisations across Doncaster to reaffirm our collective pledge to take meaningful action against racism. This built on the commitment we made in 2024, alongside other South Yorkshire NHS partners, to adopt and implement the anti-racism framework developed by NHS organisations in the North West.

Since then, we've made positive progress in the three priority areas we committed to:

- ***Messaging:*** We are currently developing a video and an animation, working with Doncaster partners, to help colleagues better understand what anti-racism means in practice. These resources will also highlight the importance of allyship – the active support of those facing racism and other forms of discrimination – and how each of us can play a role in creating a fairer, safer workplace.
- ***Recruitment:*** In April, a Positive Action webinar brought together more than 30 colleagues from across our partner organisations. This session explored how organisations can take deliberate steps to improve diversity and remove barriers in recruitment processes. In addition, we are in the final stages of developing our DBTH inclusive recruitment practices e-learning for recruiting managers and will share these resources soon.
- ***Workforce Training:*** We are mapping existing training across organisations to identify areas of good practice and shared priorities. This work will help to shape practical actions to support learning and development for colleagues, with the aim of building confidence and understanding around race equity and inclusion.

These steps are part of an ongoing journey – and we know there is more to do. We are grateful to everyone who continues to contribute, challenge, and champion this important work. Together, we are building a culture where everyone feels valued, respected, and empowered.

Award winning DBTH

We were thrilled to be named *Large Employer of the Year* at the 2025 South Yorkshire Apprentice Awards in May, followed by further success in June when we were recognised as *Employer of the Year* at the Doncaster College Awards.

This recognition is not only a reflection of the hard work and dedication of our apprentices, mentors and wider teams, but also underlines our strategic commitment to developing local talent and investing in the future of our workforce. Apprenticeships are vital to ensuring we have the skills and expertise needed to provide outstanding care for our communities, now and in the years to come.

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

ICB updates

At their last Board meetings both South Yorkshire and Nottingham & Nottinghamshire ICBs set out the content of the NHS England Publication: Working together in 2025/26 to lay the foundations for reform.

The publication states that ICBs will be central to future plans as strategic commissioners, playing a critical role in realising the ambitions of the Ten-Year Health Plan; however, all ICBs will be required to reduce their management costs by 50%.

The role of the ICBs will be to maintain or invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management, and contracting. ICBs will also commission and develop neighbourhood health models.

Since these meetings it has been announced that ICBs will consolidate to 27 clusters, with South Yorkshire remaining independent and Nottingham and Nottinghamshire forming a cluster with Derby and Derbyshire and Lincolnshire ICBs.

Acute Federation Launch Paediatric Dental Surgery Hub in Doncaster

The South Yorkshire and Bassetlaw Paediatric Elective Surgical Hub Pilot launched in March, provides essential surgical care for children requiring exodontia (tooth extractions).

The hub is located at Doncaster and led by specialist consultants in paediatric dentistry from Sheffield.

The Paediatric Dental Surgery Hub is being piloted as an elective surgery provision to improve dental health for children in the region, to clear the backlog of children and young people waiting for surgery, and to reduce the wait times for dental intervention surgery in the future.

The pilot will run for 12 months, adding much-needed capacity to reduce wait times and to test the regional hub model, which could be implemented permanently in the future

The South Yorkshire & Bassetlaw Acute Federation Annual Report for 2024/25 is available on the following website:
https://syics.co.uk/application/files/5617/4738/7239/AF_Annual_report_2025_v7.pdf

Local Government elections – local council make-up

Doncaster - In the recent City of Doncaster Council elections, Reform UK secured 37 seats, Labour 12, and the Conservatives six. However, Labour's Ros Jones was re-elected as Mayor. Under Doncaster's directly elected mayoral model, the Mayor and her cabinet retain decision-making power on approximately 95% of key issues.

Nottinghamshire – Reform UK gained control of Nottinghamshire County Council, taking over from the Conservatives. In Bassetlaw eight seats were secured by Reform and one by the Conservatives. As a Trust we congratulate the successful candidates and look forward to working with the newly constituted councils to support our communities.

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

Financial position update

As we move further into the financial year, our Trust, like all NHS organisations, faces significant financial challenges, with rising demand for services, high national performance expectations, and the need to deliver a £31.4 million Cost Improvement Programme (CIP). Safety remains our priority, and we are clear that good financial management and high-quality care go hand in hand.

A comprehensive paper with detailed plans is included in this month's Board pack. Success will rely on collective effort, with colleague contributions – through initiatives such as the Bright Ideas Clinic – playing an important part in helping us meet this challenge and ensure long-term sustainability.

State-of-the-art Stroke Rehabilitation gym nears completion at Montagu Hospital

As part of a wider £1.4 million investment in stroke services, this cutting-edge facility will offer innovative therapies designed to enhance recovery for stroke patients across Doncaster and Bassetlaw, with the potential to benefit individuals further afield.

The building is nearing completion and is awaiting the installation of specialist rehabilitation equipment, including the Lexo gait trainer, which will be completed onsite by specialists arriving from Austria. The facility will then be ready to welcome patients from mid-June.

A first for the NHS, the advanced rehabilitation technology housed within the gym has been made possible thanks to generous funding from the Fred and Ann Green Legacy, alongside support from DBTH Charity.

2507 - BOARD LEARNING & REFLECTION

09:55

2507 - A5 RESEARCH & INNOVATION UPDATE

Information Item | Zoe Lintin, Chief People Officer | 09:55

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

15 minutes

REFERENCES

Only PDFs are attached

A5 - Research & Innovation Update (1).pdf

Research and Innovation Update

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

Our Trust vision

At Doncaster and Bassetlaw Teaching Hospitals (DBTH), our vision is simple but powerful:

Healthier together – delivering exceptional care for all.

This vision shapes everything we do, driving our ambition to deliver the best outcomes for patients while creating a supportive, respectful, and empowering environment for colleagues.

To help us achieve this, we're guided by our values and behaviours, known as '**We Care**', which are brought to life through living the '**DBTH Way**'.

We care

The DBTH Way

Our Strategic Priorities

Patients

We deliver safe, exceptional, person-centred care.

People

We are supportive, positive and welcoming.

Partnerships

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

Pounds

We are efficient and spend public money wisely.

Our Strategic Ambitions

Provide the best care environments

We are improving care spaces by modernising facilities, enhancing community care, and reducing pressure on DRI, with a focus on funding, safety, and service integration.

Tackling health inequalities

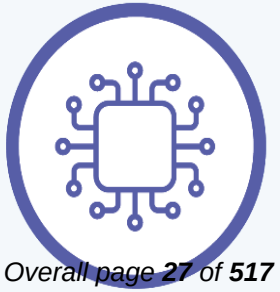
We prioritise health equity through prevention, partnerships, training and targeted support for underserved communities.

Becoming a leading centre for research and education

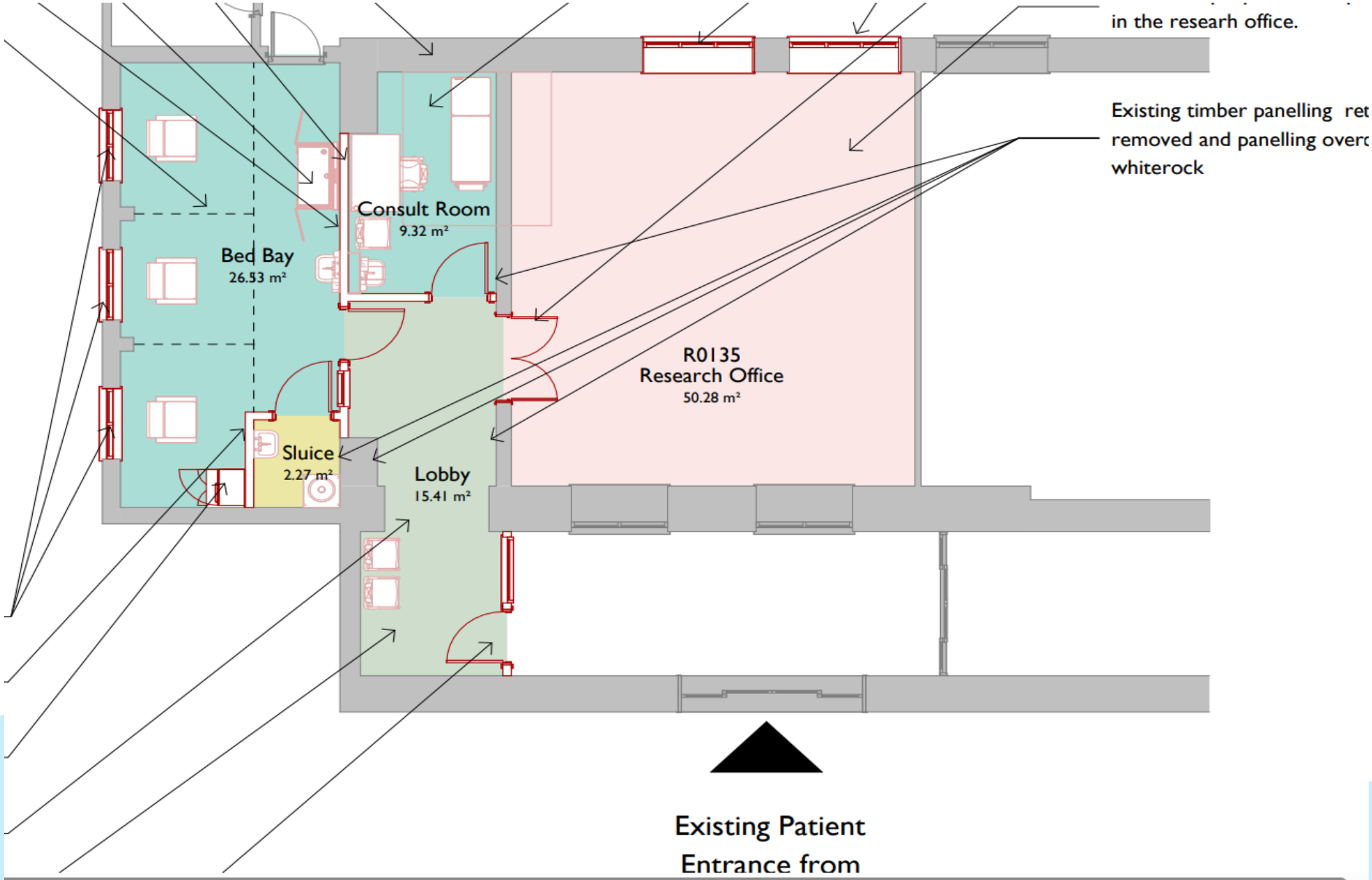
We aim to enhance patient care, expand student placements, invest in facilities, and grow clinical trials and funding.

Becoming a digitally enabled and mature organisation

Intergrating technology and innovation to improve care, enhance support for colleagues and improve efficiency through an electronic patient record, AI and shared records.



Maximising opportunities for R&I activity:



Building on our strengths:

Rheumatology:

- Existing track record in commercial research:
  - Requests to over recruit from Sponsors
  - Patients referred outside of our region
  - Preferred partner in our region

- Dr Yee, Consultant Rheumatologist selected for Chief Investigator for a commercial study

- Ambition to grow Rheumatology research to compliment commercial research track record
  - Limited research activity within the region
  - Better treatment options in diseases that have significant burden for both patients and the NHS

Quote from Dr Yee:

"For DBTH, research puts us at the forefront of best practice and supports continuous improvement in skills to provide the best care. For patients research provides options for high quality care that they wouldn't get on the NHS. "

Quote from Amy:

"Being a part of research makes me feel good as I've been diagnosed with a condition that can only be managed and can't be cured. I don't have many treatment options and thinking about the future can sometimes be very upsetting. I feel that anything I do that can help others in my position can only be a good thing. "

Quote from Joy:

"I hope that in the future it will help other people even if it doesn't help me right now. Research is very interesting and has taught me a lot about my conditions and clinical trials. "

Growing Innovation:

Innovation Expedition:

- Workshop designed to develop innovation understanding and clinical entrepreneurs
- Two groups developing innovation projects:
  1. Enhanced and updated patient information sheets for post haemorrhoidectomy (Patient Information Leaflet Enhancement Service PILES)
  2. Autoinjectable vitamin B12 pen
- Next steps:
  - Medipex to support with market analysis and value proposition for PILES
  - Patient and stakeholder involvement
  - Commercialisation route development

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Questions and feedback

2507 - B PATIENTS

10:10

2507 - B1 AUDIOLOGY SERVICE UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

B1 - Audiology Service Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Audiology Service Update**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive Dr Nick Mallaband, Acting Executive Medical Director			
Authors:	Claire Jones, Audiology Recovery Programme Lead			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	~~Information~~	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	BAF 1, 2, 3, 4 & 6			

Executive Summary – Key messages and Issues

The Board of Directors received a report in May 2025 providing an update on 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 an 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.

The Trust is making significant 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. To seek assurance on the improvements and mitigations that have been made since the external review in January 2024, an assurance visit will take place over the summer with colleagues from NHSE and the ICB.

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.

Since the last Board update, further harm reviews have been completed by NHS England for our paediatric recall cohort. We are saddened to report a case of severe harm has been identified. We are sorry this has occurred and have undertaken Duty of Candour discussions with the family. Further details are provided within the report alongside the wider recall cohort outcomes.

The Trust remains committed to addressing the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically and are sorry for the impact this has caused individuals.

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

Recommendations

The Trust Board is asked to review and discuss the content of the report.

Healthier together – delivering exceptional care for all

<table>
<tr><td>Patients</td><td>This report highlights the actions taken by the Trust to recover and improve its audiology provision to be in a position to reinstate a safe service.</td></tr>
<tr><td>People</td><td>This report highlights the Trust’s commitment to support its people through training and development and investment in equipment and infrastructure.</td></tr>
<tr><td>Partnerships</td><td>This report identifies how the Trust is working in partnership to support the recovery and delivery of the audiology service through the provision of mutual aid, use of insourcing, outsourcing and with the support of subject matter experts.</td></tr>
<tr><td>Pounds</td><td>To ensure the Trust works efficiently and spends public money wisely.</td></tr>
<tr><td>Health Inequalities</td><td>To mitigate the impact due to service limitations.</td></tr>
<tr><td>Legal/ Regulation:</td><td>This report does not identify any legal or regulatory impact.</td></tr>
<tr><td>Partner ICB strategies</td><td>There remains a system and national focus on audiology services and partner ICBs are aware of the work of the Trust.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Executive Team, Trust Leadership Team, Quality Committee & Finance and Performance Committee. Various dates in 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>• 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</td></tr>
<tr><td>Is this in line with Current risk appetite

YES/NO</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
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Context

As previously reported to the Board of Directors in May 2025, the audiology service across DBTH has offered a limited provision to our patients since September 2024, as we undertake a process of improvement. Since the last update it is positive to report that a number of elements of the audiology service recovery plan are now delivering and we can report an improvement in the number of patients that we are seeing across many parts of the audiology pathway. Whilst we are not currently able to offer the complete end to end paediatric audiology pathway, it is felt that the service we are now offering shows a marked improvement 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 May 2025.

The Audiology recovery programme

To enable the audiology service to recommence, there are a number of areas of the service that need specific focus [Estates, Digital, workforce etc.]. Each area has been allocated to a work stream and each week separate workstream meetings are held, where all of the related issues are identified, discussed and resolved. The work streams form the core of the audiology recovery programme, which is striving to deliver a safe and effective audiology service for patients and families to access.

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 the elements of the improvement work come to fruition. In the month of April 1409 adults and children were

seen were seen in our audiology service through a mixture of insourcing activity and our own DBTH activity. This compares to 1358 in May 2025 [there was a slight dip in activity in May due to the close down of the service for three days to allow the data migration to take place on to the new AuditBase system]. The projected number for June is 1420.

The audiology recovery programme consists of six key workstreams, see below. Each workstream has both an operational lead and an executive lead and progress in each of the workstreams are reported into the bi-weekly audiology recovery group meeting, chaired by the Audiology programme recovery lead. Executive oversight is maintained via regular meetings between the programme recovery lead and Deputy Chief Executive and Acting Executive Medical Director. Progress is reported to external stakeholders into the bi-weekly Paediatric Audiology Integrated Care Board [ICB] meeting, and the Adults audiology ICB meeting chaired by the ICB Deputy Director of Nursing.

Engagement with our patient stakeholder groups continues and in the month of May, we have met with the Doncaster Deaf Society, a local Audiology Action Group and the Doncaster Deaf Trust, where we engaged with young people who shared their experiences.

Harm reviews update – paediatric audiology

To date 62 cases have been reviewed by NHS England Subject Matter Experts (SMEs) and levels of harm allocated out of a total of 125 previously reported. There are 29 children that were not brought to appointments, in all these cases we have followed the Trust's *was not brought* policy. 34 children are yet to be reviewed due to pathways of care yet to be completed.

Of the 62 children reviewed for harm the outcomes to date are:

41 - no harm
10 - low harm
10 - moderate harm
1 - severe harm

Duty of Candour part two (second contact with families following harm review outcomes) has been commenced in all cases and followed up formally 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.

Severe harm has sadly been identified in one child as a result of a lack of appropriate hearing testing. The child is profoundly deaf in one ear and has mild loss in the other ear. Due to the delay in diagnosis, the child has poor access to sounds and speech and now has a speech delay. As a result of this the child was fitted with bilateral hearing aids. The child is under the care of the Speech and Language Therapy Department at DBTH and is receiving support and Duty of Candour has been undertaken with the family.

We are sincerely sorry for the harm that has been confirmed for the children reported here and the impact that this will have on both the children and their families. Lessons learned will be shared and applied across the service for the future.

Mutual aid update

The provision of mutual aid [support from other hospitals to see our patients] continues to be supported by the South Yorkshire and Bassetlaw Acute Federation, and we have agreed pathways for the most urgent activity to be seen at other Trusts.

Sheffield Children's Hospital [SCH] have been supporting us with seeing children who require recall appointments and support with baby fittings, which are particularly time critical, and urgent repairs. In the last three months SCH have seen 284 children who are classified as new referrals for pre-school and school age hearing assessments. From the end of May, SCH are providing ongoing support with urgent baby fittings and urgent paediatric repairs only to ensure Sheffield children referred to SCH are being seen in a timely manner. The position will be reviewed regularly.

The Rotherham Foundation Trust are undertaking specialist activity in the assessment of patients who require Bone Anchored Hearing Aids and have accepted urgent adult referrals for patients requiring immediate care.

Clinical Workforce update

Our paediatric audiologists are currently attending SCH to undertake their remaining competency assessments and the remaining adult audiologists will be assessed on site at DBTH by a visiting adult audiology SME. It is anticipated that this process will complete in the late summer.

The competency assessments will be complemented by additional input from a senior training audiologist from SCH in June and 2 days at Leeds University over the summer.

Satisfactory completion of the above requirements will provide confidence that all audiologists are delivering practice that meets the National British Association of Audiology standards.

Digital update

The new digital AuditBase audiology system is now fully integrated into the audiology service across the Trust, replacing the RioMed system which had been installed last year.

The process to 'go live' was delivered ahead of the planned date. The conversion and integration of historical data from the previous Practice Navigator system was a success. Following the integration phase there were 524 patient records that required manual merging in to the system, this piece of work is now complete.

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.

Infrastructure and Estates update

Estates work commenced at the start of February 2025 on the three paediatric audiology rooms in the Doncaster Royal Infirmary paediatric outpatients department, to modernise and incorporate the required standard of soundproofing and observation spaces. The works in this area were completed on time. This now enables paediatric assessments to be carried out safely and effectively.

Remedial work at Bassetlaw Hospital has taken place resulting in one main soundproofed room, that meets the guidelines enabling both adult and paediatric work to be undertaken in this space and a second room that will be utilised for repairs and fittings that now has more extensive sound treatment. The new rooms

will be handed back to the service on 19th June and acoustic measurements and calibration, to provide the optimum sound proofed environment, will take place on the 24th June to enable the rooms to fully utilised.

Improvements to one of the DBTH Ear, Nose and Throat (ENT) outpatient audiology booths commenced on 14th April 2025. These works are now fully completed and the new testing booth is fully operational.

Data update

Both the paediatric and adults waiting lists have been validated. The paediatric waiting list has been classified into age ranges and by priority-code [clinical priority]. The adult waiting list has been split by category [diagnostic, fitting etc] and priority-coding is included for each cohort.

The next phase of work is to develop a reliable Patient Tracking List [PTL] for both the adults and paediatrics waiting list. This is being done with external independent support from the NHSE Intensive Support Team. When complete, the PTL will enable a clear overview of the capacity in the audiology service and the demand placed upon it. The PTL will also crucially allow for the audiology service to manage each patients' treatment pathway to ensure that they receive timely care by helping to manage waiting times, prioritise patients and ensure efficient resource allocation.

NHSE and ICB assurance visit to Audiology Services at DBTH

Following the review of the paediatric audiology service in January 2024 and the associated feedback, the ICB and NHSE are undertaking a focussed visit to the paediatric audiology service at a point over the summer. The purpose of the visit is to focus on the immediate mitigations identified during the enhanced improvement phase to ensure a safe and quality led service.

The scope of the visit will include a review of the recovery improvement areas covered above in this report.

The audiology service team are continuing to work hard to ensure that full-service provision is restored for the populations of Doncaster and Bassetlaw as soon as possible. We remain deeply sorry for the impact on patients and families of the disruption to our service and apologise for the long waiting times that so many of our patients continue to endure.

2507 - B2 MATERNITY & NEONATAL UPDATE

Decision Item | Karen Jessop, Chief Nurse | 10:20

Lois Mellor, Director of Midwifery

10 minutes

REFERENCES

Only PDFs are attached

- B2 - Maternity & Neonatal Update.pdf
- B2 - Appendix 1 - PMRT Q4.pdf
- B2 - Appendix 2 - SBL.pdf
- B2 - Appendix 3 - Neonatal Medical Workforce Plan.pdf
- B2 - Appendix 4 - ATAIN Q4.pdf
- B2 - Appendix 5 - Maternity Dashboard.pdf
- B2 - Glossary of Terms - Maternity.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Maternity & Neonatal Update**			
Executive Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse, Paediatrics Danielle Bhanvra, Deputy Director of Midwifery			
Appendices:	Appendix 1 - PMRT Q4 Appendix 2 - SBLs Q3 Appendix 3 - Neonatal medical workforce action plan update Appendix 4 - ATAIN Q4 Appendix 5 - Trust Quality Metrics			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF6, BAF7			

Executive Summary – Key messages and Issues

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. Confirmation has now been received that the service achieved 10/10 for CNST year 6.

Recommendations

For the Trust Board of Directors to take assurance from the detail provided within this maternity and neonatal safety report and to record in the Trust Board minutes to provide evidence for the maternity incentive scheme the following:-

- Reviewed and approved the Q4 Perinatal Mortality Report
- Reviewed and approved SBLs Q3
- Reviewed and approved neonatal & nursing medical workforce progress updates against last year's plan
- Reviewed and approved Q4 ATAIN

- Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce have not been met and approved the neonatal medical workforce action plan progress update against last year's plan
- Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal nursing workforce have not been met and approved the progress update against last year's plan
- 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.
- Discussed the midwifery workforce biannual report (separate paper)
- Noted that 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.
- Noted that 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.

Healthier together – delivering exceptional care for all	
Patients	*We deliver safe, exceptional, person-centred care*
People	*We are supportive, positive, and welcoming.*
Partnerships	*We work together to enhance our services with clear goals for our communities.*
Pounds	*We are efficient and spend public money wisely*
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	

Assurance Route	
Previously considered by - including date:	The Maternity and Neonatal Safety Quality Group Divisional Governance Meetings
Any outcomes/next steps / time scales	Support to continue improvements in maternity & neonatal service, and achieve year 7 CNST standards
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Bi Monthly Board Report
April / May 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

2.1 Stillbirths and late fetal loss > 22 weeks

April 2025 we have had 0 stillbirth and 0 late fetal loss that are reportable to MBRRACE
May 2025 we have had 1 stillbirth, 0 late fetal loss that are reportable to MBRRACE

2.2 Neonatal Deaths

April we have had 1 late neonatal death that is reportable to MBRRACE
May we have had 0 neonatal deaths

2.3 Perinatal Mortality Review Tool (PMRT) April and May 2025

May	Stillbirth	Antenatal	July meeting for discussion
May	Neonatal death (late)	Neonatal	July meeting for discussion

2.4 Learning from PMRT reviews

Issues
Discussions about timing of birth for diabetic women are being actioned by the LMNS and taking to maternal medicine and diabetic networks for further discussion.

Learning

Q4 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	21
Current active cases	0
Exception reporting	0

There were no cases referred to MNSI in April 2025 and May 2025.

3.2 Reports Received since last report

None.

3.3 Current investigations

None.

3.4 Coroner Reg 28 made directly to the Trust

None.

3.5 Maternity Patent Safety Incident Investigations (PSII)

There were no PSII in April or May.

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

The service continues to work on delivering the single delivery plan by March 2026, which remains on track.

There is a continued focus on improving the culture and relationships in the maternity service. The joint general medical council and nursing and midwifery council workshop was well received with attendees from the medical and midwifery professions. Multidisciplinary training continues across the maternity, neonatal and theatres services on a monthly basis.

The maternity self-assessment tool is reviewed on a quarterly basis. Work is ongoing and there is continued progress.

5. Training Compliance for all staff groups

Training figures as at April and May 2025 are detailed below:-

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

April 2025

Staff Group	CA Compliance April 25	Study Day Compliance April 25
90% of Obstetric Consultants & SAS Drs	**89.47%**	**89.47%**
90% of all other obstetric doctors contributing to the obstetric rota	**92.31%**	**92.31%**
90% of midwives	**89.80%**	**90.20%**

May 2025

Staff Group	CA Compliance May 25	Study Day Compliance May 25
90% of Obstetric Consultants & SAS Drs	**89.47%**	**89.47%**
90% of all other obstetric doctors contributing to the obstetric rota	**100%**	**100%**
90% of midwives	**89.34%**	**90.57%**

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

Table 3 & 4 - PROMPT figures

April 2025

Staff Group	Prompt Compliance April 25
90% of Obstetric Consultants & SAS Drs	**100%**
90% of all other obstetric doctors contributing to the obstetric rota	**73.53%**
90% of midwives	**84.90%**
90% of maternity support workers and health care assistants	**81.94%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**60%**
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	**53.33%**

May 2025

Staff Group	Prompt Compliance May 25
90% of Obstetric Consultants & SAS Drs	**100%**
90% of all other obstetric doctors contributing to the obstetric rota	**72.97%**
90% of midwives	**87.30%**
90% of maternity support workers and health care assistants	**80.56%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**66.67%**
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	**53.33%**

Table 5 & 6 - NLS figures

April 2025

Staff Group	NLS Compliance April 25
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**94%**
90% of neonatal junior doctors (who attend any births)	**96%**
90% of neonatal nurses (Band 5 and above who attend any births)	**95%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification	**100%**
90% of midwives	**80%**

May 2025

Staff Group	NLS Compliance May 25
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**94%**
90% of neonatal junior doctors (who attend any births)	**96%**
90% of neonatal nurses (Band 5 and above who attend any births)	**94%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification	**100%**
90% of midwives	**79.51%**

PLEASE NOTE - Due to staffing and clinical need a number of training session have had to be cancelled, this has been reflected in the training compliance numbers in April 2025 and May 2025. Additional sessions have been added to the schedule for the rest of the year to ensure training compliance returns to over 90%.

6. Safety Champion meetings

A meeting was held on 22nd May 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 where the neonatal unit and central delivery suite were visited. The areas were clean, tidy and calm. The staff were positive about working at DBTH.

6.2 Concerns raised by the visit and staff

The teams were positive and engaged with the visit, there were no concerns raised.

6.3 Concerns raised by service users

Ongoing work continues with the LMNS and ICB as the Trust remains without an MNVP chair and is working closely with the LMNS to ensure that the user voices is heard. This was escalated in line within CNST requirements to the LMNS Collaborative Board held on 20th May 2025. The MNVP strategic lead shared that a DBTH MNVP meeting had been well attended and is currently reviewing the current work plan with updates for 25/26.

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

The maternity & neonatal culture improvement plan following the SCORE survey has reviewed and progress continues with the action plan. Emotional thriving remains the focus for the action plan.

The Divisional leadership team (including the quads) are undertaking monthly visits to clinical areas, and is in place for current financial year. The neonatal and maternity teams continue to work closely on all action plans and ongoing plans.

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 (SBLv3)

7.1 Update

The SBLv3 was launched in May 2023 and represents Safety Action 6 of the Clinical Negligence Scheme for trusts.

Ongoing quarterly review meetings with the LMNS continue. Following these meetings the LMNS has confirmed that it is assured that all best endeavours and significant progress is being made in line with the locally agreed improvement trajectories.

Please see the attached Appendix 2 Board report for details.

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

Confirmation has now been received that the service achieved 10/10 for CNST year 6. Publication of Year 7 was released on 2nd April 2025.The new requirements have been reviewed and work is ongoing to work towards achieving them.

9. The number of patient safety events logged graded as moderate or above

April-12
10 were reported due to unexpected admission to the neonatal unit and 2 were 3rd degree tears

May - 16
10 were reported due to unexpected admission to the neonatal unit, 5 were 3rd degree tears, and 1 was an off pathway births (born at 25 weeks at DRI) this will follow the normal process and will a full review at MG PSERP including representation from the neonatal team and then within the LMNS PQSF meeting.

All cases have been reviewed within the patient safety incident review framework (PSIRF) process. 4 cases were discussed at LFPSE panel 3 cases had no further learning response

required, 1 case requires MDT. No immediate concerns have been identified from all other reviews, and learning is shared within the maternity and neonatal services.

10. Safe Maternity & Neonatal Staffing

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

The bi annual maternity staffing report is included with this update as a separate paper covering the staffing and safety issues related to midwifery.

Midwifery staffing
Midwifery staffing remains stable, and currently the service has 211.60 WTE contracted midwives (Band 3-7), against 221.07 WTE recommended by birthrate+ (after 90:10 skill mix).

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

All rotas were planned to have a supernumerary coordinator on every shift for April 2025 and May 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 88% recruited with 85% 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 74%. In April there were 6 shifts at DRI and 1 at BDGH below BAPM standards due to no co-ordinator and in May there were 3 shifts at DRI and 0 at BDGH due to no co-ordinator.

Below is an update on our compliance to BAPM Nurse staffing standards. As we do not meet the standards for a coordinator at Bassetlaw, Qualified in Speciality (QIS) Ratio on NNU (DRI) or for Allied Health professional as outlined in the 4 year proposal submitted to the board in 2025 we will continue to provide an update on progress to the Trust Board.

In year 6 a business case was 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 are currently out to advert. We have had challenges recruiting QIS nurses which is a national problem due to training ceasing during covid. To support increased QIS in the long term we have recruited band 5 to support and develop our own but this will affect our QIS ratio and adherence to BAPM standards over the next 2 years.

Below is a summary of the 4 year plan with a progress update;

Year	Investment	Progress Update
2023/2024	Increase clinical roles to 25% uplift at SCBU and NNU	Business case approved - recruitment in progress ongoing
2024/2025	Quality roles on SCBU and coordinator at night NNU	Business case approved – Quality roles appointed into & coordinator brick now on Eroster.
2025/2026	24 hr coordinator for SCBU at night	The data regarding activity, acuity is being reviewed and a briefing paper will be developed by the end of July to support the discussion and agree the next steps. 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'

For year 7 the action plan from year 6 will continue with progress updates approved by the Trust Board and shared with the LMNS & ODN. It is also registered on the risk register and is monitored weekly via the patient safety meeting, monthly via the divisional governance meeting and bi monthly at the MNSQG.

The Trust Board is asked to formally record in the Trust Board minutes that it does not meet the relevant BAPM recommendations of the neonatal nursing workforce and agree the progress update on the previously agreed action plan.

10.2 Obstetric Staffing

2 new consultant obstetricians are in the process of being 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 April / May 2025 there were no episodes of non-compliance. The Trust is required to audit from February 2025 to August 2025.

Trusts are required to audit any 3 month period from February 2025 to 30 November 2025 to ensure they are complaint with consultant attendance in person to the clinical situations listed in the RCOG workforce document 2022 and must be compliant for at least 80% of applicable situations. The Trust has audited March 2025 – May 2025 and was 88.33% compliant in meeting the standard. The episodes where attendance has not been possible are being reviewed at unit level as an opportunity for departmental learning with agreed strategies and actions plans to prevent further non-attendance.

10.3 Neonatal medical staffing

A review has been undertaken against the year 7 requirements and the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce and the requirements have not been met at DRI due to not being funded for a separate dedicated night SHO for neonates. The action plan developed and agreed in year 6 has been reviewed and updated in light of this which is attached in Appendix 3. The Trust Board is asked to formally record in the Trust Board minutes that it does not meet the relevant BAPM recommendations of the neonatal medical workforce and agree the updated action plan / progress update.

10.4 Anaesthetic Workforce

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

10.5 Red Flags

The red flags are recorded on the birth rate+ ® app on a four hourly basis and for April and May 2025 have been recorded below:

Table 7 & 8 - DRI

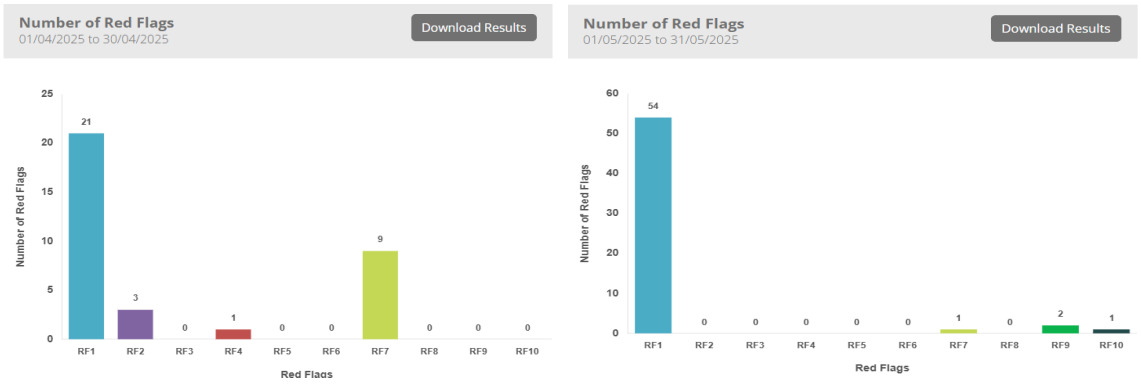


Table 9 & 10 - BDGH

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

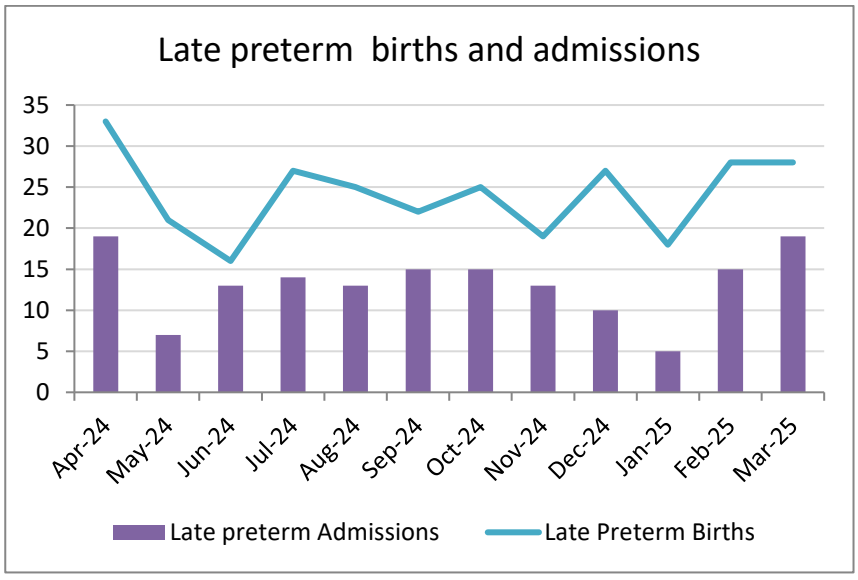
The service has an annual plan that has been developed in conjunction with the MNVP, and maternity user voices are collated via different groups and support from the LMNS MNVP leads.

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 and 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 the 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.

12.2 DBTH transitional care

The transitional care project progress has been shared at the Board Safety Champion meeting in May 2025, and governance meetings. The neonatal and maternity services are working together to improve the provision of transitional care. Areas have been identified on both sites to create transitional care areas. A meeting took place in April to progress the project and scope the resources required to commence the service by Q4 of 2025/26.

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, no current gaps identified for tier 3 awaiting current tier 2 survey results
Increasing scanning requirements that are greater than current capacity	Plans in place for all women who require one. Requests for scans reviewed for clinical need, and MDT discussions	Review of capacity vs demand, and options discussed between CSS & Children's & Families Division

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 work to replace the roof is underway. 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 neonatal representative came to visit both neonatal units. They praised the strong leadership and positive culture as staff felt able to raise concerns. The estate was flagged as noted above as we cannot accommodate beds for parents at the cot side. They noted the positive approach to staff development. It was noted that the provision of a sim card for parents to aid involvement in care was not consistent across maternity and neonates. This is being addressed as part of the involvement in care and inclusion in the ward round.

15. Perinatal Metrics

The Trust maternity dashboard has been included in Appendix 1.

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
- Neonatal deaths
- 3rd and 4th degree tear

Metrics with a significant improvement:

- HIE
- Stillbirth rate

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:

- Bi annual midwifery report (separate paper)
- Q4 Perinatal Mortality Report (Appendix 1)
- Q3 SBLv3 report (Appendix 2)
- Neonatal Medical Workforce Action plan progress update against last year's plan (Appendix 3)
- Neonatal nursing workforce progress update against last year's plan
- Q4 ATAIN Report (Appendix 4)

And formally record that:

- the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal nursing & medical workforce have not been met and approved the neonatal nursing & medical workforce progress updates against last year's plan
- 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 4 period: 01/01/2025 to 31/03/2025

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 30th 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 fourth quarter of 2024-2025, from 1st January 2025 to 31st March 2025 there have been **5** stillbirths (4 in the antenatal period of which one family lost twins, and 1 intrapartum stillbirth all at DRI) and **1** medical termination of pregnancy (MTOP) for fetal abnormality above 24 weeks gestation (also at DRI). Of this time period, there were a total of 1,039 births, of which 713 births at DRI and 326 Births at BDGH.

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

This provides a trust adjusted stillbirth rate of **4.81 per 1000 births for this quarter 4**, from 24 weeks gestation; which is an increase from last quarter (quarter 3 of 2024-2025 adjusted stillbirth rate of 0.96 per 1000 births).

Combining the figures from quarters 1, 2, 3 and 4 of 2024-2025 the rolling adjusted stillbirth rate is **2.79** per 1000 births. This equates to 12 stillbirths from 24 weeks of gestation (total births for this period is 4,300 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 fourth quarter of 2024-2025, from 1st January 2025 to 31st March 2025 there has been **1** Neonatal and post-Neonatal deaths of the 1,039 births across both sites. 713 births being at DRI and 326 Births being at BDGH.

This provides the Trust with a stabilised and adjusted rate for this quarter 4 of 2024-2025 of **0.96** per 1,000.

Combining the figures from quarters 1, 2, 3 and 4 of 2024-2025 (excluding the deaths under 22+0 and MTOP resulting in NND) the rolling adjusted neonatal and post-neonatal deaths rates of 2 equates to a rate of **0.47** per 1000 births from 22 weeks of gestation (total births for this period is 4,300 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.

CNST Year 7 – Safety action 1

Requirements	CNST requirement compliance	CNST Trust Compliance
a) All eligible perinatal deaths from 1st December 2024 should be notified to MBRRACE-UK within seven working days.	**100%**	**100%**
b) For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1st December 2024 onwards	**95%**	**100%**
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**95%**	**100%**
	75%	**100%**
	50%	**100%**
d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1st December 2024.		**Q3 presented to Trust Board in March Q4 detailed within this report will be reported at Trust Board in July**

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 7

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
7	1	4	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
3	2	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

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							
	36-45			4*				4
	46+							
Smoking status	Never smoked		1	2				3
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker			2*				2
	Unspecified							
Ethnicity	White			4*				4
	Black		1					1
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4		1	4*				5
	5-7							
	8-10							
	Not available							
Employment	Employed		1					1
	Not employed			3*				3
	Student							
	Homemaker			1				1
	Sick/Disabled							
	Unknown							
Marital status	Married / Civil Partner		1					1
	Single			1				1
	Cohabiting			3*				3
Learning or communication difficulties	Yes							
	No		1	4*				5

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		1					1
	26-35							
	36-45							
	46+							
Smoking status	Never smoked							
	Non-smoker stopped before conception		1					1
	Non-smoker stopped after conception							
	Smoker							
Ethnicity	White		1					1
	Black							
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4							
	5-8		1					1
	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	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	2	0	0	0	2
Antepartum stillbirths	*0*	*0*	*2*	*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	1	0	0	0	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	1	2	0	0	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	1	2	0	0	0	3
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	2	0	0	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	1	2	0	0	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	0	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	1	0	0	0	0	1
Neonatal care re-orientated	0	0	0	0	0	0	0

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

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 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	2	100% (2)
Vice Chair	0	0%
Admin/Clerical	3	100% (2)
Ambulance Team	0	0%
Bereavement Team	4	100% (2)
Community Midwife	0	0%
External	2	100% (2)
Management Team	4	100% (2)
Midwife	16	100% (2)
MNVP Lead	0	0%
Neonatal Nurse	4	100% (2)
Neonatologist	14	100% (2)
Obstetrician	26	100% (2)
Other	0	0%
Risk Manager or Governance Team	5	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	1	100% (1)
Vice Chair	0	0%
Admin/Clerical	3	100% (1)
Ambulance Team	0	0%
Bereavement Team	3	100% (1)
Community Midwife	0	0%
External	1	100% (1)
Management Team	2	100% (1)
Midwife	17	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	2	100% (1)
Neonatologist	7	100% (1)
Obstetrician	15	100% (1)
Other	1	100% (1)
Risk Manager or Governance Team	2	100% (1)
Safety Champion	1	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	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	2	0	0	0	2
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	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	2	0	0	0	2
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	1	0	0	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the 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	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 baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	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	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	**0 causes of death out of 0 reviews**
Stillbirths	**2 causes of death out of 2 reviews**
	The cause of death was undetermined
	The cause of death was undetermined
Neonatal deaths	**1 causes of death out of 1 reviews**
	Extreme Prematurity
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 baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out	2	Growth USS was performed later than planned as patient DNA's the earlier appointment. All scans were requested and booked in line with guidance
This mother booked late. Are there any organisations to consider in relation to her booking late?	2	Multiple booking appointments were given and DNA's by the patient. DNA's were managed appropriately and in line with local and national guidance
This mother booked late. Did this affect her care?	2	Multiple appointments provided for patient to attend. Pulled patient information from archived pregnancy noted to assist with planning pregnancy this time
This mother's progress in labour was monitored on a partogram but the partogram was only partially completed	2	Audit a wider group of patients and review the use of the partogram, is this isolated to fetal losses or is there wider learning regarding completion of the partogram

*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
Although indicated this mother was not offered chromosome analysis for her baby	2	Communications to be sent to all staff regarding the criteria for cytogenetics
		No action entered
This mother's risk status during labour was not assessed during the course of her labour	2	Was risk assessed on admission to Delivery Suite. Laboured quickly and therefore no risk assessment performed in labour. Cares were appropriate and
		would not impact the outcome.
This mother's progress in labour was not monitored on a partogram	1	Audit a wider group of patients and review the use of the partogram, is this isolated to fetal losses or is there wider learning regarding completion of the partogram

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

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

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Patient Factors - Social Factors – Lifestyle (smoking/ drinking/ drugs/diet)	1	This mother booked late. Did this affect her care?
		This mother booked late. Are there any organisations to consider in relation to her booking late?
		This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out
Patient Factors - Social Factors – Lifestyle (smoking/ drinking/ drugs/diet)	1	This mother booked late. Did this affect her care?
		This mother booked late. Are there any organisations to consider in relation to her booking late?
		This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out
Task Factors - Guidelines, Policies and Procedures	1	This mother's progress in labour was monitored on a partogram but the partogram was only partially completed
Task Factors - Guidelines, Policies and Procedures	1	This mother's progress in labour was monitored on a partogram but the partogram was only partially completed

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	**11-Mar-25**
ICB Accountable Officer	**Cathy Winfield, Executive Chief Nurse**
Trust Accountable Officer	**Karen Jessop, Chief Nurse**
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.

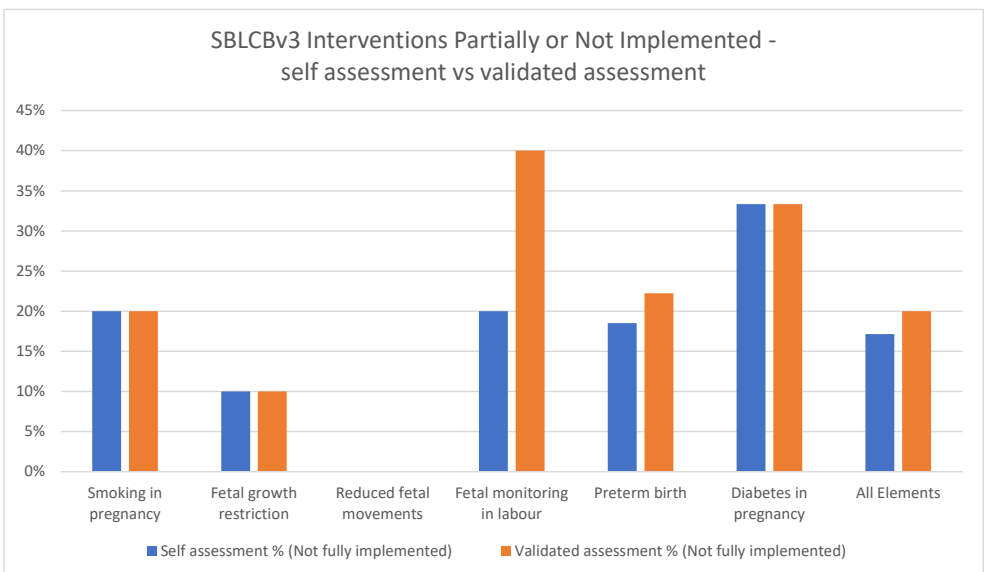
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

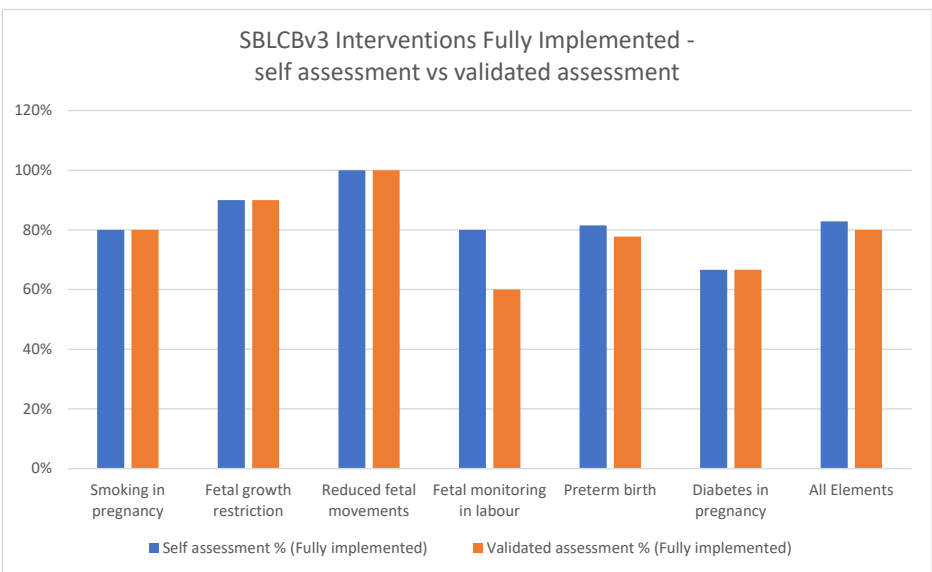
Implementation Grading

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**	90%	**Partially implemented**	90%	CNST Met
Element 3	Reduced fetal movements	**Fully implemented**	100%	**Fully implemented**	100%	CNST Met
Element 4	Fetal monitoring in labour	**Partially implemented**	80%	**Partially implemented**	60%	CNST Met
Element 5	Preterm birth	**Partially implemented**	81%	**Partially implemented**	78%	CNST Met
Element 6	Diabetes	**Partially implemented**	67%	**Partially implemented**	67%	CNST Met
All Elements	TOTAL	**Partially implemented**	83%	**Partially implemented**	80%	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.	March 25 - discussed: % of women referred who set a quit date (1c) is around 12% target > 30%. With variation between ABL and RDaSH . Target achieved for 1e (quit at 4 weeks) but to note ABL are low
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	March 25 - discussed at meeting. Ongoing audit evidence required to demonstrate ongoing implementation. Plan in place for RDASH and expect to present for Q4. ABL considering same approach.
1.8	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	March 25 - remains partially implemented. Note progress in training compliance (now 79%) 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.	March 25 - remains partially implemented. Note progress in training compliance (now 77%) 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.
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	Partially implemented	Partially implemented	Fully meets standard - continue with regular monitoring of implementation.	March 25 - fully implemented during 23/24. Past 2 quarters <90%, therefore amended to partially implemented. New failsafe process in place. To review in Q4.
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.	March 25 - gap training compliance dip noted and <95%. Ongoing training plan, with trajectory to 95% in 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. March 25 - note data refers to Q2, confirm that audit has been done
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 2

Element 3	**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.	March 25 - had previously requested risk assessment on admission
	4.3	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Fully implemented during 23/24. March 25 - discussed changing audit process - now reviewing hourly
	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.	March 25 discussed - 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.	March 25 - discussed. Further decline from 50% in Q2 to 40% in Q3
	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. March 25 - no off-pathway deliveries in Q3.
	5.20	Partially implemented	Partially implemented	Fully meets standard - continue with regular monitoring of implementation.	March 25 discussed. Fully implemented during 23/24. Continue with quarterly monitoring of implementation. Trust have reviewed birth interval data and provided evidence.
	5.21	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	March 25 - 100% and alignment of data. Now fully implemented.
	5.22	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	March 25 - discussed. Only indicator with significant data variation. Manual DQ check process underway. Action plan updated with continued focus. (and action plan to be uploaded as evidence)
	5.23	Partially implemented	Partially implemented	Fully meets standard - continue with regular monitoring of implementation.	March 25 - note progress (and data alignment) <75% so partially implemented. Action plan updated and continued focus. (and action plan to be uploaded as evidence)
	5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.

5.25	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Sept 24 - discussed. Compliance has varied and more recent data
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fully implemented during 23/24. Continue with quarterly monitoring of implementation.

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Sept 24 - discussed. Ongoing discussions regarding separate clinics. Registered as a QI project and risk register. Trust Board sighted and working across divisions. Women are receiving care but is not
6.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	March 25 - 100% of women offered CGM (fully implemented) Staff training element - some information received - continue to chase in order to evidence for Q4 (plan to include on staff ESR so
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.	March 25 - discussed. Was previously fully implemented. Evidence uploaded and 44% 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.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Neonatal Medical Workforce

Action plan to meet BAPM standards at DRI, Tier 1

June 25

Gap	Actions	Lead	Timescale	Progress Update
Increase SHO compliment to allow for a 2nd SHO at night time to provide dedicated cover for neonatal services.	Complete rota options appraisal	Dr Rao	31/08/24	Rota options now completed and agreed. Need 3 more tier 1 resident doctors to make the rotas compliant
	Draft and seek approval of business case	Nigel Brooke/ Sarah Plowman/ Helen Burrows	30/06/2025	General manager to meet with the department accountant to work out costings and then proceed with a business case. Timescale not met due to delay in agreeing rota and actions required to develop business case. Timescale revised to 30/11/24. Q3 update - Paused and included in annual planning submission for the division for 25/26. Once signed off or agreed use as evidence of progress. Q4 update - Business case (BC) drafted, costings are being finalised.

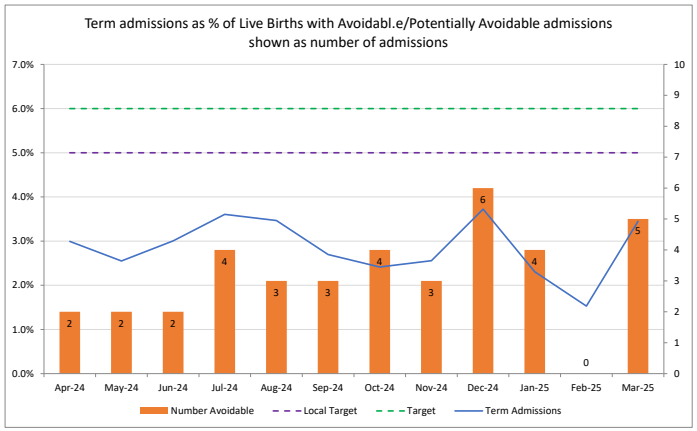
				Latest update June 25 - Revised costings have been finalised. The BC to be transferred into the Trust's new BC format by the DGM, and the finance section to be completed by the FBP. The BC will then be submitted to CIG for consideration and approval.
	Commence recruitment	Sarah Plowman	31/07/2025	Recruitment would commence if and when the BC is approved by CIG.
	SHO in place	Sarah Plowman	31/12/2025	Aiming for 31/12/2025, but will depend on the length of the recruitment process.

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

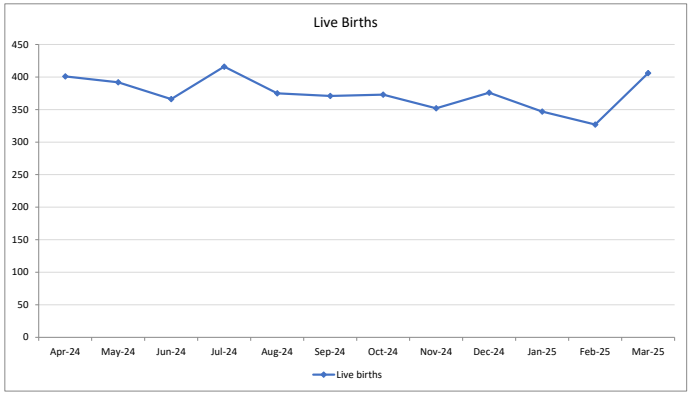
Month	Live Births All Gestations	All Inborn Admissions (excl transfers)	Inborn TERM admissions (37/40)	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions	Case Reviews MDT	Case Reviews Other
Apr-24	401	39	12	3.0%	5.0%	6.0%	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%	6	42.9%	14	
Jan-25	347	24	8	2.3%	5.0%	6.0%	4	50.0%	8	
Feb-25	327	46	5	1.5%	5.0%	6.0%	0	0.0%	5	
Mar-25	406	47	14	3.4%	5.0%	6.0%	5	35.7%	14	



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	4	3		3	13
Hypothermia/temperature management									1	1	1			3
Hypoglycaemia/management of blood glucose		1		1									1	3
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									1				1
Other: Other	Incorrect of syntocinon ? RDS												1	1
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**	**6**	**4**	**0**	**5**	**38**

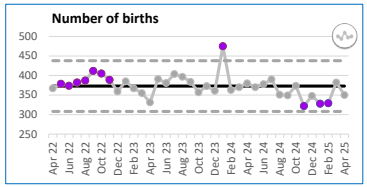


Maternity overview

Trust Total

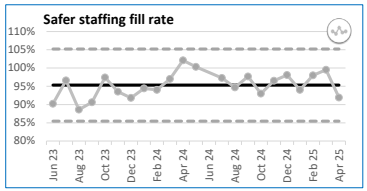
Latest month 01/04/25
Number of births **350**

No significant change



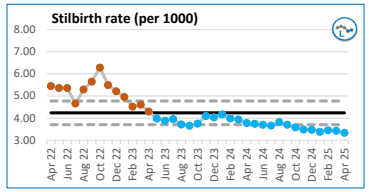
Latest month 01/04/25
Safer staffing fill rate **92%**

No significant change



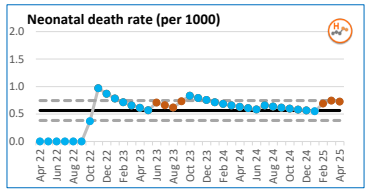
Latest month 01/04/25
Still birth rate/1000 **3.3**

Significant Improvement



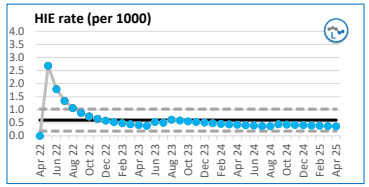
Latest month 01/04/25
Neonatal Death rate/1000 **0.7**

Significant deterioration



Latest month 01/04/25
HIE rate/1000 **0.4**

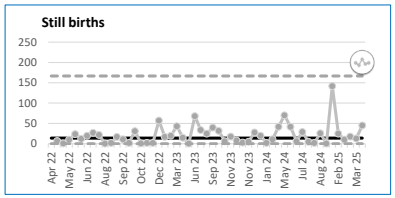
Significant Improvement



Date of last stillbirth 09/05/25

Average days between stillbirths **13.8**

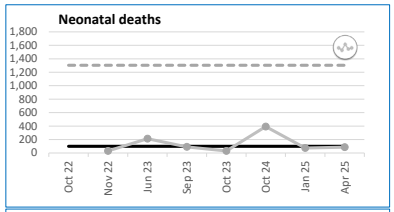
No significant change



Date of last neonatal death 08/04/25

Average days between deaths **99.6**

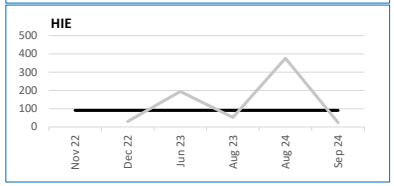
No significant change



Date of last HIE 11/09/24

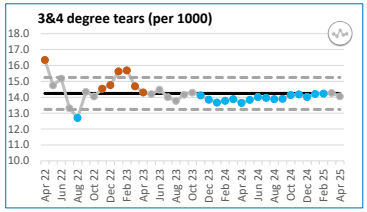
Average days between HIE **90.8**

No significant change



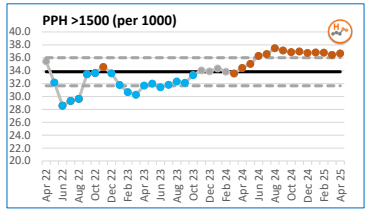
Latest month 01/04/25
3&4 degree tears (per 1000) **14.1**

No significant change



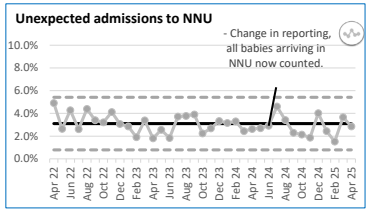
Latest month 01/04/25
PPH >1500 (per 1000) **36.7**

Significant deterioration



Latest month 01/04/25
Unexpected admissions to NNU **0.0**

No significant change



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

2505 - B3 BI-ANNUAL MIDWIFERY WORKFORCE REPORT

Discussion Item | Karen Jessop, Chief Nurse | 10:30

Lois Mellor, Director of Midwifery

10 minutes

REFERENCES

Only PDFs are attached

B3 - Bi-annual Midwifery Workforce Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Bi-annual Midwifery Workforce Report**			
Executive Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Danielle Bhanvra, Deputy Director of Midwifery and Gynae Services			
Appendices:	None			
Purpose of the report	**Assurance**	Decision required	Information	Discussion
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF6, BAF7			

Executive Summary – Key messages and Issues

Purpose of the report & Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 7.

Recommendations

For the Trust Board of Directors to take assurance from the detail provided within this workforce report, highlighting the additional scrutiny and monitoring that have been applied to ensure all aspects of safe staffing have been triangulated.

Healthier together – delivering exceptional care for all

Patients	We deliver safe, exceptional, person-centred care.
People	We are supportive, positive, and welcoming.
Partnerships	We work together to enhance our services with clear goals for our communities.
Pounds	We are efficient and spend public money wisely.
Health Inequalities	
Legal/ Regulation:	CQC - Regulation 12 Potential high impact Clinical Negligence Scheme for trusts - High impact
Partner ICB strategies	South Yorkshire ICB and NHS Nottingham & Nottinghamshire ICB

Assurance Route

Previously considered by - including date:	Governance Meetings
Any outcomes/next steps / time scales	
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

1. Introduction

The aim of this report is to provide assurance to the Board of Directors that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q3/4 of 2024/25 inclusive. This forms part of the Developing Workforce safeguards published by NHSE in October 2018. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) for safety action 5 where the following standards are used:

Table 1

a	A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.
b	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
c	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
d	All women in active labour receive one-to-one midwifery care.
e	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

2. Birthrate Plus® Workforce Planning

NHS Resolution's maternity incentive scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests Birthrate Plus (BR+) is utilised to provide this. The Royal College of Midwives (RCM) also strongly recommends using BR+ to undertake as BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well- used decision support tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3).

A Birthrate Plus® (BR +) assessment was last completed in August 2022 and this has been used to calculate the workforce required to deliver safe maternity services at DBTH.

Birth Rate Plus Recommended Midwife WTE

	Recommended in 2022
DRI	157.44
BDGH	63.63
Specialist / Managerial	22.11
Total	**243.18**

3. Workforce Model for 24/25

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

Planned Versus Actual Staffing levels
Below is the current funded workforce model and the proposed workforce model from the 2022 assessment together with the people in post currently.

Funded model	2024/2025	In post	Variance
Midwives Band 3 -7	221.07	211.60	- 9.47
Managerial & Specialist excluding 8a and above	22.34	23.73	+1.39
HCA Band 2	30.2	30.9	+0.7

Specialist Midwives
Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives.

The current percentage of specialist midwives employed is 11.21%. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within working hours. This includes posts that are externally funded through NHSE and the Local Maternity and Neonatal System (LMNS).

The specialist roles support national recommendations to ensure the service has the correct specialist posts for the demographic served and are in line with current national initiatives with some posts receiving external funding through the LMNS.

The service has a wide range of specialist midwifery posts at Band 6 and band 7 detailed below totalling 23.73 WTE. Some roles are funded externally.

Job Title	WTE	Banding
Bereavement Midwife	0.9	7
Bereavement Midwife	0.63	6
Infant Feeding	1.5	7
PDM	2.61	7
Antenatal and newborn Screening	1.6	7
PMA	0.6	7
Fetal Monitoring lead	1.00	7
Digital Midwife	1.2	7
Midwife sonographer	2.00	7
Workforce lead	0.93	7
Governance midwife	1.00	7
Audit and Guideline midwife	0.8	7
Public Health Midwife	0.9	7
Pelvic Health Midwife	0.8	7
Diabetic Lead Midwife	1.00	7
Maternal Medicine Midwife	0.80	7
Induction of labour lead Midwife	1.00	7
Perinatal mental Health Midwife	0.68	7
Perinatal Mental Health Midwife	0.48	6
Birth Afterthoughts midwife	0.6	7
Trainee Advanced Clinical Practitioner	0.8	7
Safeguarding Midwife	1.3	7
Preterm/Twins lead	0.6	6
Total	23.73	

4. Midwife to Birth ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. The below table represents the midwife to birth ratio for all births which is determined by the number of births divided by the number of staff available each month. The figures are also impacted by staff unavailability through sickness or maternity leave.

This "worked" calculation shows greater fluctuations in the ratio but provides a realistic measure of the number of available midwives measured against actual births each month. The midwife: birth ratio does not take into consideration the acuity/requirements of the woman being cared for in labour.

The table outlines the real time monthly birth to midwife ratio.

Month	Midwife to Birth ratio
October 2024	1:20.40
November 2024	1:20.49
December 2024	1:20.32
January 2025	1.20.22
February 2025	1:20.07
March 2025	1:20.13

The recommended midwife to birth ratio nationally is 1:28 with the ratio used as a guide in conjunction with birthrate +® and clinical judgement.

5. Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

The following table outlines the compliance by month:

Month	Doncaster Planned	Doncaster Actual	Bassetlaw Planned	Bassetlaw Actual	Compliance
October 24	**62**	**62**	**62**	**62**	**100%**
November 24	**60**	**60**	**60**	**60**	**100%**
December 24	**62**	**62**	**62**	**62**	**100%**
January 25	**62**	**62**	**62**	**62**	**100%**
February 25	**56**	**56**	**56**	**56**	**100%**
March 25	**62**	**62**	**62**	**62**	**100%**

There was a supernumerary coordinator rostered on every shift throughout the 6 month period with the red flags below evidencing that there were four occasions at Doncaster site and no occasions at Bassetlaw site where the coordinator was unable to remain fully supernumerary throughout the whole shift. Mitigation is in place if the coordinator is absent with clear guidance to escalate to the manager on call if required.

6. Red Flag Events

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool and reviewed by the Head of Midwifery.

The following tables demonstrate red flag events on each site:

Doncaster

NICE 2015	Red Flags	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
RF1	Delayed or cancelled time critical activity	2	0	1	2	1	18
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0	1	0	0	2
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0
RF5	Delay between presentation and triage	0	0	0	0	0	0
RF6	Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
RF7	Delay between admission for induction and beginning of process	0	0	3	0	0	1
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established	0	1	0	0	0	1
RF10	Coordinator unable to maintain supernumerary status-providing 1:1 Care	0	0	1	0	1	2

Bassetlaw

NICE 2015	Red Flags	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
RF1	Delayed or cancelled time critical activity	1	0	1	0	2	3
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0	0	0	0	0
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0
RF5	Delay between presentation and triage	0	0	0	0	0	0
RF6	Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0

RF7	Delay between admission for induction and beginning of process	0	0	0	0	0	2
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established	0	0	0	0	0	0
RF10	Coordinator unable to maintain supernumerary status-providing 1:1 Care	0	0	0	0	0	0

Red flags remain stable with 'Delayed or cancelled time critical activity' remaining the highest red flag at DRI. To mitigate the risk there are twice daily huddles to manage staffing and make plans to ensure the services remain safe. This includes protecting the status of the supernumerary coordinator. The service also has a 24/7 senior manager on call to support the clinical areas to maintain safe staffing levels at all times.

7. One to One Care in Labour

Women in established labour (4cms dilated with regular contractions) are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month

Month	Doncaster	Bassetlaw	Trust
October 2024	100%	100%	100%
November 2024	100%	100%	100%
December 2024	100%	100%	100%
January 2025	100%	100%	100%
February 2025	100%	100%	100%
March 2025	100%	100%	100%

8. Conclusion

Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels continues to be complex due to increased pressures on the workforce.

The service has continued to see an improvement in the overall staffing position. DBTH has a robust recruitment plan and has continued to advertise and recruit large cohorts of early career midwives to continue to strengthen their position.

Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service.

2507 - C PEOPLE

10:40

2507 - C1 GUARDIAN OF SAFE WORKING QUARTERLY REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 11:20

Mohammad Khan, Guardian of Safe Working

10 minutes

REFERENCES

Only PDFs are attached

C1 - Guardian of Safe Working Quarterly Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Guardian of Safe Working Quarterly Report**			
Executive Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Mohammad I Khan, Guardian of Safe Working Hours			
Appendices:	N/A			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1, 2			

Executive Summary – Key messages and Issues

This report includes data for a three month period between 1 February 2025 and 30 April 2025. The reporting system in use is HealthRota and all the data presented is taken and categorised as per this software.

The total number of Exception Reports (ERs) filed in this period was 71. The majority of Exception Reports have been by trainees working in larger specialties like General Surgery, General Medicine and Obstetrics/Gynecology. 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 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.

Recommendations

The Board is asked to note and take assurance from this quarterly report.

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Patients	Resident doctors support the delivery of safe and effective patient care.
People	The Guardian of Safe Working Hours role supports the resident doctor workforce.
Partnerships	The Guardian of Safe Working Hours is part of regional and national networks to share learning and knowledge.
Pounds	The report describes the usage of medical bank/agency and the application of fines.
Health Inequalities	None identified
Legal/ Regulation:	-
Partner ICB strategies	-

Assurance Route

<table>
<tr><td>Previously considered by - including date:</td><td>N/A</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

YES</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING, DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Author: Mohammad I Khan, Guardian of Safe Working Hours

Report date: 1 July 2025

Executive Summary

The number of overall and education-related Exception Reports (ERs) is similar to data presented in July 2024 (71 Vs 67). The vast majority of ERs were filed by foundation year doctors or residents in their earlier journey in training (57 vs 14 by ST4 or above) 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. Healthrota has made it easier for the trainees to file ER with the user friendly app that can be downloaded on the mobile phone. However it collects and categorises data slightly differently and the data presented in the paper reflects this change. NHS Employers have published a new framework with reforms to the ER system after agreements between the government and the BMA resident doctors committee. There are several significant changes to the current processes and NHS trusts have been given time until 12 September 2025 to implement these reforms which will apply to all doctors and dentists employed under the 2016 Terms and Conditions of Service.

The highest number of ERs have been submitted by trainees working in General Medicine, General Surgery and Obstetrics/Gynaecology during this quarter. 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 Hours (GOSWH) with regards to the 2016 Terms and Conditions for resident doctors to assure the Board of the safe working of resident doctors. This quarterly report is for the period 01 February 2025 to 30 April 2025. The Board should receive a quarterly report from the Guardian as per the 2016 contract, which will include:

• Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade

• Details of fines levied against departments with safety issues

• Data on rota gaps, vacancies and locum usage

• A qualitative narrative highlighting areas of good practice and / or persistent concern.

Table 1. Number of exception reports by month, 1 February 2025 to 30 April 2025.

Month	Complete	Pending	Total
February 2025	12		12
March 2025	31		32
April 2025	27		27
Grand Total	**71**		**71**

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.

Table 2. Number of exception reports by specialty, 1 February 2025 to 30 April 2025.

Specialty	2025-02	2024-03	2024-04	Grand Total
General medicine	3	15	15	33
General surgery	3	6	1	10
Obstetrics + gynaecology	5	6	6	17
Paediatrics		2		2
Ophthalmology			1	1
Urology	1	3	4	8
Grand Total	**12**	**32**	**27**	**71**

Over the past 12 months, the majority of ERs have been submitted by trainees working in General Medicine and 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 2025 to end of April 2025

Difference in total hours of work (including opportunities for rest breaks)	85%
Min daily working rest of 11 hrs reduced to <8	11%
Unable to attend scheduled teaching/training attendance	4%
Total	**100%**

Over the past 12 months, the vast majority (85%) of ERs were submitted in relation to additional hours worked with or without missed breaks, reflecting the high workload of resident doctors requiring them to stay late in order to ensure patient safety. Four percent of reports (3) were made in relation to missed educational opportunities and in all these cases the reasons were linked to work areas being understaffed or having a busy shift with sick patients forcing trainees to miss scheduled teaching sessions. All three ERs were filed by FY 1 doctors missing educational opportunities due to workload and understaffing. Senior members of the divisional team are responsible for facilitating Trainees to attend by reviewing the barriers to attendance within their Specialty and mitigating these but at times it is not always possible for arrange cover at short notice.

a) Work schedule reviews

There has been one review of a rota in Urology as mentioned in the previous board report, led by specialty doctors on the same rota due to the out of hours' intensity on the non-resident rota. However in this quarter, there have been 8 ERs filed by a trainee in Urology for 8 shifts where the minimum rest period at night was breached for non-resident on call (NROC). This has been escalated and communications have taken place with the Urology team members with steps identified in order to resolve this. There is ongoing work on the Urology rota underway with some planned steps being implemented by the end of October 2025.

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 2025 to 1 April 2025.

Row Labels	01/01/2025	01/02/2025	01/03/2025	01/04/2025	Grand Total
Acute Medicine	1617.67	2277.25	2734.5	1601.5	8230.92
Anaesthetics and Critical Care	758.5	779	655	579	2771.5
Anaesthetics and Maternity	324.33	242.83	232.5	314.83	1114.49
Anaesthetics and Theatres	1997.5	2102.67	2188.75	2849.5	9138.42
Breast Surgery	450.76	282	345.83	455.42	1534.01
Cardiology (Medical)	323.5	343.5	243.5	199.75	1110.25
Care of the Elderly	926.33	368.25	749.25	597	2640.83
Dermatology	272	283.5	126.25	139	820.75
Emergency Medicine	6451.77	7459.04	8562.72	7892.11	30365.64
Endocrinology and Diabetes	701.33	777.5	650.5	166.5	2295.83
ENT	769.83	693.75	861.91	609.5	2934.99
Gastroenterology	446.5	260.5	444.5	337.25	1488.75
General Medicine	707.83	301.75	645.25	460.58	2115.41
General Surgery	500.92	507.51	899.75	1039.1	2947.28
Haematology	398.5	419	477.25	361.75	1656.5
Infectious Diseases	98.58	56	99	149.5	403.08
Intensive Care		12	39		51
Obstetrics and Gynaecology	1637	1088.25	1243.16	1694.59	5663
Orthopaedic & Trauma for Emed				8	8
Orthopaedic and Trauma Surger	3171.2	3116.6	3770.46	3803.2	13861.46
Paediatrics and Neonates	1422.58	1121.5	889.67	1014.92	4448.67
Palliative Medicine	116.5	159.75	90	97.5	463.75
Renal Medicine	192	147	210.5	210.5	760
Respiratory Medicine	552	327.25	425.17	167.75	1472.17
Rheumatology	20	99	108.25	81.75	309
Stroke Medicine	69	114	89	27	299
Urology	789.25	569.75	629.25	719.25	2707.5
Vascular Surgery	207	84	154	208.5	653.5
Ophthalmology	682.5	534	683	601.5	2501
Gynae Cancer Alliance	18.5				18.5
Radiology	49	51	48	42	190
Community Diagnostic Hub	84	164	240	264	752
Endoscopy - Surgical	56	79	164	180	479
AMU - SDEC	66	48	72	8	194
Orthodontics	16	16	16	16	64
Oral and Maxillofacial Surgery	36	58	92.5	56.5	243
Medical Examiner	129	32	4	30	195
Anaesthetics and Pain	12.75	59.25	106.75	38.75	217.5
Anaesthetics	51.5	81	91	160.5	384
Oral Surgery		16			16
Clinical Haematology		24		52	76
Community Paediatrics			8		8
Diabetes				15.5	15.5
Grand Total	**26123.63**	**25155.4**	**29090.17**	**27250**	**107619.2**

As expected, most of the hours covered by bank usage is for busy specialties like Acute Medicine / Emergency Medicine, anaesthetics and paediatrics.

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

Count of Job No	Column Labels				
Row Labels	01/01/2025	01/02/2025	01/03/2025	01/04/2025	Grand Total
Additional session	309	309	457	407	1482
Annual Leave	190	131	97	103	521
Compassionate/Special leave	48	20	22	19	109
Deanary gap - Vacancy	178	230	279	240	927
Entrustability	9	2		3	14
Exempt from on calls for health reasons	57	47	40	55	199
Extra Cover	180	120	144	134	578
Induction/Rotation		18	7	3	28
Less Than FT Trainee Gap	63	54	91	81	289
Maternity/Paternity leave	82	51	53	44	230
Restricted Duties	4	16	14	13	47
Seasonal Pressures	203	158	182	27	570
Sick	231	154	143	156	684
Study Leave	20	11	4	7	42
Vacancy	1502	1634	1883	1906	6925
Acting Down	1		1		2
Grand Total	**3077**	**2955**	**3417**	**3198**	**12647**

The majority of locum cover since January 2025 was to provide staffing for leave / sickness, rota vacancies / gaps / extra cover or additional sessions. The number of locum shifts covering rota vacancies has, in general, remained steady in this period.

c) Vacancies

In this quarter, monthly rota vacancies have stayed stable at 46 WTE as shown in table below.

Table 6. Trainee vacancies by specialty, February 2025 to April 2025.

	VACANCIES (WTE)	Posts	February	March	April
Medicine	FY2	7	1	1	1
	CT/ST GPST 1-3	25	0.5	0.7	0.9
	ST3+	25	3.2	3.2	3.4
	Elderly Medicine	**22**	**2.8**	**2.8**	**2.8**
	FY1	3	0	0	0
	FY2 (No FY2 placements)	No FY2 placements			
	CT/ST GPST 1-3	15	2.8	2.8	2.8
	ST3+	4	0	0	0
	Renal	**7**	**1**	**1**	**1**
	FY1 (No FY1 placements)	No FY1 placements			
	FY2	6	1	1	1
	CT/ST GPST 1-3	No CT/GPST placements			
	ST3+	1	0	0	0
U&EC	**Urgent & Emergency Care**	**38**	**11.4**	**13.2**	**11.4**
	FY1	5	0	1	0.2
	FY2	6	0.4	0.4	0.2
	CT/ST GPST 1-3	25	11	11.8	11
	ST3+	2	0	0	0
Women's & Children's	**Obstetrics & Gynaecology**	**28**	**3.6**	**3.6**	**5.2**
	FY1	4	0	0	1
	FY2	1	0	0	0
	CT/ST GPST 1-3	12	0.2	0.2	0.2
	ST3+	11	3.4	3.4	4
	Paediatrics	**33**	**4**	**4.4**	**3.4**
	FY1	4	0.2	0.2	0.2
	FY2	1	1	1	0
	CT/ST GPST 1-3	20	1.8	3.2	3.2
	ST3+	8	1	0	0
	GU Medicine	**No longer taking GUM trainees**			

Surgery & Cancer	ENT	8	3.2	2.2	2.2
	FY1	No FY1 placements			
	FY2	2	0	0	0
	CT/ST GPST 1-3	3	2.2	1.2	1.2
	ST3+	3	1	1	1
	General Surgery	24	5	4	5
	FY1	9	0.2	0.2	1.2
	FY2	1	0	0	0
	CT/ST GPST 1-3	7	4	3	3
	ST3+	7	0.8	0.8	0.8
	Ophthalmology	11	0	0	0
	ST3+	1	0	0	0
	Urology	6	1	1	1
	FY1	2	0	0	0
	FY2	2	1	1	1
	CT/ST GPST 1-3	No CT/GPST placements			
	ST3+	2	0	0	0
	Trauma & Orthopaedics	6	4	4	3.6
	FY1	No FY1 placements			
	FY2	1	0	0	0
	CT/ST GPST 1-3	5	3	3	3
	ST3+	5	1	1	0.6
	Vascular	7	2	2	2
	FY1	3	0	0	0
	FY2	No FY2 placements			
	ST3+	4	2	2	2
Clinical Specialties	Anaesthetics	16	0.7	0.7	0.7
	FY1 (No FY1 placements)	No FY1 placements			
	FY2	No FY2 placements			
	CT/ST GPST 1-3	11	0	0	0
	ST3+	5	0.7	0.7	0.7
	ICT	12	0.8	0.6	0.6
	FY1 (No FY1 placements)	No FY1 placements			
	FY2	6	0.4	0.4	0.4
	CT/ST GPST 1-3	4	0.2	0	0
	ST3+	2	0.2	0.2	0.2
	Total	324	46.6	46.8	46.6

c) Fines

A total of 8 fines have been levied during this quarter. This relates to the same trainee in Urology for 8 shifts where the minimum rest period for NROC was breached. The money collected from the fines is held in the corporate account of GOSWH which can be used for the benefit of resident doctors at the trust with a proportion of fine being paid to the doctor as well:

1. ST3 Urology Rota due to breach of rest period for NROC X 8

Qualitative information

The last Resident Doctor's Forum (RDF) meeting took place on 21 May 2025 which was poorly attended by trainees as we only had one resident doctor on the forum.

This was despite sending a survey twice to the resident doctors asking for their preferred time and day of the week to conduct the meeting. Despite reminders, there was a small proportion of trainees who responded to the survey and the days and timings of the future RDF meetings were changed according to the trainees' wishes. It was very disappointing then to see that we still struggle to attract the resident doctors to attend this forum. The plan was to discuss the ER reform that has been agreed and go through it in detail for the benefit of the resident doctors. This was still discussed with useful input from the BMA representative to let the senior team members know about the changes being implemented and how the process is going to change. Some of these changes include:

1. Providing access to doctors for submitting ERs within 7 days of starting at the trust with remote access (fines for breaches)
2. Automatic approval for up to 2 hours of additional hours' work within 10 days (trainee can choose TOIL or Payment)
3. Supervisors are no longer required to review/ approve ERs (this responsibility has been shifted to Medical HR teams)
4. ERs have to be treated as confidential and can't be shared without trainee's consent (fines for breaches)
5. Changes to the systems used for ER reporting with a list of mandatory fields
6. GOSWH reports to be standardised to a national template

Summary

Ongoing exception reports highlight high workloads for resident doctors, especially in the busy specialities despite significant improvements. High workload and understaffing are the usual causes for resident doctors being unable to undertake educational opportunities. It is a busy time for NHS trusts to implement the proposed changes to the ER reporting and processing procedures by the deadline of 12 September 2025.

Engagement

The regional Guardians meeting is planned for 2 July while the national annual Guardians' Conference is due to take place in November 2025. It is anticipated that both meetings would include discussions regarding the ER reform and provide clarifications on the processes.

An ongoing programme of engagement to raise awareness of exception reporting, and to encourage attendance and participation in the RDF is being planned:

- 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 is planned for August. There is a need for a resident doctors' rep to represent trainees in forums and encouragement to take up such positions is being considered.
- There is ongoing work collaboratively with the Freedom of Speak Up Guardian and Trust SuppoRTT Champions. Engagement sessions have already occurred and further sessions may be planned as and when needed. A special GMC/DBTH engagement session on "Speaking Up structure, processes and best practice" was held on 6 June in the DRI lecture theatre.

Recommendation

The Board of Directors can be assured that a clear majority of trainee doctors are able to work safely. Trainees and the supervisors are used to the new system of reporting through Healthrota and there is positive feedback on the ease of using the app. Monthly regular meetings run between GOSWH and HR colleagues to action any outstanding ERs and make decisions. This also helps in regularly chasing supervisors for timely action on open ERs to ensure they are dealt with in a timely fashion although moving forwards supervisors won't need to review ERs for the resident doctors.

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.

2507 - C2 WORKFORCE RACE & DISABILITY EQUALITY STANDARDS

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

5 minutes

REFERENCES

Only PDFs are attached

C2 - Workforce Race & Disability Equality Standards 2024-25.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	Board of Directors		**Meeting Date:**	1 July 2025
Report Title/ Ref:	Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) report 2024-2025			
Executive Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Kirby Hussain, Equality Diversity & Inclusion Lead			
Appendices:				
Purpose of the report	Assurance	Decision required	**Information**	Discussion
Impacts on Strategic Risks (BAF 1-7)	BAF2			

Executive Summary – Key messages and Issues

The information below summarises the DBTH workforce data for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions. The data was collected on 24 April 2025, covering the period 1 April 2024 to 31 March 2025.

The data needed to be submitted nationally by 31 May 2025, therefore, an earlier version of this paper was circulated to People Committee members by email in May 2025 for any comments and support prior to submission. It was then presented and noted at the People Committee meeting on 17 June 2025.

This summary highlights the areas of positive change in comparison with last year's data whilst recognising there is still work to do in order to see continued improvements, with key areas of focus outlined below.

WRES Key Achievements

- **Significant increase in the number of BME colleagues**: There was an increase of 69 BME employees in clinical roles, alongside a significant reduction of 231 employees from a White background compared to last year's WRES Figures
- **Increased number of BME colleagues in non-clinical roles**: 14 more colleagues across bands 2, 4, 5, 6, 7, and 8A

WRES Notable Improvements:

- Non-clinical BME colleagues increased from 82 to 96 employees
- Clinical Band 3 BME colleagues increased from 9 to 57 employees
- Clinical Band 5 BME colleagues increased from 417 to 455 employees
- Clinical Band 6 BME colleagues increased from 75 to 106 employees
- Medical & Dental consultants increased from 192 to 195
- Medical & Dental Trainee grades increased substantially from 93 to 232

WDES Key Achievements

- **Increased disability declaration in the number of clinical colleagues**: 60 additional colleagues either joining or declaring disabilities
- **Increased disability declaration in the number of non-clinical colleagues**: 18 more colleagues across bands 2, 4, 5, 6, 7, and 8A

WDES Notable Improvements:

- Non-clinical Colleagues with disabilities increased from 99 to 142
- Clinical colleagues with disabilities increased from 233 to 265
- Clinical Band 2 colleagues with disabilities increased from 48 to 78
- Clinical Band 3 colleagues with disabilities increased from 20 to 24
- Clinical Band 4 colleagues with disabilities increased from 8 to 14
- Clinical Band 5 colleagues with disabilities increased from 4 to 6
- Clinical Band 8 colleagues with disabilities increased from 2 to 7
- Medical & Dental consultants with disabilities increased from 7 to 8
- Medical & Dental Trainee grades with disabilities increased from 6 to 16
- WDES shortlisting numbers have increased from 120 in the previous year to 128 in the current year. Similarly, appointments have seen a slight rise from 62 to 63 compared to last year.

Areas Requiring Continued Focus

- **Shortlisting disparities**: In regards to WRES shortlisting data in 2024, there were 399 BME candidates shortlisted. This is less than 2023, there were 408 candidates shortlisted. There were 162 BME Candidates appointed in 2024 (40.6% appointed). This is less than the 2023 data where 168 BME candidates were appointed (41.2% appointed).

Ongoing Actions

- The **Board Development Delegate Programme** supporting senior-level diversity has launched its third cohort with two delegates; seven delegates have completed the programme with positive feedback
- The fourth cohort of the **Reciprocal Mentoring Programme** is underway to support aspiring leaders
- We are strengthening **colleague network groups** and actively promoting them as part of recruitment efforts, including the newly established **Internationally Educated Colleagues Network**
- We are currently in the final phase of developing a comprehensive eLearning toolkit focused on inclusive recruitment. This toolkit will consist of five modules, addressing the following areas:
    - Recruiting the DBTH Way
    - Preparations Prior to Advertising the Role
    - Advertising the Role
    - Interview and Selection Process
    - Post-Interview Procedures

- **Cultural Competence training** has begun to support communities of internationally educated colleagues, with plans for broader implementation via our internationally educated colleagues network
- **Cultural curiosity sessions** to be rolled out with the first session delivered in May 2025 at the Nursing & Midwifery conference at DRI.

Progress has been made in several key areas, and both the number of BME colleagues and disabled colleagues in clinical and non-clinical roles have continued to increase. However, challenges remain including decreased representation in some bands, shortlisting outcomes. These actions and others are included within the overarching Equality, Diversity and Inclusion action plan which also incorporates the NHSE High Impact Actions. The action plan is monitored through the EDI Forum with regular reporting and oversight at People Committee, most recently at the June 2025 meeting.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board is asked to note the information provided in the report and that the data was published in line with the national deadline of 31 May 2025 as part of mandated EDI reporting. This report was supported by the Executive team on 14 May 2025 and People Committee on 17 June 2025.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>We strive to have a diverse workforce that is reflective and awareness of the needs of the people it provides services for.</td></tr>
<tr><td>People</td><td>We are supportive, positive, and welcoming. Attracting and retaining a diverse workforce. The DBTH EDI Improvement Plan with NHS 6 high Impact actions</td></tr>
<tr><td>Partnerships</td><td>We work in partnerships with our networks, and create participation with those with protected characteristics.</td></tr>
<tr><td>Pounds</td><td>Maximising our appeal as an inclusive recruiter will result in more people applying for job vacancies thus reduce the need for external temporary workers through bank and agency.</td></tr>
<tr><td>Health Inequalities</td><td>We want fair outcomes for everyone. Addressing avoidable or remediable differences in health between groups of people. To achieve health equity, some groups may need more or different support or resources to achieve the same outcomes.</td></tr>
<tr><td>Legal/ Regulation:</td><td>NHS Mandated duties WRES/WDES Workforce</td></tr>
<tr><td>Partner ICB strategies</td><td>N/A</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Executive Team – 14 May 2025
People Committee – 17 June 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Supported by People Committee for national submission and publication</td></tr>
<tr><td>Is this in line with Current risk appetite

YES</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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BREAK 10:55 - 11:10

2507 - D PARTNERSHIP

11:10

2507 - DI DONCASTER & BASSETLAW HEALTHCARE SERVICES UPDATE

Discussion Item | Sam Wilde, Chief Finance Officer | 11:10

5 minutes

REFERENCES

Only PDFs are attached

D1 - Doncaster & Bassetlaw Healthcare Services Update.pdf

Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Doncaster and Bassetlaw Healthcare Services – Performance Update 2024/25**			
Executive Sponsor:	Sam Wilde & Dr Nick Mallaband - Doncaster and Bassetlaw Healthcare Services Directors			
Authors:	Mark Olliver, Managing Director - Doncaster and Bassetlaw Healthcare Services			
Appendices:				
Purpose of the report	**Assurance**	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)				

Executive Summary – Key messages and Issues

This briefing document provides the Trust Board with an update on the performance of its wholly owned subsidiary Doncaster and Bassetlaw Healthcare Services Ltd.

The business continues to perform strongly financially, exceeding budget for the 5th year in succession and delivering a record level of profit.

The information below outlines the year-end performance (2024/25) and presents all financial information in full, including visibility of the current assets and liabilities register.

The report also includes information relating to the strategic pillars of the business and how current activity is providing financial benefit and cost savings to Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust.

Recommendations

Board is asked to NOTE and TAKE ASSURANCE from the update.

Healthier together – delivering exceptional care for all

Patients	
People	
Partnerships	Wholly owned subsidiaries are an organisational and governance form that NHS providers can legally adopt to manage part of their organisation. Subsidiaries can deliver many benefits to the NHS, offering an alternative to outsourcing services to the private sector. Successful businesses can allow Trusts to reinvest savings back into the NHS to improve patient care, income which would otherwise transfer into the private sector. Doncaster and Bassetlaw Healthcare Services (the subsidiary) was incorporated in October 2019. The business continues to perform favourably and, as a result, has provided routine regular dividend payments to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (the parent). This report aims outlines current performance and to encourages stronger alignment (between the Trust and subsidiary) in the short, medium and long term.
Pounds	DBHS Ltd has now delivered £450k of dividend payments to the Trust in addition to £10M of direct savings through purchasing efficiencies on outpatient pharmacy.
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	

<table>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>N/A</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
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Quality</td><td>Finance</td><td>People</td><td></td></tr>
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Executive Summary

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

The business continues to perform strongly, exceeding budget for the 5th consecutive financial year and delivering record profit numbers.

The information below outlines the year-end performance (2024/25) and presents all financial information in full, including visibility of the current assets and liabilities register.

The report also includes information relating to the strategic pillars of the business and how current activity is providing financial benefit and cost savings to Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust.

Financial Performance 2024/25

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

Year to 31 March 2025 (£k)	**Actual**	**Budget**	**Variance**
Turnover	11,732	10,524	1,208
Cost of Sales	(10,659)	(9,524)	(1,135)
Gross Profit	**1,073**	**1,000**	**73**
Admin Expenses	(786)	(876)	90
Profit before tax	**287**	**124**	**163**
Tax	(73)	(28)	(45)
Profit after tax	**214**	**96**	**118**

The financial information provided is a true reflection of the ratified year-end accounts which are still subject to audit. The board are asked to note the following

- The pre-tax profit position of £287k exceeded budget by £163k
- Gross margin was reported at 9%
- Non pay expenses continue to be managed efficiently and appropriately
- The overall profit position post tax sits at £214k

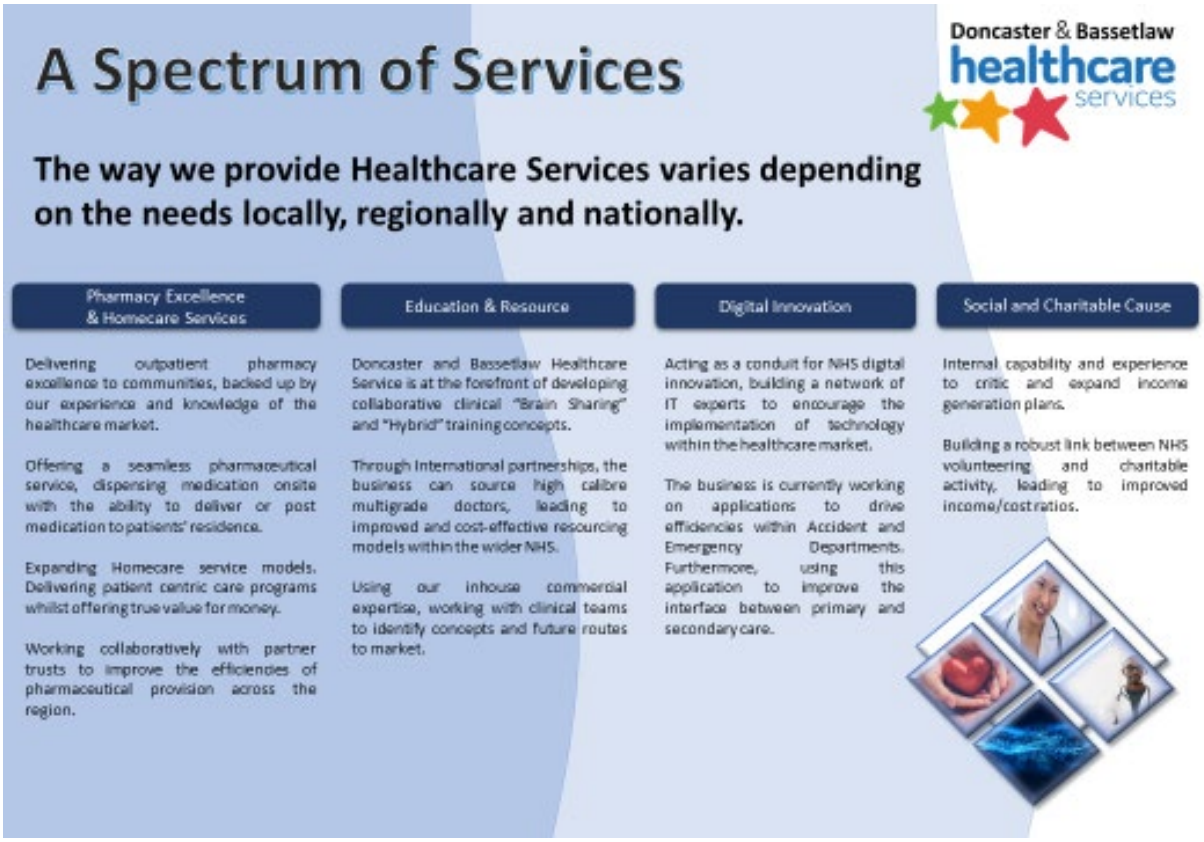
Table 2: Assets and Liabilities Register

As at 31 March 2025	
Current assets	£000
Inventory	528
Accounts receivable	945
prepayments	891
VAT receivable	551
Cash	255
Total	**3,169**
Current Liabilities	
Accounts payable	991
Accruals	979
Intercompany	422
Corporation Tax payable	72
Total	**2,464**
Net assets	**704**
Share Capital	550
I&E Reserve	154
Total capital Employed	**704**

The I@E reserve of £154k is healthy, remaining above the threshold level of 100k

Strategic Plan 2023-26

The board are asked to note the following strategic aims of the business



Financial Highlights

Doncaster and Bassetlaw Healthcare Services continues to work closely with Doncaster and Bassetlaw NHS Teaching Hospitals NHS Foundation Trust, exploring mutually beneficial arrangements to deliver improved financial performance and patient care.

Since incorporation in 2019, the business has delivered strong financial performance, enabling total dividend payments of £450k to the Trust so far. Moreover, by utilising the business to deliver and manage the outpatient pharmacy (rather than the Trust operating it directly) a further £10m of savings have been realised through purchasing efficiencies.

The business will continue to build a strong commercial offer, to ensure that the funding pipeline continues to grow.

Pharmacy excellence

The outpatient pharmacy continues to perform strongly, with current numbers operating at above 30% of initial baseline data, witnessed prior to incorporation.

Extensive work has been undertaken to increase 'in-house' dispensing and remove the financial burden associated with community FP10 prescriptions. The imminent arrival of e-prescribing will further enhance this. Current work is reviewing short and medium term prescribing cost savings and the business has identified a potential £100k saving that could be realised at pace. Conversations are now taking place to implement these plans accordingly.

Homecare Services

The business has now successfully incorporated two homecare services into the commercial portfolio. These services were previously provided by external private healthcare providers, at significant cost.

Working closely with the inpatient pharmacy team and the relevant haematology and rheumatology departments an alternative model has been implemented, reducing costs significantly whilst maintaining good patient care.

This operational change has resulted in an initial cost saving of £40k-£50k, and further annual savings of approx. £30k per annum (for the 2 services provided). These new service lines will also have a positive influence on business profitability, further enhancing future dividend payments.

The business is keen to explore further homecare options and requires Trust guidance and collaboration on this matter. At present the business is set up to support simple homecare service provision. However, future service(s) could adopt higher complexity and the business would increase capability accordingly.

Resourcing

Working in collaboration with QIMET International, the business continues to provide alternative resourcing solutions across healthcare. Whilst originally focussing on Emergency Medicine, the programme is now being expanded to provide training across a number of specialities. Furthermore, the programme will also cover clinician training across a number of levels and can include in-situ doctors currently within the UK.

The programme aims to provide Trusts with a steady pipeline of international candidates, supporting departments in reducing agency spend and improving continuity of care. The programme has been rolled out to other partner Trusts, with notable success. Indeed some doctors have now taken up permanent placements within the UK.

The business continuous to work with the Trust, to identify future opportunities that align to the resourcing requirements of the Trust. When initially incorporated into Doncaster Royal Infirmary in 2019/20, agency shift spend was reduced by approx. 32% across the financial year. A thorough review of current resourcing complexities would be prudent, to explore future cost savings and commercial gain.

As the Trust no longer faces the challenges recruiting emergency department doctors it once did, notice has been served to QIMET and DBHS Ltd on this element of the contract moving forward and no further trainees will be recruited to the HIEM scheme for DBTH.

Digital Innovation

Doncaster and Bassetlaw Healthcare Services has been collaborating with Healthcare Engineering Limited and Physiotec (Wibbi) to develop a digital application for hospital emergency departments and minor injuries units. The application enables patients to provide clinical history through a structured questionnaire, completed pre-consultation. Furthermore, the software allows patients to gain access to enriched healthcare content, for review post discharge. The process allows patients to be proactive in self-care and to link in with other support measures available within the primary care setting.

On application review, post historical pilot at Doncaster Royal Infirmary, The York Health Economics Consortium (YHEC) evaluation noted the following:

- Notable reduced times at registration, triage and consultation, providing 6 min saving per patient
- Patient time spent in the department reduced by 30 min average
- Department '4 hour' breaches reduced by circa 1,300 per annum

The software application has undergone an extensive overhaul, to provide a more user friendly system whilst incorporating improved functionality. The product is expected to be ready for full pilot rollout to commence in August/Sept 2025, at which point Mexborough minor injuries clinic has been identified as a logical environment to test the concept. All relevant stakeholders will be notified and informed accordingly.

Future partnerships between the Trust and Doncaster and Bassetlaw Healthcare Services

Throughout the next 12-18 months, the financial pressures facing the NHS and Trust are extensive. It is therefore essential that the partnership between the business and Trust exploits all commercial opportunities to the full.

Short term focus will prioritise the development and expansion of the pharmacy offer, exploring prescribing patterns and the further enhancement of the homecare offer. This will have 2 priorities in mind i.e. developing commercial return for the business and realising cost savings at the Trust.

Substantial consideration must also be given to other business sectors, including clinical and non-clinical settings. It is imperative that all relevant processes and contracts are reviewed at the Trust and pressure tested, to explore whether a more practical and commercially efficient model could be developed utilising the business and its commercial standing.

These conversations are currently taking place and any future activity will be explored in full, whilst adopting the right levels of assurance and governance.

DBHS Board Composition

Dr Nick Mallaband has recently become a Director of DBHS Ltd

Conclusion

2024/25 Has been a successful year for Doncaster and Bassetlaw Healthcare Services. The business has delivered record profits and a further dividend payment has been made to the Trust.

The business is keen to explore further symbiotic opportunities at pace, to develop a model that delivers patient excellence, as well as strong financial grip and control.

Mark Olliver

Managing Director

July 2025

2507 - D2 TRUST STRATEGY AND STRATEGIC PRIORITIES SUCCESS MEASURES

Decision Item

Zara Jones, Deputy Chief Executive

10 minutes

REFERENCES

Only PDFs are attached

- D2 - Trust Strategy & Strategic Ambitions Success Measures.pdf
- D2 - Appendix 1 Healthier Together Trust Strategy.pdf
- D2 - Appendix 2 Success Measures.pdf
- D2 - Appendix 3 Strategic Ambitions and Success Measures Progress Report Template.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	**1 July 2025**
Report Title/ Ref:	**Healthier together - Doncaster and Bassetlaw Teaching Hospitals Strategy & Strategic Ambition Success Measures**		
Executive Sponsor:	Zara Jones, Deputy Chief Executive		
Authors:	Emma Shaheen, Director of Communications Rebecca Allen, Associate Director of Strategy, Partnerships and Governance James Tabor, Associate Director of Planning Performance and Improvement		
Appendices:	Appendix 1: Healthier together - Doncaster and Bassetlaw Teaching Hospitals Strategy document Appendix 2: Success Measures Appendix 3: Strategic Ambitions and Success Measures Progress Report Template		
Purpose of the report	~~Assurance~~	Decision required	Information / Discussion
Impacts on Strategic Risks (BAF 1-7)	BAF 1-7		

Executive Summary – Key messages and Issues

This paper presents the final version of DBTH's new organisational strategy for 2025–2029, Appendix 1, developed through extensive engagement with staff, patients, local communities, and health and care partners.

The strategy defines the Trust's vision, mission, strategic priorities and long-term ambitions to guide future direction. It aligns with national NHS priorities and is supported by detailed enabling plans to drive delivery.

Appendix 2 sets out the proposed success measures for ongoing monitoring and assurance, and how these map to the elements of the Trust Strategy. Appendix 3 is a proposed Board progress report template to provide updates on the strategic ambitions and success measures

Recommendations

Board members are asked to approve the strategy, success measures and progress reporting format ahead of formal launch.

Healthier together – delivering exceptional care for all	
Patients **People** **Partnerships** **Pounds** **Health Inequalities**	The strategy sets out all the strategic priorities and ambitions, including addressing Health inequalities
Legal/ Regulation:	The Board strategy should align to the decision making framework for the Trust.
Partner ICB strategies	ICB strategies have been considered to ensure alignment in the development of the DBTH strategy

Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Healthier Together – Doncaster and Bassetlaw Teaching Hospitals Strategy

Summary

This paper presents the final version of the new organisational strategy for Doncaster and Bassetlaw Teaching Hospitals (DBTH) for 2025–2029. Following an extensive period of development, engagement, and review throughout 2024/25, the strategy sets out a clear vision, mission, and priorities that will guide the Trust's direction over the coming years.

The paper summarises the process undertaken to develop the strategy, highlights its key components, and outlines the next steps to embed it within the organisation. Board members are asked to approve the final version of the strategy ahead of formal launch.

Process, engagement and involvement

The strategy has been developed through extensive engagement with colleagues, patients, local communities and representative groups and our health and care partners at local and system level.

In March 2024, following workshops with senior colleagues from across DBTH two proposed vision statement and four suggested strategic priorities were proposed to colleagues. 814 colleagues (around 11% of all Team DBTH) completed a short questionnaire indicating their preferred vision statement, and provided additional feedback, which further shaped a final suggested statement.

91% agreed that the strategic priorities reflected what should be our priorities. Additionally, 676 (84%) believed they were easy to understand.

More than 400 members of the community (including patients), also identified what is most important to them, and where improvements could be made. This was established through a digital survey and in person attendance at community events, such as family fun days, PRIDE, multicultural events, and a focus on farmer's event, amongst others.

All system partners we're invited to inform the vision, priorities and key areas of focus for the strategy. Seven partners, including Integrated Care Board partners contributed, identifying where they believe our focus should be.

This approach has ensured that the strategy is both ambitious and grounded in the realities of our patients, people, and partners.

The strategy also aligns with wider priorities, including national NHS programmes.

Key components of the strategy - Our Vision, Mission and Priorities

Vision: *Healthier Together, Delivering Exceptional Care for All.*

Strategic Priorities

- **Patients** – Deliver safe, exceptional, person-centred care that empowers patients.
- **People** – Foster a supportive, inclusive workplace for all colleagues.
- **Partnerships** – Work collaboratively with partners across sectors.
- **Pounds** – Use public resources transparently, sustainably, and effectively.

Strategic Ambitions (Long-term enablers of transformation):

- Tackling Health Inequalities,
- Becoming a leading centre for research and education,
- Becoming a digitally enabled organisation,
- Improving our estate to provide the best care environments.

Delivery and Implementation and next steps

The strategy is underpinned by enabling plans (People, Quality, Estates & Net Zero, Maternity, Health Inequalities and others), ensuring that the vision is translated into achievable, measurable actions.

The strategy will be integrated into operational planning, governance, performance management, which is already in place at Board level.

The document and website, which enable more accessibility (such as browsealoud and translation into different languages), will be officially launched, initially to colleagues through Team Brief.

As an organisation we will continue to engage with staff, patients, and partners to ensure the strategy remains live and responsive to emerging needs.

Success Measures

Appendix 2 outlines the success measures that underpin delivery of the Trust Strategy, the lead Executive Director and the governance forum to drive delivery.

Appendix 3 provides a format for Board progress reporting, highlighting progress across all of the strategic ambitions and success measures.

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Healthier together -

Doncaster and Bassetlaw Teaching Hospitals Strategy

2025 to 2029

Our Strategy at a glance

Our Strategy is shaped by our **Vision**, underpinned by our **Values**, and delivered through clear **priorities** and bold **ambitions**.

Our Trust Vision

At Doncaster and Bassetlaw Teaching Hospitals (DBTH), our Vision is simple but powerful:

Healthier together – delivering exceptional care for all.

This Vision shapes everything we do, driving our ambition to deliver the best outcomes for patients while creating a supportive, respectful, and empowering environment for colleagues.

To help us achieve this, we're guided by our Values and behaviours, known as '**We Care**', which are brought to life through living the '**DBTH Way**'.

We care

The DBTH Way

Our Strategic Priorities

Patients

We deliver safe, exceptional, person-centred care.

People

We are supportive, positive and welcoming.

Partnerships

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

Pounds

We are efficient and spend public money wisely.

Our Strategic Ambitions

Provide the best care environments

We are improving care spaces by modernising facilities, enhancing community care, and reducing pressure on our hospitals, with a focus on funding, safety, and service integration.

Tackling health inequalities

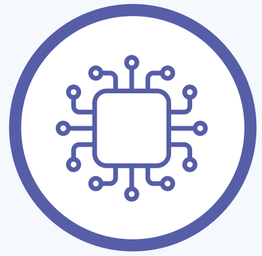
We prioritise health equity through prevention, partnerships, training and targeted support for underserved communities.

Becoming a leading centre for research and education

We aim to enhance patient care, expand student placements, invest in facilities, and grow clinical trials and funding.

Becoming a digitally enabled and mature organisation

Intergrating technology and innovation to improve care, enhance support for colleagues and improve efficiency through an electronic patient record, AI and shared records.



Healthier together –
Delivering exceptional care for all

Foreword

At Doncaster and Bassetlaw Teaching Hospitals, we are proud to serve our patients and our communities with care that is compassionate, outstanding, and continually evolving.

In 2024, we worked closely with patients, colleagues, and partners to refresh our organisational Strategy – a shared commitment to a stronger, healthier future. Together, we have shaped a new direction that responds to national priorities, rising expectations, and the rapidly changing healthcare landscape.

Our Vision – ***Healthier Together: Delivering Exceptional Care for All*** – captures this renewed purpose, reflecting our drive to work together and deliver outstanding care for every patient. It speaks to the very heart of what we do, and why we do it: Providing safe, high-quality, and innovative care that makes a real difference to people's lives.

This Strategy builds upon the foundations of the DBTH Way and connects with national healthcare ambitions, drawing inspiration from the Lord Darzi report and the Government's 2024 three strategic shifts:

1. Empowering people to take greater control of their health.
2. Transforming care models to improve patient outcomes.
3. Harnessing technology to drive innovation across the NHS.

We believe this is a once-in-a-generation opportunity. By embracing new ways of working, strengthening partnerships, and unlocking the creativity and expertise of our colleagues, we can not only respond to the challenges ahead but actively shape a better future for healthcare – for our Trust, our communities, and beyond.

The pages that follow set out our key priorities and ambitions. But they also represent an invitation: To dream bigger, to push further, and to deliver the very best care, together. By living our Values and leading with purpose, we will ensure that Doncaster and Bassetlaw Teaching Hospitals continues to be a place where patients thrive, colleagues grow, and communities are healthier, together.

Richard Parker OBE
Chief Executive

Suzy Brain England OBE
Chair of the Board

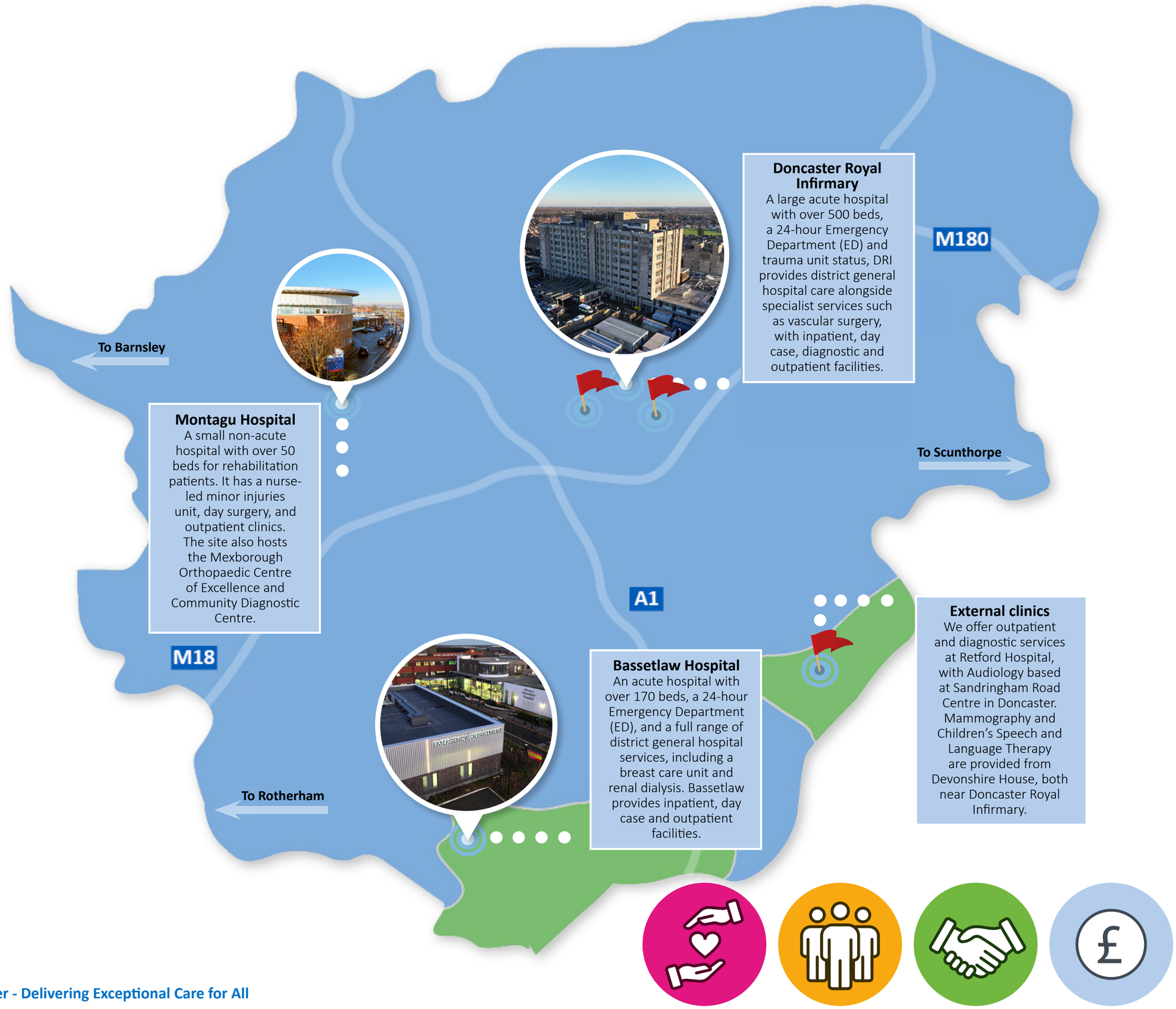
Our Trust

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 outpatient and diagnostic services within external clinics.

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.

With over 7,300 colleagues, our teams are united by the **DBTH Way** – our shared approach to delivering outstanding care. It's built on our **We Care** Values of being kind, keeping respectful, and working together to give colleagues what they need to thrive.

This way of working is how we ensure safety, compassion and quality in everything we do, ultimately providing the best services for patients.



Key facts

£650 million

annual turnover, 65% spent on workforce.

£164 million

capital investment to improve our buildings, our facilities and equipment over the past five years.

3.6 million

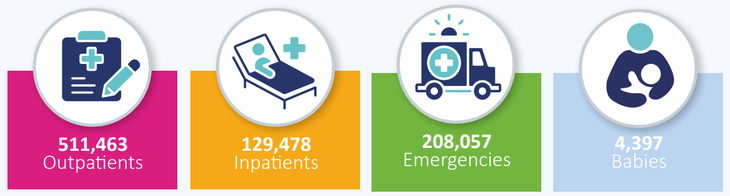
telephone calls received across 12 months and directed onwards to an appropriate service or individual.

1 million

medical instruments processed by our sterile services team each and every single year.

900,000+

patient contacts a year, including:



our emergency departments are consistently some of the busiest in South Yorkshire.

425,000

meals served every year to our patients and colleagues.

7,300

colleagues, making us one of the largest employers in the region.

3,500

participants as part of our Born and Bred in Doncaster clinical research

1,400+

apprentices, undergraduates and post graduates.

700+

beds across our hospitals, including 500 at Doncaster Royal Infirmary, 170 at Bassetlaw Hospital and 50 at Montagu Hospital.

Eight

scanners, including four MRI, four CT, and a state-of-the-art robotic surgeon.

Our Values

At DBTH, our **We Care** Values are at the heart of everything we do. They underpin the **DBTH Way** - setting out how we work together, lead by example, and support each other. Both are more than a set of words; they are the standards we hold ourselves to, creating a culture that is kind, inclusive, empowering, and accountable.

The DBTH Way

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

We are

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

We show

- Attentive listening
- Integrity and honesty
- Courage and positivity

Our **Vision statement** is clear:

Healthier together -
Delivering Exceptional Care for All

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

Patients

We deliver safe, exceptional, person-centred care.

People

We are supportive, positive, and welcoming.

Partnerships

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

Pounds

We are efficient and spend public money wisely.

Our Strategic Ambitions

Our Strategic Ambitions set out what we aim to achieve over time to deliver better care, strengthen our services, and build a sustainable future. Each ambition ultimately supports our Vision of Healthier together – Delivering Exceptional Care for All, and is underpinned by our Strategic Priorities, which guide the actions we need to take.

This connection is illustrated in the **DBTH Strategic Wheel** later in this document, and we will also explore each of our ambitions in greater depth to show how they shape our future direction.

Provide the best care environments

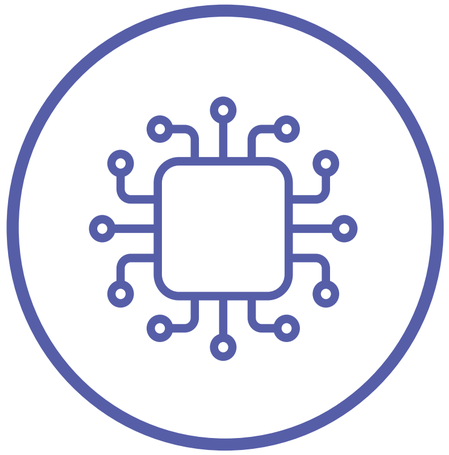
We are improving care spaces by modernising facilities, enhancing community care, and reducing pressure on DRI, with a focus on funding, safety, and service integration.

Tackling health inequalities

We prioritise health equity through prevention, partnerships, training, and targeted support for underserved communities.

Becoming a leading centre for research and education

We aim to enhance patient care, expand student placements, invest in facilities, and grow clinical trials and funding.



Becoming a digitally enabled and mature organisation

Integrating technology and innovation to improve care, enhance support for colleagues, and improve efficiency through an electronic patient record, AI, and shared records.

Exploring our **Strategic Priorities:**

Patients -

We deliver 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 under-served communities receive the support they need to access services.**
- **Empower patients to take an active role in their care.**

Providing **person-centred care**, **empowering people** to take **greater control** of their health.

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

Exploring our **Strategic Priorities:**

People -

Fostering a supportive, positive and welcoming environment.

Our people are the heart of the great care we give to patients. DBTH colleagues routinely show strength, innovation, and a strong commitment to providing exceptional care.

As healthcare changes, we are dedicated to creating a supportive and welcoming workplace. This means building inclusive practices, helping careers grow, and meeting modern needs like flexible working and new ways of delivering care.

We want our people to feel valued, confident, and prepared for today's challenges and future goals, so they can thrive while providing outstanding care.

We will:

- **Position DBTH as an employer of choice.**
- **Deliver the objectives of our People and Research and Innovation.**
- **Embed a culture of speaking up and inclusion.**
- **Further implement and embed talent management and succession planning.**

We want our people to **feel valued**, **supported**, and **prepared** for today's challenges and future goals, so they can **thrive while providing outstanding care**.

People -

Fostering a supportive, positive and welcoming culture.

Exploring our **Strategic Priorities:**

Partnerships -
Collaborating to enhance our services

Providing high-quality, accessible, and lasting healthcare depends on strong partnerships across our system, including charities, social care, education institutes and beyond.

By working closely with others, we can improve services, find new solutions, and tackle the wider factors that affect our community's health.

We will:

- **Deliver seamless care that meets the diverse needs of our population, in the right place.**
- **Promote health education and prevention efforts aimed at improving health outcomes.**
- **Advance cutting-edge medical research, digital transformation, and evidence-based care.**
- **Leverage resources, expertise, and funding from both public and private sectors.**

Partnerships -
Collaborating to enhance our services.

Transforming care to improve outcomes: By **working closely with others**, we can improve services, **find new solutions** and tackle the wider factors **that affect our community's health**.

Exploring our **Strategic Priorities:**

Pounds -

Ensuring efficiency and wise spending of public funds.

To provide outstanding healthcare, we need a strong financial foundation that supports innovation, quality care, and long-term stability.

We are committed to managing our resources wisely, making the most of what we have, and seeking new funding through partnerships, innovation, and research.

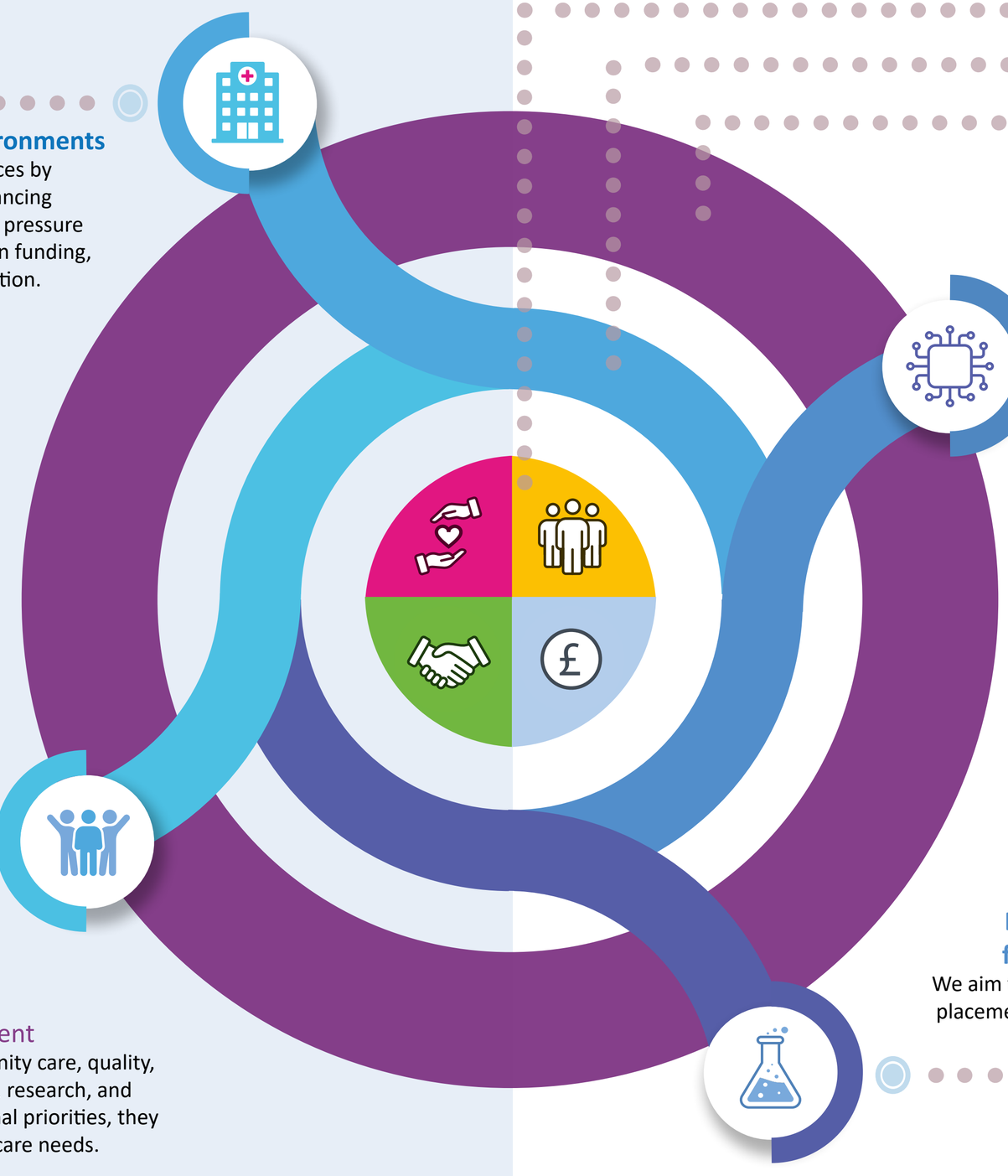
We will:

- **Enhance operational efficiency, streamlining workforce processes, and improve procurement practices to reduce costs without compromising care quality.**
- **Diversify funding sources through grants, research collaborations, philanthropic efforts, value-based payment models, and public-private partnerships.**
- **Strategically direct funds toward digital transformation, modernising infrastructure, and implementing new care models that enhance efficiency, outcomes, and the experiences of both patients and colleagues.**
- **Align financial incentives with the delivery of the best patient outcomes, ensuring every pound is used for high-impact, cost-effective interventions.**

Pounds -

Ensuring efficiency and wise spending of public funds.

Every pound we spend should **make the biggest difference** – we will **harness technology** to **drive innovation** and **improvements** at DBTH



Strategic Priorities

Strategic Ambitions

Enabling and alignment

Provide the best care environments

We are improving care spaces by modernising facilities, enhancing community care, and reducing pressure on our hospitals, with a focus on funding, safety, and service integration.

Becoming a digitally enabled and mature organisation

Integrating technology and innovation to improve care, enhance support for colleagues, and improve efficiency through an electronic patient record, AI, and shared records.

Tackling health inequalities

We prioritise health equity through prevention, partnerships, training, and targeted support for under-served communities.

Becoming a leading centre for research and education

We aim to enhance patient care, expand student placements, invest in facilities, and grow clinical trials and funding.

Enabling Plans and alignment

Our Enabling Plans drive key areas like maternity care, quality, health inequalities, digital, estates, people, research, and speaking up. Aligned with national and regional priorities, they ensure our services evolve with healthcare needs.

Exploring our **Strategic Ambitions**

Provide the best care environments

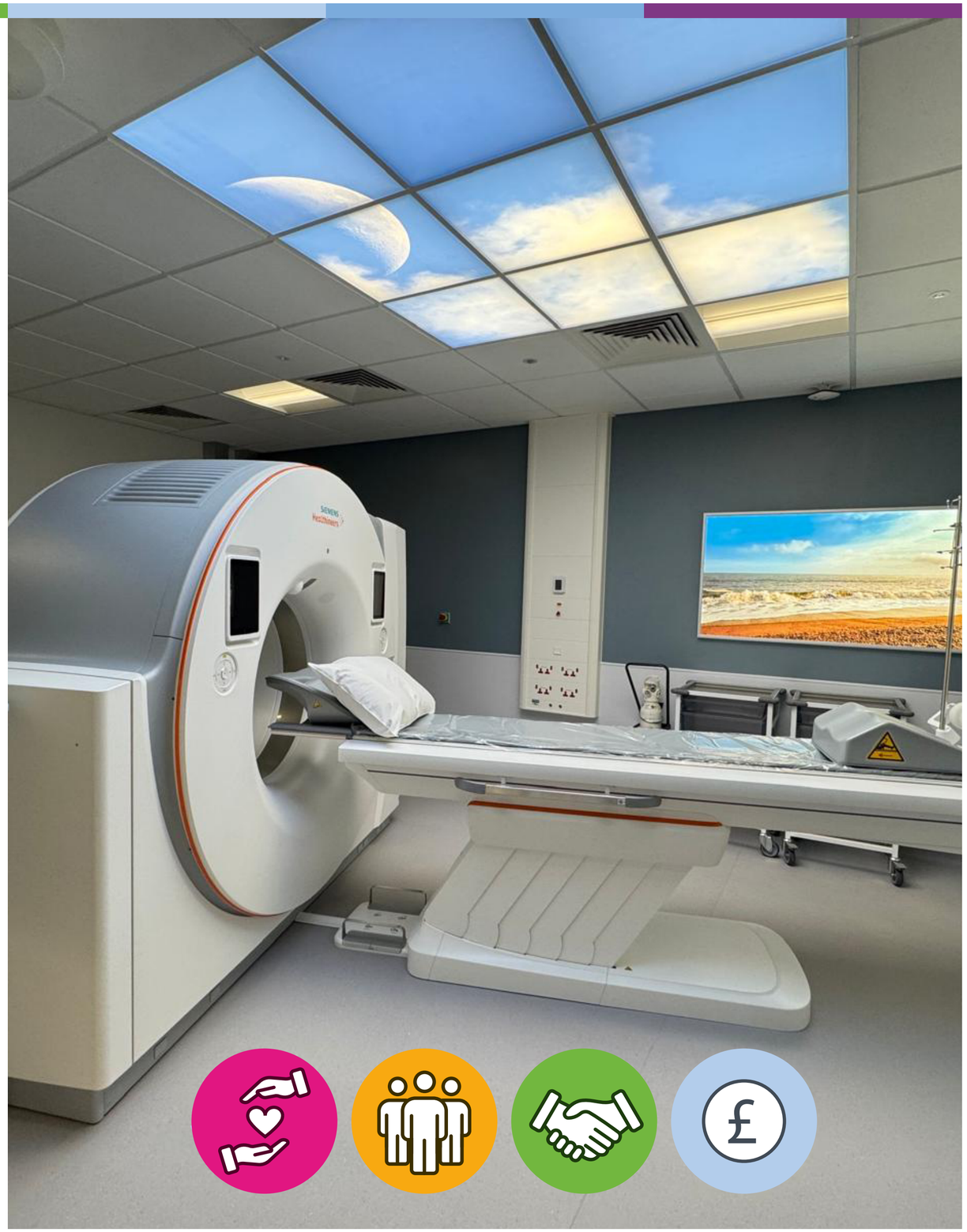
Our ambition is to create high-quality care spaces by improving our buildings, changing how we deliver services, and working more closely with community healthcare, whilst also working towards Net Zero.

Our goal is to provide safe, modern facilities that reduce critical infrastructure risks, improve efficiency and bring services closer together. By designing spaces that maximise the use of new technology and support joined-up care, we can make sure patients get the right care in the right place, reducing unnecessary hospital visits and focusing on keeping people well.

Recent developments at Bassetlaw Hospital and Montagu Hospital showcase how modern facilities can support care in the future. Our evolving Vision will see some services (including ambulatory and elective care) provided in other settings, improving access to services, supporting our colleagues' well-being, and easing pressure on the busy, ageing, challenged DRI site, helping with its future redevelopment. To achieve this, we must tackle challenges like securing funding, managing building work, and creating strong partnerships across services.

Our key deliverables include:

- Identifying opportunities for national programmes and capital funding.
- Achieving 'Code Category B' standards for all buildings, addressing structural risks.
- Delivering care closer to the community, reducing footfall on hospital sites where clinically appropriate.
- Co-locating services to enhance integrated pathways between primary and secondary care.



Exploring our **Strategic Ambitions**

Tackling health inequalities

Tackling health inequalities is not just a priority — it is a principle embedded into everything we do. Our ambition is to place health equity at the core of every decision, ensuring that our services pro-actively address disparities, focus on prevention, and improve outcomes for the most disadvantaged groups.

By reducing the impact of lifelong illnesses, promoting early detection, and making sure every contact counts, we aim to transform the health landscape for those who need it most.

Success in this area requires robust infrastructure to track progress reliably and share data across organisations. This will allow us to identify areas of greatest need and focus our resources where they can make the most difference. By building capacity within the Trust, we aim to implement targeted initiatives that address the root causes of

Our key deliverables include:

- Embedding a framework to ensure every decision we make will be viewed through the lens of its impact on health inequalities.
- Working closely with partners, patients, and local communities to advance initiatives that prioritise prevention and quality improvement, ensuring that our services are inclusive, accessible and effective.
- Rolling out Health Inequalities training to our colleagues and partners.
- Providing support and initiatives to achieve better health outcomes to colleagues who may face inequalities in health.

Exploring our **Strategic Ambitions**

Become a leading centre for research and education

Our ambition will see the organisation become a leading centre for research and education, enhancing patient care and contributing significantly to healthcare innovation and professional development.

As the largest local employer, we support school age young adults in work experience through to specialist training, creating careers for life.

Success will be measured by clear outcomes that demonstrate our growth, impact, and readiness to meet the criteria defined by The University Hospitals Association (UHA).

Our key deliverables include:

- Maintaining and expanding student placements, in line with our workforce needs, providing positive experiences for learners, and establishing career pathways for all, including clinical academics.
- Investing in teaching and research facilities, securing additional funding streams, and developing infrastructure.
- Enhancing the research offer each year by expanding clinical trials, commercial opportunities and funding grants.

Exploring our **Strategic Ambitions**

Becoming a digitally enabled and mature organisation.

We are committed to using digital technology to improve healthcare, making care better for patients, supporting our people, and working more efficiently.

By adopting new, patient-focused solutions, we aim to give everyone fair access to services, help patients manage their own care, and make work easier for our teams.

Our Digital enabling plan guides us in using technology to provide the best care, work closely with partners, and make the most of our shared resources. Digital innovation is key to everything we do at DBTH.

Our key deliverables include:

- Developing digital health literacy programmes to help patients confidently use online services and take an active role in their care.
- Expanding shared care records to improve data accessibility and collaboration with our partner organisations.
- Rolling out an electronic patient record (EPR) system across DBTH, enabling healthcare professionals to access accurate, up-to-date patient information to deliver timely and efficient care.
- Implementing artificial intelligence and remote monitoring tools to enhance diagnostic accuracy, enable proactive interventions, and reduce the burden on traditional healthcare settings.

Our delivery time line

2025/26

Deliver Year 3 of the People Plan.

Deliver Year 2 of the Research & Innovation enabling plan.

Deliver the national access standards in the 2025/26 plan.

Improve patient safety by reducing hospital-acquired pneumonia, optimising antimicrobial prescribing, and strengthening Mental Capacity Act compliance.

Deliver Year 2 of the three-year maternity and neonatal services plan.

Strengthen clinical effectiveness and efficiency, meeting Getting It Right First Time, national standards, and benchmarks.

Deliver Health Inequalities Board commitments for 2025/26.

Embed stronger governance and risk management at Board and committee level.

Invest in digital platforms and deliver Electronic Patient Record business case milestones for 2025/26.

Deliver the 2025/26 financial plan and improve financial sustainability.

2026/27

Speaking up embedded into DBTH culture.

Improved access for our most vulnerable families.

Clinically led transformation of services delivered with health and care partners.

EPR project is live.

Sharing core business services to reduce the cost base.

Develop and invest in research infrastructure and facilities.

Increase NHS App usage.

2027/28

Enhanced learner experience and research opportunities.

Services moved to appropriate place-based settings.

One public estate and co-location of services with partners.

Health inequalities framework embedded.

All information we share with patients and colleagues is accessible.

EPR successfully implemented.

Business case for the East Block (DRI) delivered.

Increase in research investment delivered.

Talent and innovation expertise grown.

2028/29

To the best of our ability, we provide the best care environment.

Health equity is prioritised in everything we do.

We are a leading centre for education and research.

We are digitally enabled and mature.

Our Enabling Plans

Although presented as individual documents, our Enabling Plans are interconnected, with the Strategic Priorities and Strategic Ambitions acting as golden threads that integrate all actions towards a unified direction. All of our Enabling Plans can be viewed here:
www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy/

People: This plan ensures we can attract, recruit, and retain the best by being a welcoming and inclusive employer of choice within our local area. Aligned to the four pillars of the NHS People Plan, it focuses on improving the working lives and experiences of all our colleagues within Team DBTH.

Estates and Net-Zero: Focused on improving and providing the best environments for both patients and colleagues, this plan ensures healthcare facilities meet the highest standards. It aligns with the Trust's annual capital expenditure and includes a rolling programme of works to achieve these ambitions.

Health Inequalities: This plan addresses societal challenges and sets out plans for prevention, elective care pathways, urgent and emergency care, maternity and early life care, children and young people, and research and innovation. It also enhances awareness of health inequalities among our workforce and provides a framework for improvement.

Maternity: Aligning with national maternal and neonatal care themes, this plan integrates its actions with the Health Inequalities document. It supports vulnerable families, strengthens workforce retention and development, and improves patient experience through compassionate, person-centred care in a supportive environment.

Quality: Designed to deliver safe, exceptional, person-centred care, this plan outlines how systems and processes will ensure safety, quality, and effectiveness. It emphasises listening to feedback to provide compassionate, personalised care for all patients.

Quality Improvement and Innovation: Aligned with the NHS Impact model, this plan takes a holistic approach to improvement by building shared purpose, investing in culture and people, and developing leadership behaviours.

Speaking Up: Aligned with national principles, this plan outlines how we will listen to and support colleagues who need to speak up. Integrated with the People document, it provides measurable actions to foster a listening, learning organisation and a more positive workplace for all.

Research and Innovation: This plan outlines our Vision to become a leading centre of research excellence. It supports the goal of achieving University Teaching Hospital status, growing research talent and increasing innovation capacity to secure grants and funding.

Monitoring and evaluation

We evaluate our progress through established governance structures, using key performance indicators, data analytics, and regular reporting to ensure transparency and alignment with our goals. Enabling Plans are continuously refined based on feedback, outcomes, and emerging trends.

Provide the best care environments

We are improving care spaces by modernising facilities, enhancing community care, and reducing pressure on DRI, with a focus on funding, safety, and service integration.

Tackling health inequalities

We prioritise health equity through prevention, partnerships, training and targeted support for underserved communities.

Becoming a leading centre for research and education

We aim to enhance patient care, expand student placements, invest in facilities, and grow clinical trials and funding.

Becoming a digitally enabled and mature organisation

Intergrating technology and innovation to improve care, enhance support for colleagues and improve efficiency through an electronic patient record, AI and shared records.

Management team

DBTH Board of Directors

- Quality Committee
- Finance and Performance Committee
- People Committee
- Audit and Risk Committee

Glossary

AI (Artificial Intelligence): Using computers for tasks like diagnostics, predictive analysis, and remote healthcare monitoring.

Code Category B Standards: For safe, high-quality healthcare facilities.

CQC (Care Quality Commission): Regulator ensuring health and social care services are safe, effective, and high-quality.

Digital Health Literacy: Patients' ability to use digital tools and apps to manage their care.

Electronic Patient Record (EPR): A digital system for sharing accurate, up-to-date patient information.

Health Inequalities: Differences in health outcomes linked to social, economic, or demographic factors.

Integrated Care Board (ICB): NHS bodies coordinating health and care services for local areas.

Integrated Care Partnership (ICP): Collaboration between NHS, councils, and partners to improve care.

KPIs (Key Performance Indicators): Measures used to track progress towards specific goals.

Lord Darzi Report: A key report shaping NHS quality, safety, and innovation.

NHS Impact Model: A framework for NHS quality improvement and system change.

University Teaching Hospital Status: Recognition for hospitals leading in education, research, and training.

Healthier together –
Delivering exceptional care for all

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Document designed by DBTH's Communications and Engagement Team.

Strategic Ambitions and Success Measures

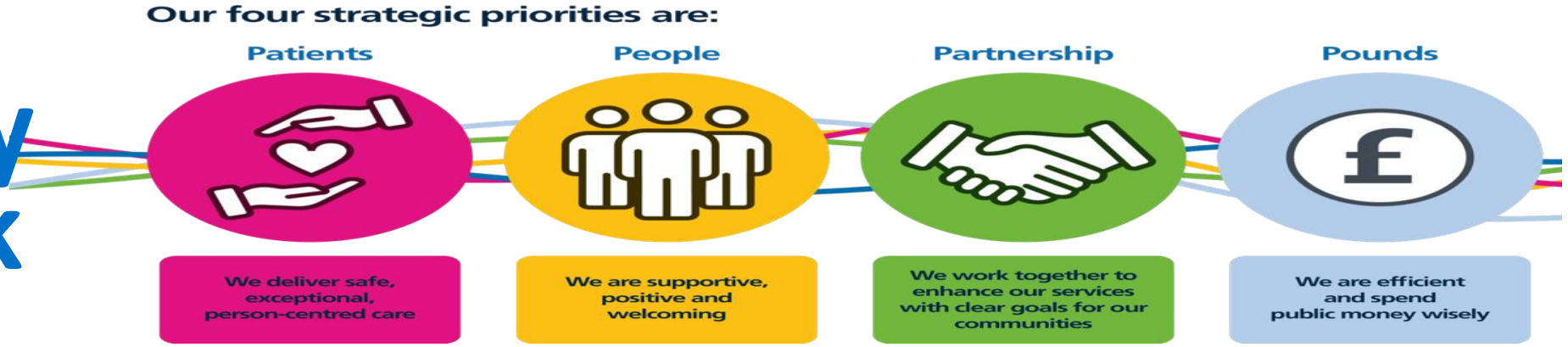
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Strategic Ambitions

- Tackling Health Inequalities
- Leading Centre for Research and Education
- Digitally Enabled and Digitally Mature Organisation
- Improved Estate and the Best Care Environment

Success Measures	Lead Executive Director	Lead Board Committee
Delivery of year 3 of the People Strategy	Zoe Lintin, Chief People Officer	People Committee
Delivery of year 2 of Research & Innovation strategy	Zoe Lintin, Chief People Officer	People Committee
Delivery of the national priorities as set out in our 25/26 operational plan	Denise Smith, Chief Operating Officer	Finance and Performance Committee
Delivery of the 3 Quality priorities: 1. Reduction of Hospital Acquired Pneumonia 2. Antimicrobial Prescribing 3. Compliance with Mental Capacity Act	Karen Jessop, Chief Nurse & Nick Mallaband, Acting Executive Medical Director	Quality Committee
Completion of the three-year plan for maternity and neonatal services	Karen Jessop, Chief Nurse	Quality Committee
Ensure clinically and operationally effective services by delivering strong performance aligned to GIRFT, national standards and benchmarks	Nick Mallaband, Acting Executive Medical Director & Denise Smith, Chief Operating Officer	Finance and Performance Committee
Deliver the boards Health Inequalities commitments for 25/26	Zara Jones, Deputy Chief Executive	Board of Directors
Embed improved trust governance and risk management at Board and committee level to support robust leadership and decision making	Zara Jones, Deputy Chief Executive	Board of Directors
Investment into digital platforms for improvements to care, and delivery of the Electronic Patient Record business case deliverables for 25/26	Sam Wilde, Chief Finance Officer	Finance and Performance Committee
Delivery of the 25/26 financial plan and improvement in the underlying financial sustainability	Sam Wilde, Chief Finance Officer	Finance and Performance Committee

4 P Delivery Framework



Success measures				
Delivery of year 3 of the People Strategy		✓		✓
Delivery of year 2 of Research & Innovation strategy	✓	✓	✓	
Delivery of the national priorities as set out in our 25/26 operational plan	✓	✓	✓	✓
Delivery of the 3 Quality priorities: 1. Reduction of Hospital Acquired Pneumonia 2. Antimicrobial Prescribing 3. Compliance with Mental Capacity Act	✓	✓		
Completion of the three-year plan for maternity and neonatal services	✓	✓	✓	
Ensure clinically and operationally effective services by delivering strong performance aligned to GIRFT, national standards and benchmarks	✓	✓		✓
Deliver the boards Health Inequalities commitments for 25/26	✓	✓	✓	✓
Embed improved trust governance and risk management at Board and committee level to support robust leadership and decision making	✓	✓	✓	✓
Investment into digital platforms for improvements to care, and delivery of the Electronic Patient Record business case deliverables for 25/26	✓	✓		✓
Delivery of the 25/26 financial plan and improvement in the underlying financial sustainability		✓		✓

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Trust Strategic Ambitions and Success Measures Progress Report

June 2025

Strategic Ambitions

Progress Update – Key Highlights

Tackling Health Inequalities

- Key highlights
-

Leading Centre for Education and Research

- Key highlights

Digitally Enabled and Digitally Mature Organisation

- Key highlights

Improved Estate and the Best Care Environment

- Key highlights

Success Measures

Delivery of year 3 of the People Strategy

Zoe Lintin, Chief People Officer

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Delivery of year 2 of Research & Innovation strategy

Zoe Lintin, Chief People Officer

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Success Measures

Delivery of the national priorities as set out in our 25/26 operational plan

Denise Smith, Chief Operating Officer

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Delivery of the 3 Quality priorities:

1. Reduction of Hospital Acquired Pneumonia
2. Antimicrobial Prescribing
3. Compliance with Mental Capacity Act
Karen Jessop, Chief Nurse & Nick Mallaband, Acting Executive Medical Director

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Success Measures

Completion of the three-year plan for maternity and neonatal services

Karen Jessop, Chief Nurse

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Ensure clinically and operationally effective services by delivering strong performance aligned to GIRFT, national standards and benchmarks

Nick Mallaband, Acting Executive Medical Director & Denise Smith, Chief Operating Officer

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Success Measures

Deliver the boards Health Inequalities commitments for 25/26

Zara Jones, Deputy Chief Executive

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Embed improved trust governance and risk management at Board and committee level to support robust leadership and decision making

Zara Jones, Deputy Chief Executive

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Success Measures

Investment into digital platforms for improvements to care, and delivery of the Electronic Patient Record business case deliverables for 25/26

Sam Wilde, Chief Finance Officer

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

Delivery of the 25/26 financial plan and improvement in the underlying financial sustainability

Sam Wilde, Chief Finance Officer

Lead Director Progress Update	Next Steps
• Progress update	• Next steps

2507 - E POUNDS

11:25

2507 - E1 FINANCIAL & ACTIVITY REPORT ? MONTH 2

Information Item | Sam Wilde, Chief Finance Officer | 11:25

10 minutes

REFERENCES

Only PDFs are attached

- E1 - Finance & Activity - Month 2.pdf
- E1 - Appendix Finance and Activity Report - Month 2.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	Finance and Activity Report Month 2			
Executive Sponsor:	Sam Wilde, Chief Finance Officer Denise Smith, Chief Operating Officer			
Authors:	Yasmin Ahmed, Deputy Director of Finance Matthew Bancroft, Interim Associate Director of Finance Suzanne Stubbs, Deputy Chief Operating Officer			
Appendices:	Appendix A – Finance and Activity Report			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	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			

Executive Summary – Key messages and Issues

The Trust is reporting a £0.3m deficit in month bringing the year-to-date position to a £1.8m deficit. Surplus/deficit performance is essentially on plan in both the month and year to date. However, £1.2m of non-recurrent technical benefits have been made earlier than planned to support the position.

Driven by further identification and progression of efficiency schemes, the overall net risk to delivery of the financial plan has continued to decrease (£20.5m in planning submission, £14.9m at the end of month 1, £8.2m at the end of month 2).

Elective activity in the month of May 2025 and year to date exceeded plan in all four points of delivery.

In month 2 the Trust delivered £2.5m of CIP savings bringing year to date delivery to £3.3m. Both in month and year-to-date delivery are in line with the plan submitted to NHSE. Non- recurrent technical benefits are contributing to this. The forecast outturn of £31.4m is in line with plan but with a greater proportion of recurrent savings (58% vs 53% plan). Unidentified CIP has now been eliminated from the 2025/26 programme. Levels of high-risk CIP within the programme have continued to decrease (£23.5m in planning submission, £19.7m at the end of month 1, £11.1m at the end of month 2).

The cash balance is £20.9m against a plan of £15.9m, driven by lower levels of capital expenditure than had been planned at this point.

Year to date capital expenditure of £1.2m is £8.9m below plan with business cases being developed to ensure no slippage by year end.

Recommendations

The Board is asked to **NOTE** the financial and activity performance described in the report

Healthier together – delivering exceptional care for all	
Patients	
People	
Partnerships	
Pounds	Paper outlines the financial and activity performance of the Trust
Health Inequalities	

<table>
<tr><td>Legal/ Regulation:</td><td></td></tr>
<tr><td>Partner ICB strategies</td><td></td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Finance and Performance Committee on 26th June 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

NO</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Summary Finance And Activity Report

May 2025

Executive Summary

In month and YTD surplus/deficit (May 2025)

The Trust is reporting a £0.3m deficit in month, in line with plan. Year to date there is a £1.8m deficit, also in line with plan. £1.2m of non-recurrent technical benefits have been made earlier than planned to support the position.

Annual Forecast Outturn (FOT)

FOT remains at breakeven in line with plan.

Activity

Elective activity in the month of May 2025 and year to date exceeded plan in all four points of delivery.

Efficiencies

In month 2 the Trust has delivered £2.5m of savings in line with the plan submitted to NHSE. Year to date CIP delivery of £3.3m is also in line with plan. Non-recurrent technical benefits are supporting the year to date CIP delivery.

Cash

Cash balance is £20.9m against a plan of £15.9m, favourable due to higher capital creditors.

Capital

Expenditure of £1.2m, £8.9m below plan with business cases being developed to ensure no slippage by year end.

Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance				YTD Performance			
	Budget £'000	Actual £'000	Variance to budget £'000		YTD Budget £'000	Year To Date £'000	Variance to budget £'000	
Income	(51,782)	(51,515)	268	A	(103,589)	(103,310)	279	A
Pay	34,001	35,010	1,009	A	68,807	70,641	1,834	A
Non Pay	17,257	16,526	(731)	F	35,044	33,773	(1,271)	F
Financing Costs	880	359	(521)	F	1,610	811	(799)	F
(Surplus)/Deficit for the period	**356**	**380**	**24**	**A**	**1,872**	**1,916**	**44**	**A**
Donated Asset Adjustment	(41)	(59)	(18)	F	(82)	(134)	(52)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**315**	**321**	**6**	**A**	**1,790**	**1,781**	**(9)**	**F**

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

Key

F = Favourable **A** = Adverse

Finance Risks

The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.

£6.8m improvement in net risk during month 2 driven by reduction in efficiency risk as further schemes have been identified.

The Finance Department continues to formally review the Financial Risk Register on a routine basis.

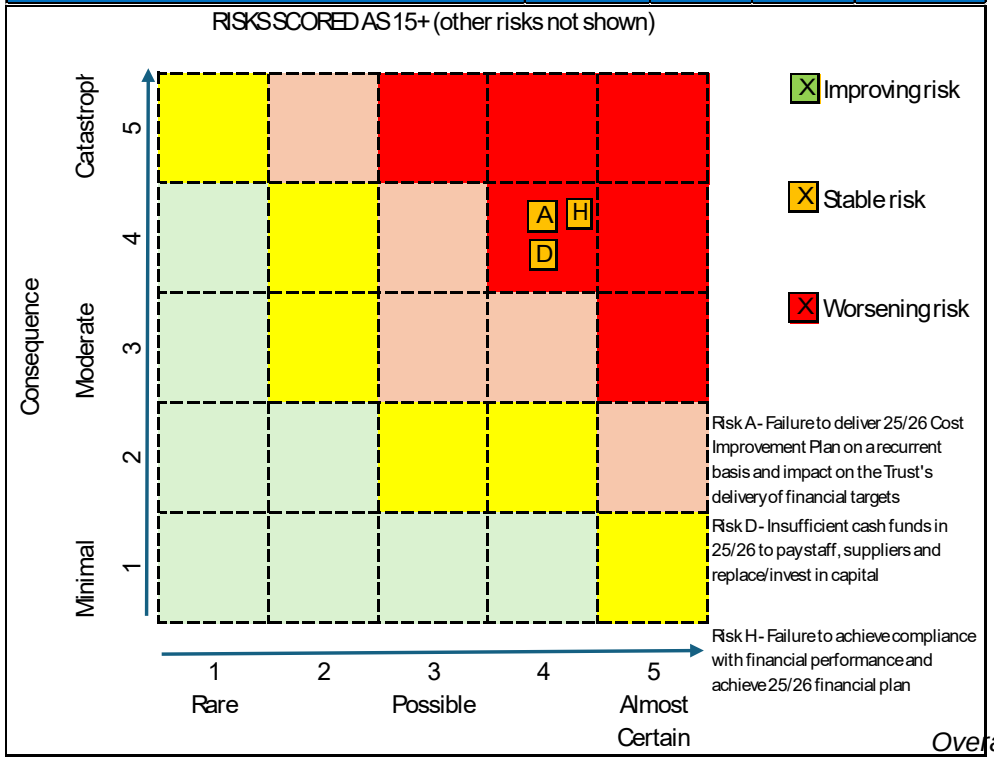
Key Risks

- Failure to achieve compliance with financial performance and achieve 25/26 financial plan
- Failure to deliver 25/26 Cost Improvement Plan on a recurrent basis impacting on the Trust's delivery of financial targets
- Insufficient cash funds in 25/26 to pay staff, suppliers and replace/invest in capital

Actions

- Executive Team and budget holders developing Cost Improvement Plans with SROs confirmed
- Trust-wide engagement sessions with Executive Team have taken place
- Bright Ideas Clinic launched and >100 ideas being assessed
- Detailed cash monitoring and forecasting on monthly basis

Risks and mitigations	25/26 Plan	M1	M2	Increase (Decrease)
	£'000	£'000	£'000	£'000
Risks				
Additional cost risk (capacity, pressures, winter)	(2,000)	(2,000)	(2,000)	0
Additional cost risk (inflation)	(6,178)	(3,707)	(3,707)	0
Efficiency risk	(22,817)	(19,739)	(10,913)	8,826
Income risk	(1,000)	(1,000)	(1,000)	0
Total Risks	**(31,995)**	**(26,446)**	**(17,620)**	**8,826**
Mitigations				
Additional cost control or income	4,000	4,000	4,000	0
Efficiency mitigation	4,000	4,000	5,457	1,457
Non-recurrent mitigation	3,500	3,500	0	(3,500)
Total Mitigations	**11,500**	**11,500**	**9,457**	**(2,043)**
Net Risk	**(20,495)**	**(14,946)**	**(8,164)**	**6,782**



Surplus/Deficit

In month/YTD

- £0.3m deficit, a £6k adverse variance to plan.
- Year to date a £1.8m deficit with a small favourable variance to plan. £1.2m of non-recurrent technical benefits have been made earlier than planned to support the position.

Income

- Income is £0.3m adverse to budget both in month and YTD adverse to budget mainly due to HEE income.

Pay

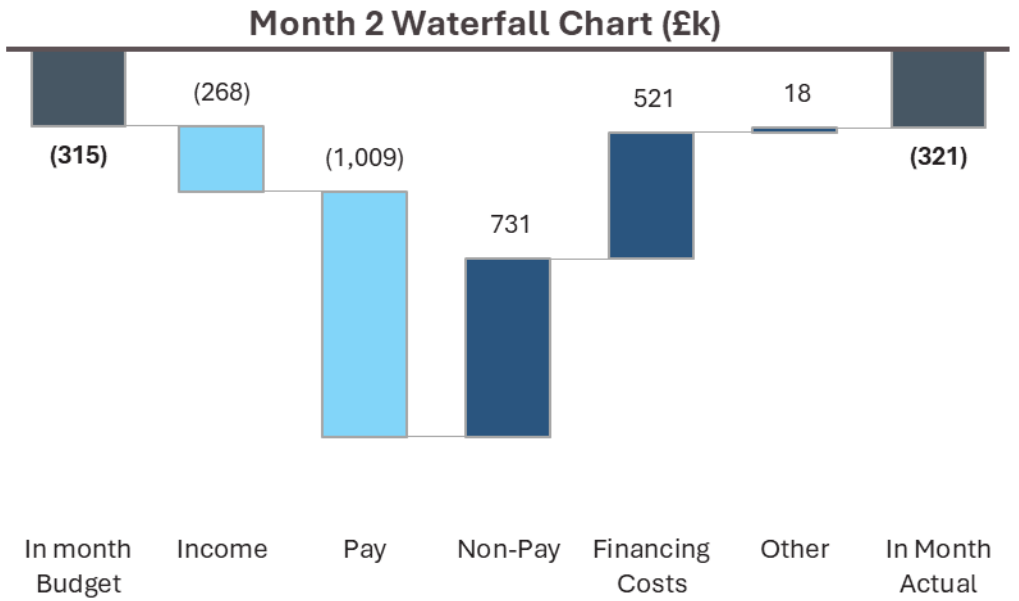
- Pay is £1m in month and YTD £1.8m adverse to budget mainly due to CIP delivery, operational pressures and premium costs.
- Bank/agency and additional medical sessions spend in month is £4.1m due to operational pressures, cover for vacant posts and sickness cover

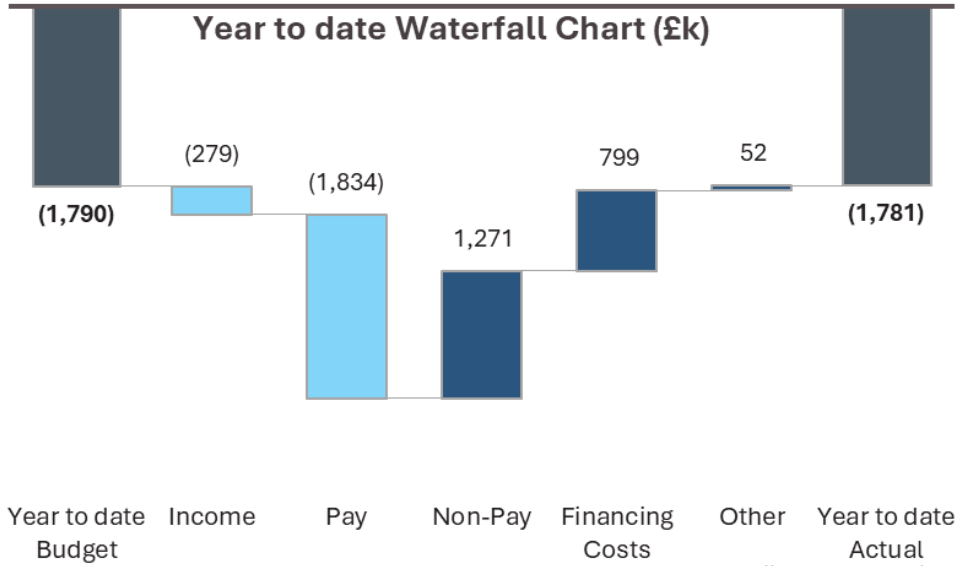
Non-Pay

- Non pay is £0.7m in month and YTD £1.3m favourable to budget mainly due to non recurrent technical benefits

Financing Costs

- Higher cash balance than planned has generated increased interest income





Financial Performance – Income

Clinical Income Position Month 2

	Plan - M2 YTD £'000	Actuals - M2 YTD £'000	Variance £'000
ICB			
NHS South Yorkshire ICB	-65,406	-65,376	30
NHS Nottingham and Nottinghamshire ICB	-18,237	-18,292	-55
NHS Humber and North Yorkshire ICB	-1,449	-1,390	58
NHS Derby and Derbyshire ICB	-1,037	-981	56
NHS West Yorkshire ICB	-703	-703	0
NHS Lincolnshire ICB	-326	-355	-29
LVA	-204	-205	0
ERF - Over performance	0	-501	-501
API	178	178	0
ICB sub total	**-87,184**	**-87,625**	**-442**
NHS England			
Specialised Commissioning	-11	0	11
Public Health	-765	-764	1
Offender Health	-273	-276	-2
Drugs and Devices	-1,893	-1,893	0
NHSE sub total	**-2,942**	**-2,932**	**9**
CDC	-1,647	-1,229	418
Clinical Income - misc	-213	-311	-99
Road Traffic Accident, Private Pat. Oversea's	-863	-865	-2
Reported Position	(92,848)	(92,963)	(115)

Contracts

The contract with SY ICB has been signed. NHSE contract values are agreed and due to be signed. Queries on some of the associates offers are still in progress. All outstanding associates will be varied into the contract at a later date. New recent national guidance expects an agreed Indicative Activity Plan (IAP) by the end of June and if not agreed the Commissioner can impose an IAP on the Trust.

ERF Performance

The below shows the current estimated ERF performance. The activity has not been fully coded and includes estimates. MEOC, T&O and urology specialties are the main over performers as at month 2.

ERF position by POD	M2 ERF Target	M2 ERF Actual	M2 variance to ERF Target
A & G	(376)	(376)	0
Daycase	(6,473)	(6,309)	164
Elective	(4,804)	(4,942)	(137)
Outpatient First	(4,249)	(4,478)	(229)
Outpatient Procedures	(2,713)	(3,011)	(298)
Total	(18,615)	(19,116)	(501)

The Clinical Income position is showing a favourable position YTD of £115k whilst Operating Income an adverse variance of £394k mainly due to HEE income, giving an overall year to date adverse income position of £279k. The main drivers of the year to date favourable clinical income performance is ERF performance at £0.5m (baseline ERF income is included in the ICB income categories) offset by lower CDC activity of £0.4m. HEE income is mainly due to the pending inflation increase.

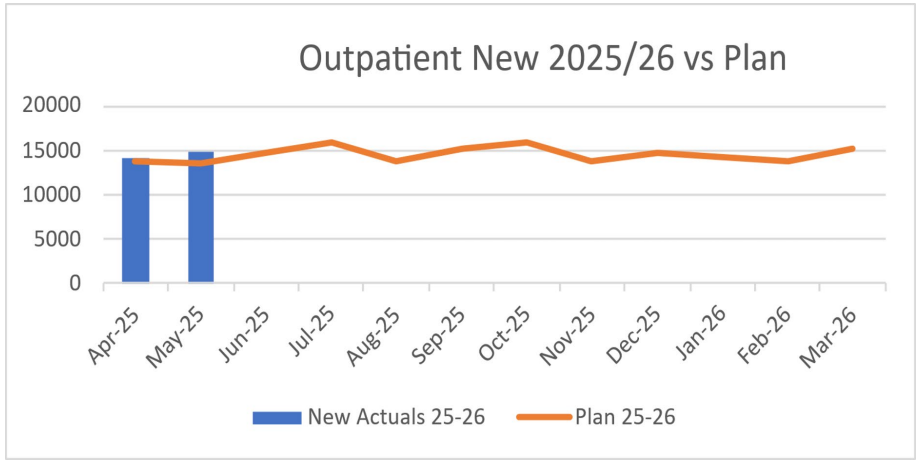
Activity Against Plan 25/26

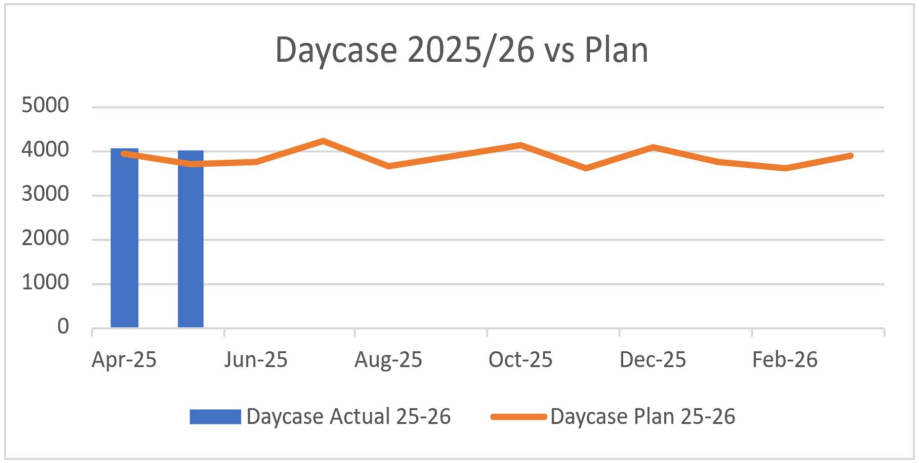
Point of Delivery	Activity vs Plan (May 2025)
Outpatients New	109.3%
Outpatient Follow up	105.9%
Daycase, excluding MEOC	109.1%
Elective, excluding MEOC	124.1%

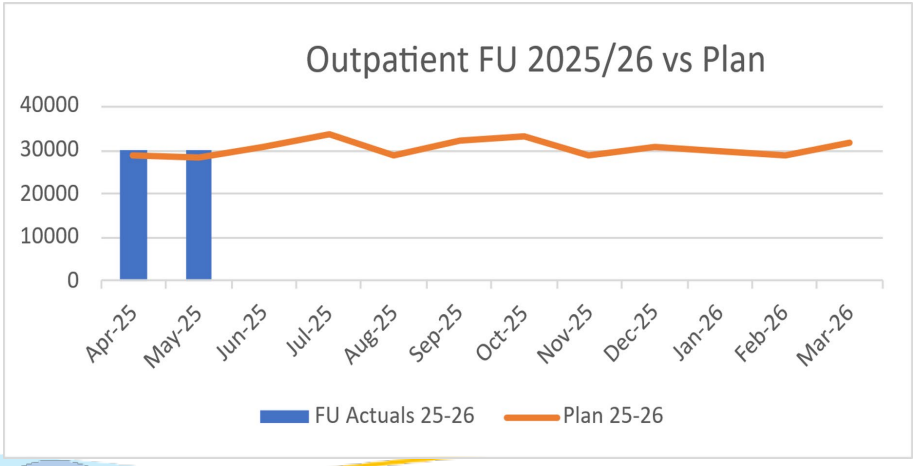
All four PODs exceeded their monthly and year to date targets, with the most significant overperformance in elective activity. We delivered 153 more treatments than planned in month and 222 YTD. The three specialties with the highest variance from plan were Urology (14 cases above plan), Trauma and Orthopaedics (22 cases above plan) and Obstetrics (17 cases above plan).

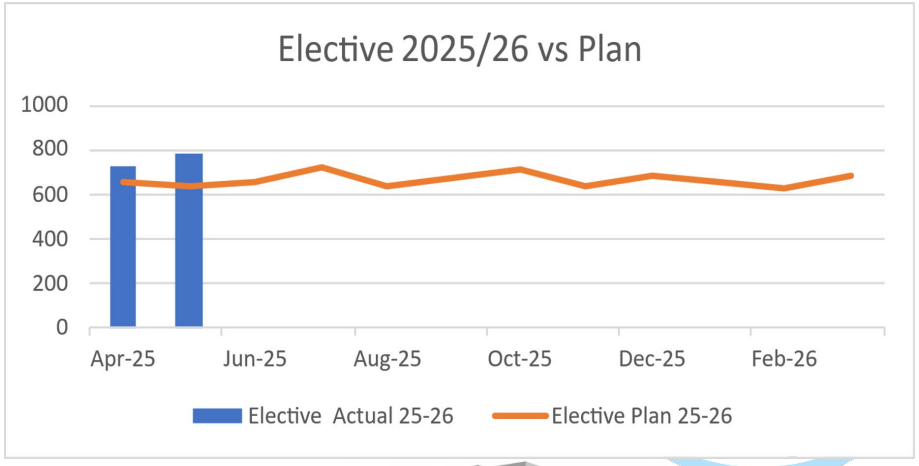
We carried out 337 more Day Case procedures than planned. The three specialties with the highest variance were Gynaecology (37 cases above plan), Gastroenterology (214 cases above plan), and Paediatric Dental (38 cases above plan).

Outpatient New appointments were 1266 above plan and Outpatient follow up were 1675 in month.







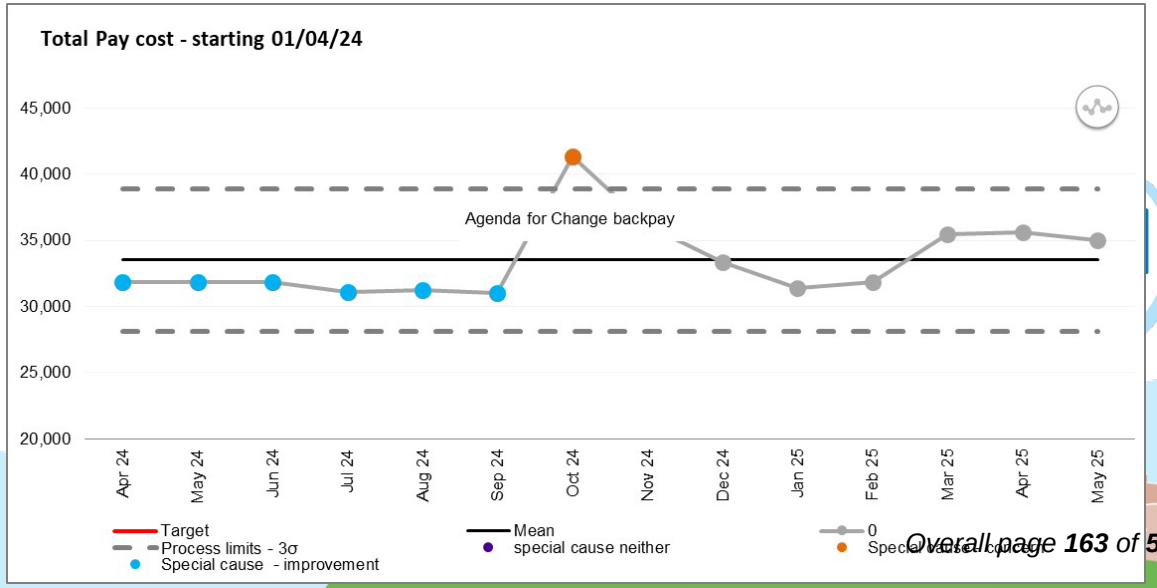


Financial Performance - Pay

In Month - £1m adverse to budget
Year to date - £1.8m adverse to budget

- Pay expenditure in month has reduced by £0.6m mainly due to additional sessions, pay arrears and a number of leavers in medical staffing.
- Bank/Agency spend has increased by £0.3m in month, and additional sessions have reduced by £0.2m.
- Adverse variance in month and year to date is mainly driven by unachieved CIP, operational pressures and premium costs of medics and nursing
- Reserves funding for approved business cases has been allocated to Divisions in month 2.

Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,294	6,088	-206	F	-229	F
Ambulance staff						
Apprenticeship Levy	131	126	-4	F	-9	F
Allied health professionals	2,915	2,835	-80	F	-123	F
Healthcare science staff	21	16	-5	F	-11	F
Medical and dental	10,614	11,081	467	A	1,568	A
Non Medical Non Clinical				A		A
Nursing & midwifery	12,987	13,028	42	A	300	A
Comprising:						
Registered nursing	*9,638*	*9,333*	*-306*	F	*-447*	F
Unregistered nursing	*3,346*	*3,696*	*350*	A	*748*	A
Scientific, therapeutic and tech	815	856	41	A	111	A
Reserves	225	979	754	A	227	A
Total Trust	**34,001**	**35,010**	**1,009**	A	**1,834**	A



Financial Performance – Non Pay

In Month - £0.7m favourable to budget

Year to date - £1.3m favourable to budget

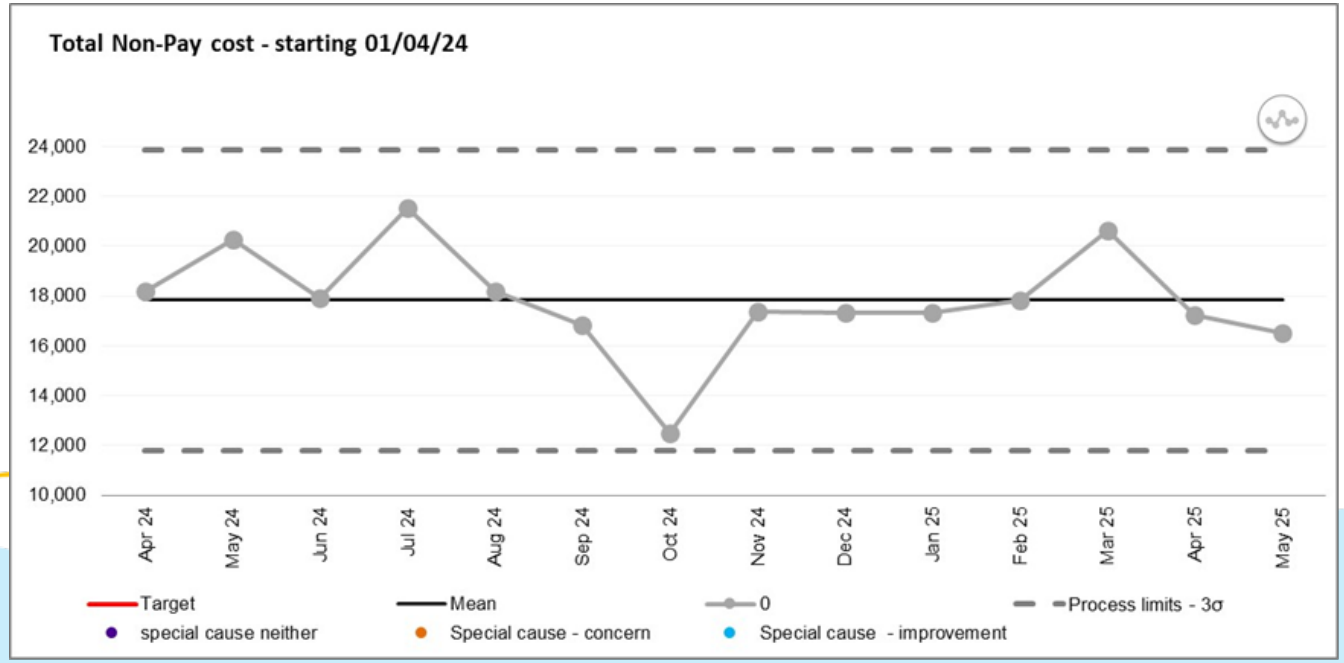
The main reasons for the favourable variance is due to:

- Other costs are adverse mainly due to unachieved CIP

Offset by:

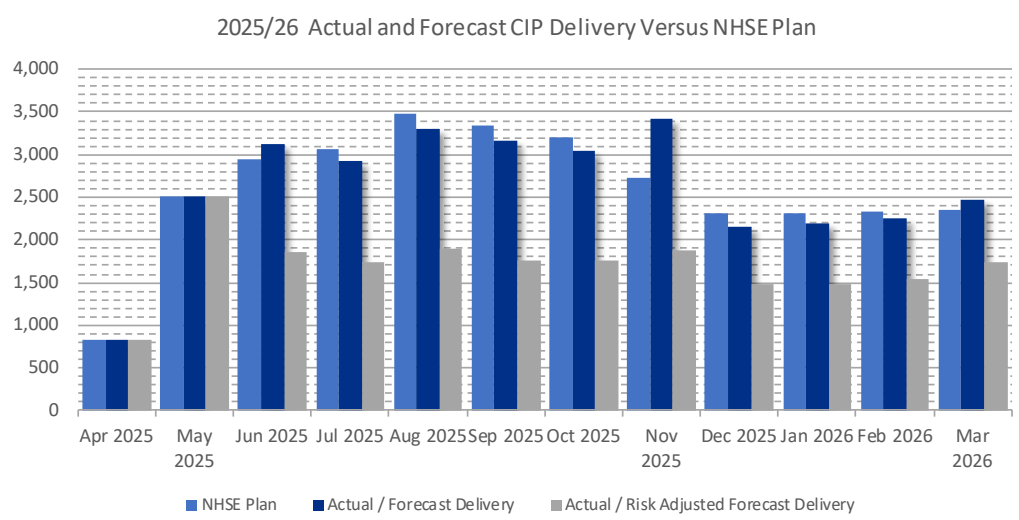
- Reserves favourable due to non recurrent technical benefits

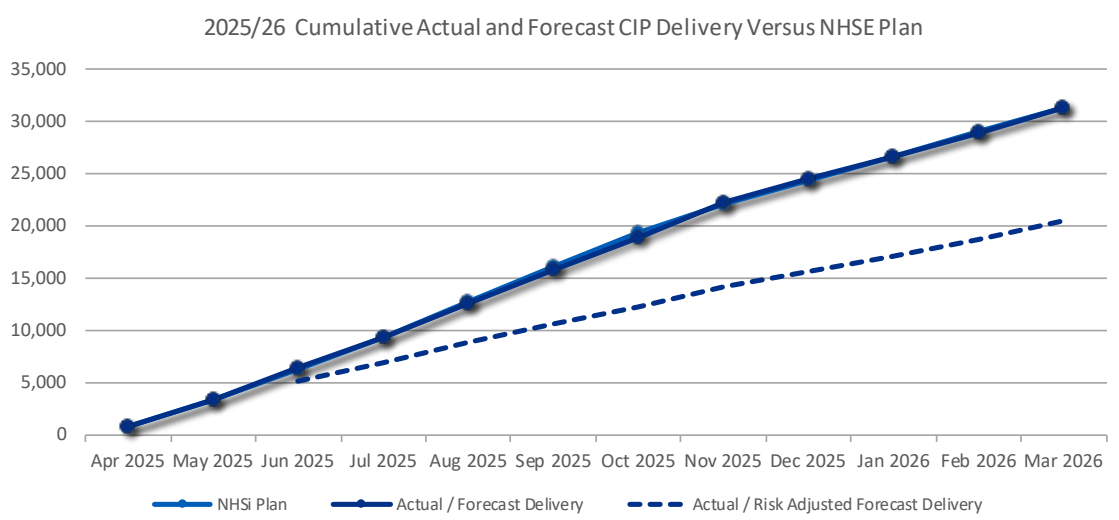
Non-pay trend by subjective	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Drugs (excluding non-PBR drugs)	1,279	1,190	-89	F	-52	F
Drugs (non PBR)	2,280	2,333	53	A	-30	F
Clinical Supplies and Services	3,074	3,021	-53	F	-79	F
Other costs	5,484	6,004	520	A	447	A
Non-Executive Directors	16	15	-1	F	-2	F
Depreciation	1,594	1,596	2	A		F
Reserves & Technical Adjustments	1,768	614	-1,154	F	-1,554	F
Recharges	1,727	1,727		A		A
Parkhill	35	27	-8	F		A
Total Trust	**17,257**	**16,526**	**-731**	F	**-1,271**	F



Efficiency Schemes

In month 2 the Trust has delivered £2.5m of savings in line with the plan submitted to NHSE of £2.5m and year to date £3.3m delivered in line with the plan. Non recurrent technical benefits are supporting the delivery of the plan in month 2. The phasing of the plan does however increase significantly until August as shown in the graph below. Further work is needed to give assurance on delivery of the overall Trust plan in conjunction with nominated executives, SROs and workstream leads. The current forecast is 58% recurrent and 42% non-recurrent, the NHSE Plan is 53% recurrent and 47% non-recurrent.





Delivery of the CIP programme is a key tenant of the Trust delivering its overall financial plan. Targets of 6.1% have been assigned to all divisions and corporate departments, with contributions to formal cross cutting workstreams and local initiatives expected.

Divisional progress is being monitored via PRM and the overall CIP governance reports into a monthly Executive Team Meeting. Divisions are due to report their CIP plans to the June PRM meetings.

The PMO continue to support the work up of the formal workstream Charters and detailed plans with the nominated SROs. They also hold regular CIP Meetings with each division to ensure ongoing identification and validation of local opportunities.

Formal feedback from NHSE/ICB is pending from the joint CIP Assurance Deep Dive Meeting in late May.

Efficiency Schemes

All schemes are assigned a delivery risk within their respective trackers. This will be agreed by the SRO and updated by the PMO project support. The purpose of this risk rating is to allow the Trust to understand it's most likely outturn position in terms of CIP delivery. The annual forecast as at month 2 remains in line with plan at £31.4m, the risk adjusted view is £20.5m.

Actual Forecast £000's	April	May	June	July	August	September	October	November	December	January	February	March	Total
NHSE Plan	837	2,503	2,945	3,069	3,480	3,342	3,203	2,733	2,311	2,304	2,329	2,343	31,397
Actual / Forecast Delivery	838	2,503	3,117	2,930	3,300	3,162	3,046	3,426	2,161	2,202	2,250	2,463	31,397
Delivery/Forecast v NHSE Plan	0	0	172	(138)	(180)	(180)	(157)	693	(150)	(101)	(78)	120	0
Cumulative NHSE Plan	837	3,340	6,285	9,353	12,833	16,175	19,378	22,111	24,422	26,726	29,055	31,397	
Cumulative Actuals and Forecast	838	3,340	6,457	9,387	12,687	15,849	18,895	22,320	24,481	26,684	28,934	31,397	
Cumulative Delivery/Forecast v NHSE Plan	0	0	172	34	(146)	(326)	(483)	210	59	(42)	(120)	0	

Risk Adjusted Forecast £000's	April	May	June	July	August	September	October	November	December	January	February	March	Total
NHSE Plan	837	2,503	2,945	3,069	3,480	3,342	3,203	2,733	2,311	2,304	2,329	2,343	31,397
Actual / Risk Adjusted Forecast Delivery	838	2,503	1,858	1,744	1,897	1,754	1,751	1,881	1,483	1,491	1,535	1,749	20,484
Delivery/Forecast v NHSE Plan	0	0	(1,087)	(1,325)	(1,583)	(1,588)	(1,451)	(852)	(828)	(813)	(794)	(594)	(10,913)
Cumulative NHSE Plan	837	3,340	6,285	9,353	12,833	16,175	19,378	22,111	24,422	26,726	29,055	31,397	
Cumulative Actuals and Risk Adjusted Forecast	838	3,340	5,198	6,942	8,839	10,593	12,345	14,225	15,709	17,200	18,735	20,484	
Cumulative Delivery/ Risk Adj. Forecast v NHSE Plan	0	0	(1,086)	(2,411)	(3,994)	(5,582)	(7,033)	(7,885)	(8,713)	(9,526)	(10,319)	(10,913)	

Risk Adjustments:	Risk Adjusted Forecast
100% of Fully Developed	15,935
50% of Plans in Porgress	1,366
25% of Opportunities	3,183
Total	**20,484**

Efficiency Category £000's	Forecast	Risk Adjusted Forecast
Income	459	424
Pay	15,734	10,563
Non-Pay	15,204	9,497
Total	**31,397**	**20,484**

Efficiency Schemes

The tables below reflect the current status and plan risk of the CIP Programme as at month 2, in line with recent NHSE guidance we have eliminated the unidentified balance by the end of May 2025. All high-risk schemes need to be reduced by the end of June 2025 which will be challenging.

Efficiency Plan Status £000's	April Plan Submission	Month 1	Month 2	Movement Month 1-2
Fully Developed	9,350	10,835	15,934	5,099
Plans in Progress	2,051	2,578	2,732	154
Opportunity	10,528	10,527	12,731	2,204
Unidentified	9,468	7,457	-	- 7,457
Total	**31,397**	**31,397**	**31,397**	**0**

Efficiency Plan Risk £000's	April Plan Submission	Month 1	Month 2	Movement Month 1-2
High	23,450	19,739	11,104	- 8,635
Medium	5,968	7,674	10,707	3,033
Low	1,979	3,984	9,586	5,602
Total	**31,397**	**31,397**	**31,397**	**0**

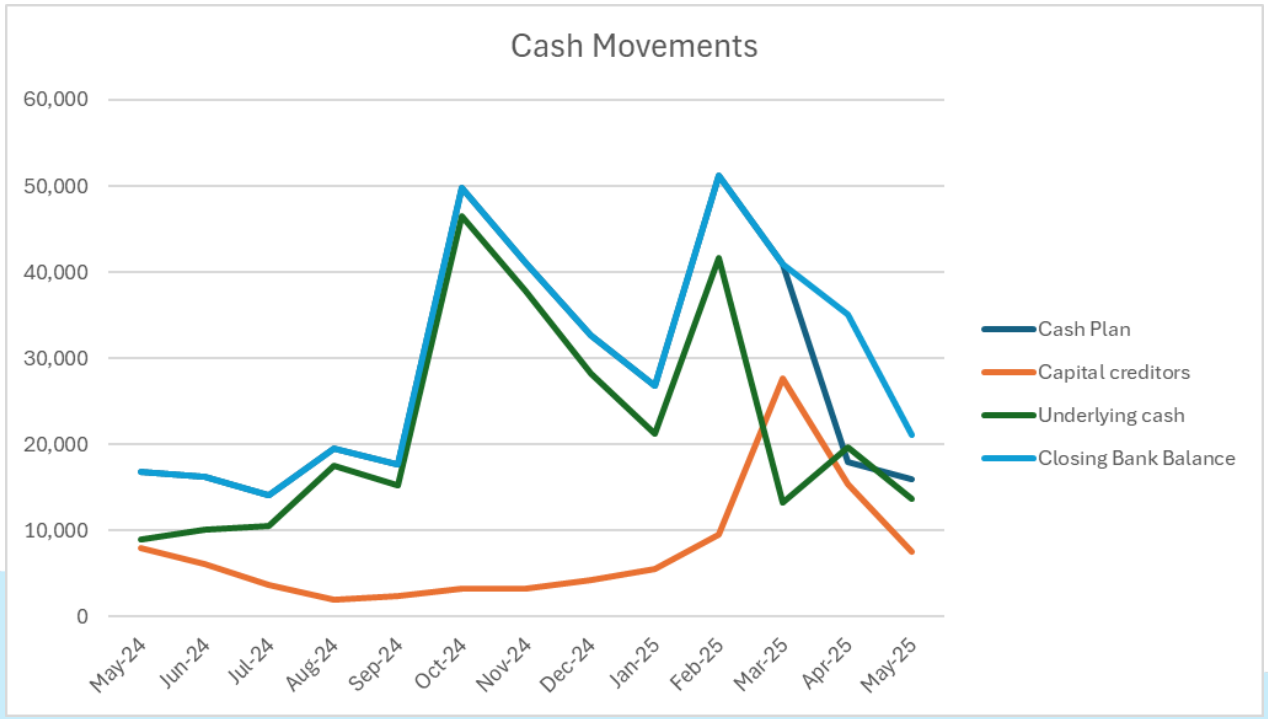
The table highlights the key changes in month to the plan for the status and risk assessment

Workstream / Scheme	Movement	Value £000's	Risk as per Month 1	Risk as per Month 2	Status as per Month 1	Status as per Month 2
Local - Reserves Release - Gas	Release - phased months 3-12	3,000	High	Low	Unidentified	Fully developed
Local - Reserves Release - IT/Drugs	Release - in month 2	1,722	High	Low	Unidentified	Fully developed
Local - Reserves Release - Outsourcing	Release - phased months 3-12	2,651	High	Medium	Unidentified	Opportunity
Local - STH Patholgy 2%	Assumed network delivery	215	High	Medium	Unidentified	Opportunity
Medicines Management - Drugs Wastage	Expected to be impacted by Robot move but actually delivering better than expected	336	High	Medium	Opportunity	Opportunity
Outpatients - A&G	A&G confidence on enabler as plans being worked up	130	High	Medium	Fully developed	Fully developed
Outpatients - Utilisation	Early delivery vs plan	71	Medium	Low	Plans in Progress	Fully developed
Diagnostics - Endoscopy	Additional sessions savings YTD quantified	32	High	Low	Opportunity	Fully developed
Diagnostics - Everlite Contract	Overnight Outsourcing Tender Output confirmed	150	Medium	Low	Opportunity	Fully developed
Local - Salary Sacrifice	Moved into full delivery	506	High	Low	Opportunity	Fully developed

Cash, Receivables and Payables

Cash reduced by £14.1m in the month to £20.9m but remains above plan. The reduction is mainly due to the level of year-end capital creditors being paid in the month (£8.5m) as well as timing of payment runs and the quarterly education income received in month 1. Underlying cash (cash less capital creditors) is £13.4m.

Better Payment Practice was relatively stable in the month.



Invoice Turnaround

Average days	Mar-25	Apr-25	May-25	YTD
Between date of invoice and date available on system	18.9	27	13.9	20.45
Between being available on system and approval	5.8	7	8.4	7.7
Between approved date and payment date	23.2	22.4	22.2	22.3
Total	47.9	56.4	44.5	50.45
Total that the Trust has control over	**29**	**29.4**	**30.6**	**30**
Number of invoices	*8,191*	*10,397*	*7,327*	*8,862*

Better Payment Practice Code (In month)

Average days	Mar-25	Apr-25	May-25	YTD
NHS - %age based on invoice count	82.25%	91.79%	86.34%	89.07%
NHS - %age based on invoice value	90.52%	89.85%	90.10%	89.98%
Non NHS - %age based on invoice count	36.84%	40.63%	36.93%	38.78%
Non NHS - %age based on invoice value	71.33%	77.48%	72.66%	75.07%
Overall - %age based on invoice count	39.06%	42.10%	38.00%	40.05%
Overall - %age based on invoice value	73.65%	74.69%	74.31%	74.50%

Capital

Capital spend in month is £0.6m, an underspend of £4.4m

The in month spend in Estates is linked to the completion of projects from 24/25 and MEG works on the BDGH X-Ray Room.

Capital allocations have been approved by the Executive Team and the sub-committees are working on the completion of business cases submission to CIG.

Capital expenditure is expected to deliver on plan by the end of the year, current underspend is linked to changes in the capital programme pre-commitments and timing of spend including DCC and Bassetlaw SDEC.

	In Month Budget (£'000)	In Month Spend (£'000)	In Month Variance (£'000)		YTD Budget (£'000)	YTD Spend (£'000)	YTD Revised Variance (£'000)		Revised Annual Plan (£'000)
Other Estates Projects	1,661	249	(1,413)		3,323	273	(3,050)		10,307
SDEC	247	5	(242)		494	4	(490)		1,338
SPECT CT	209	(1)	(210)		419	8	(411)		1,133
Pharmacy Robot	115	1	(114)		230	(1)	(231)		622
CT Scanner	156	(56)	(213)		313	(55)	(368)		847
DCC	819	4	(815)		1,638	11	(1,627)		9,827
Estates Safety	0	0	0		0	0	0		3,171
Return to Constitutional Standards Schemes	0	0	0		0	0	0		4,425
Solar Net Zero	0	0	0		0	0	0		55
Digital Transformation Projects	392	28	(363)		783	110	(673)		4,091
Electronic Patient Recording	24	26	1		49	69	20		17,621
Medical Equipment	631	372	(259)		1,262	780	(482)		4,758
Central Capital	768	(7)	(776)		1,537	(4)	(1,540)		3,062
IFRS16 Leases	0	0	0		0	0	0		964
Total Capital Spend	**5,023**	**621**	**(4,403)**		**10,047**	**1,195**	**(8,852)**		**62,221**
Charitable Funds/Donated Assets	0	1	1		0	18	18		0
Total Capital Spend inc Charitable Funds/Donated Assets	**5,023**	**622**	**(4,402)**		**10,047**	**1,212**	**(8,834)**		**62,221**

2507 - E2 ESTATES RETURN INFORMATION COLLECTION 2024/25

Decision Item | Sam Wilde, Chief Finance Officer | 11:35

10 minutes

REFERENCES

Only PDFs are attached

E2 - Estates Return Information Collection 2024-2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Estates Return Information Collection (ERIC) 2024/2025**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Sean Tyler Head of Compliance (Estates and Facilities)			
Appendices:	Appendix 1: ERIC Return Trust Level Report 2024/2025 Appendix 2: ERIC Return Site Level Report 2024/2025			
Purpose of the report	**Assurance**	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	**BAF4:** Report demonstrates measures to ensure the estate is fit for purpose enabling DBTH to continue to deliver services and reduce the impact of the estate on outcomes & experience for patients and colleagues **BAF5:** Impacts on delivery of DBTH financial plan to ensure DBTH will be able to deliver services enabling the Trust to be financially sustainable in long term			

Executive Summary – Key messages and Issues

The Estates Return Information Collection (ERIC) forms the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31 March 2025. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estate and also supports work to improve efficiency.

The report provides data collected for the financial year (FY) 24/25 ERIC return for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) at Trust Level (Appendix 1) and individual Site Level (Appendix 2). The data was provided by the Trust's Finance Department, Estates and Facilities, the Capital Planning Unit, and external consultants Oakleaf. Financial data has been verified against the ledger by the Trust Finance Department.

The report presents the main variances in the FY24/25 ERIC return compared to FY23/24. These variances are summarised below:

In total, backlog maintenance has increased from £147.8m to £151.3m (2.3%). This is the net effect of a £3.6m inflationary increase, a £0.8m increase in backlog maintenance costs due to deteriorations in mechanical and electrical infrastructure, and a £0.9m reduction in backlog maintenance as a result of the Trust's capital investment programme.

Capital investment for the period included £9.3m in new build investment to complete the Community Diagnostic Centre (CDC) at Montagu Hospital (MH) and the Bassetlaw Emergency Village (BEV), £12.7m investment in changing/improving existing buildings, £5.4m investment in maintaining existing buildings, and a £22.3m investment in equipment. This investment totalled £49.8m in FY24/25, a reduction of £7.1m (-12%) from the £56.9m invested in FY23/24.

A decrease in the book value of fixed asset after revaluation/impairment led to reduced depreciation of £3.6m (-41%) at DRI, £0.9m (-30%) at BH and £0.6m (-44%) at MH.

Contribution to Costs decreased from non-NHS organisations by -£65k (-5%) due to non-recurrent income received from an insurance claim related to building damage caused by a third party service provider at MH. While income from NHS organisations increased by -£96k (299%) due to pathology specimens transferring from DBTH to STH.

Estates and Facilities (E&F) finance costs fell significantly due to lower depreciation and reduced loan balances resulting in a £3.9m (-24%) decrease at DRI, (-12%) at BH and £0.7m (-28%) at MH.

Interest on Capital decreased overall as a result of Interest charges reducing as loans were paid off, resulting in reductions of £45k (-17%) at DRI and £10k (-21%) at MH, with BH remaining approximately the same as the previous reporting period.

Electro Bio Medical equipment maintenance costs increased by £0.3m (301%) at MH due to expanded cardio respiratory and medical imaging services requiring additional contracts. Conversely, costs decreased by £0.3m (-9%) at DRI and £0.1m (-16%) at BH.

Energy Costs reduced as a result of the Trust switching from a fixed to variable energy tariff with usage remaining broadly flat, which led to lower costs for gas and electricity of;

- Electricity savings: £0.9m (-20%) at DRI, £0.6m (-33%) at BH and £60k (-32%) at MH
- Natural gas savings: £1.4m (-45%) at DRI, £0.4m (-43%) at BH and £0.3m (-58%) at MH

Investment in the quality of buildings to remove physical backlog increased by £4.2m (34%) to £16.5m in FY24/25. It should be noted that while £16.5m has been reported as investment in backlog, approximately £10m of this relates to the enabling works to relocate the Department of Critical Care (DCC) at DRI, which is a multi-year project that will positively impact the backlog position in a future reporting period.

Finally there has been an overall reduction in waste management costs reduced by £75.4k (-7) compared to last year. This is primarily related to a change in the main waste management contract following a competitive tender exercise, and efforts to ensure that waste is processed using the most efficient waste stream.

Recommendations	
The Board of Directors is asked to note / approve the information enclosed on the ERIC 2024/2025 submission which is required to be submitted to EFM Information, HSCIC (NHS DIGITAL) on 01/07/2025 and will be released into the public domain in October 2025 as part of the full ERIC returns report.	
Healthier together – delivering exceptional care for all	
Patients	Patient safety, patient experience and the quality of care provided is directly linked to the provision of a safe, suitable environment, therefore; the effective management of The Trust Estate, its Facilities, related backlog maintenance and capital investment is imperative to the continued delivery of the core business and its services.
People	The health and wellbeing of the workforce are strongly linked to patient safety and the patient experience whilst attending hospital. Therefore the effective management of the Estate and its Facilities as well as its capital expenditure and associated backlog maintenance including critical infrastructure is directly relating to delivering a safe environment for colleagues as well it also contributing to the quality of care delivered to the patient.
Partnerships	Ensure efficient management of public money, through delivery of the Trust capital infrastructure investment continually reducing the Trust backlog maintenance total as part of the annual capital infrastructure investment programme.
Pounds	Patient safety, patient experience and the quality of care provided is directly linked to the provision of a safe, suitable environment, therefore; the effective management of The Trust Estate, its Facilities, capital investment and related backlog maintenance is imperative to the continued delivery of the core business and its services.
Health Inequalities	The continued delivery of financially sustainable Estates and Facilities services enables the Trust to directly contribute to reducing the unequal burden of adverse health events experienced by vulnerable communities, ethnic minorities, and other disadvantaged groups, therefore addressing a critical dimension of health inequalities, improving patient safety and clinical outcomes.
Legal/ Regulation:	Health and Social Care Act requirement, Violence Prevention and Reduction Standards included in the NHS Standard Contract for 2023/2024.

<table>
<tr><td></td><td>The organisation has a duty of care to protect staff from threats of violence at work. The following pieces of legislation cover violence at work:
Health and Safety at Work Act 1974 (HASAWA)
Management of Health and Safety at Work Regulations 1999
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
Safety Representatives and Safety Committees Regulations 1977
Health and Safety (Consultation with Employees) Regulations 1996.</td></tr>
<tr><td>Partner ICB strategies</td><td>N/A</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>None</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Data provision from the ERIC return to inform expenditure and provide evidence required to support business cases for the expenditure. ERIC provides evidence in relation to Estates & Facilities, also including any local investment planning. Data collected through ERIC is also used to benchmark the Trust against other Trusts to determine levels of efficiency, safety and quality.</td></tr>
<tr><td>Is this in line with Current risk appetite

YES/~~NO~~</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
</table>

Contents

1. Introduction

The following report provides an overview of the data collected for the financial year (FY) 24/25 Estates Return Information Collection (ERIC) return for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), highlighting any significant variances from the previous year's return. The data is presented at both a Trust level (Appendix 1) and individual site level (Appendix 2).

The data presented was collated by Estates and Facilities, the Capital Planning Unit and the Finance Department. The information was supplemented by an updated six-facet survey on 20% of the Trust's estate across all sites, and a desktop review of existing six-facet data by external consultants, Oakleaf. The financial data in the return has been verified against the financial ledger by the Finance Department.

2. Backlog Maintenance

The updated six-facet survey and desktop review conducted by Oakleaf resulted in a net increase of **£3.5m** in the reported backlog maintenance position, increasing from **£147.8m** in FY23/24 to **£151.3m** (2.3%) in FY24/25.

This is the net effect of increased backlog costs as a result of deterioration, inflationary cost increases, and reductions in backlog costs as a consequence of the Trust's capital investment programme. Further detail is provided below.

Deterioration - Backlog costs increased by **£0.8m** as a result of deteriorations in mechanical and electrical infrastructure.

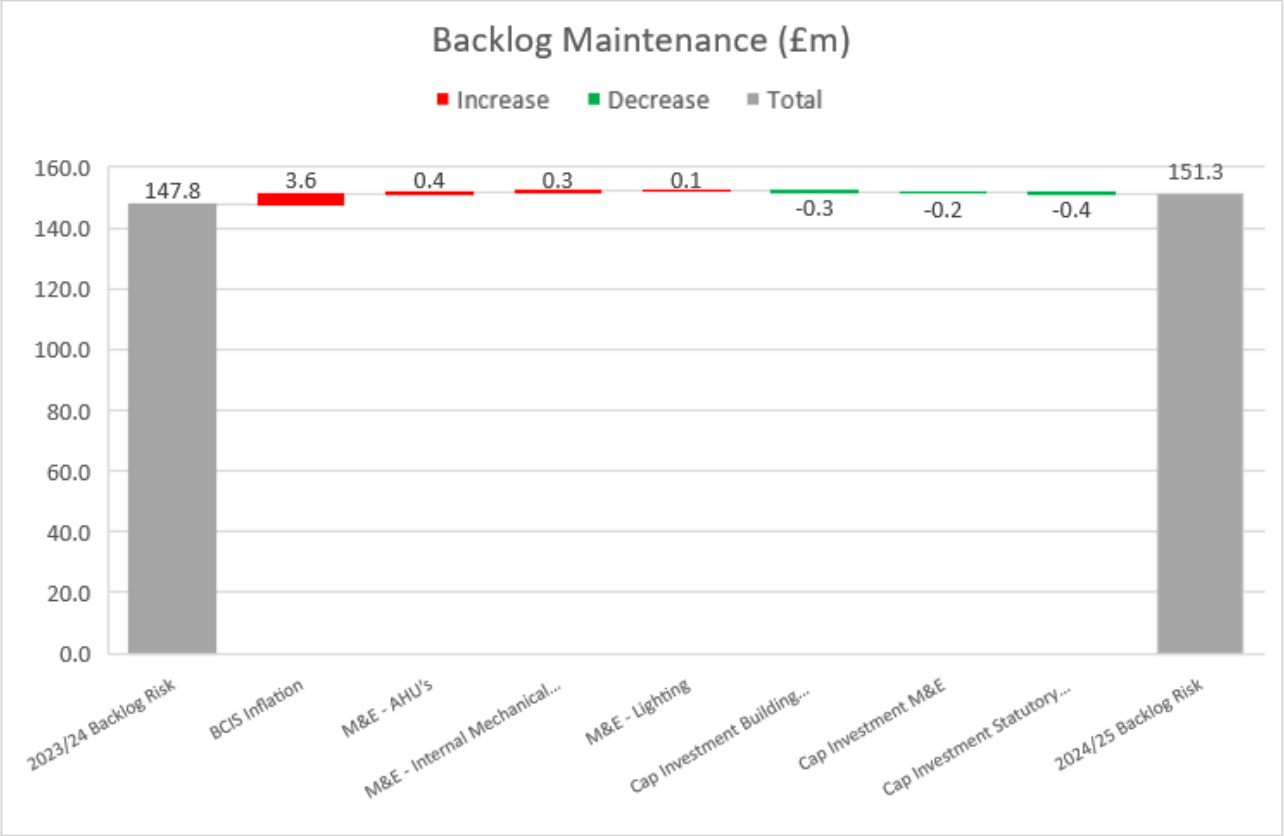
Inflation - Costs are reviewed annually and increased for inflation using BCIS PUBSEC Tender Price Index of Public Sector Building Non-Housing, in accordance with ERIC data definitions. An inflationary uplift of 3.2% was applied for the reporting period, leading to an inflationary increase of **£3.6m** split between the three sites as follows:

- **£2,963,618** at DRI
- **£485,604** at BH
- **£136,758** at MH

Capital investment - The Trust's capital investment programme led to a consequential **£0.9m** reduction in the reported backlog value.

Figure 1 illustrates the changes described above, illustrating the net increase of **£3.5m** in the total backlog maintenance costs reported.

Figure 1: Backlog Maintenance Increase for 2024/2025 Including Investment to Reduce Backlog



3. Capital Investment

Capital investment reduced by **£7.1m** (-12%) overall compared to the previous year, reducing from **£56.9m** in FY23/24 to **£49.8m** in FY24/25. The variations in investment from the previous reporting period are summarised below and presented in figure 2.

- **New Build Investment:** A total of £39.6m was invested in FY23/24 for the construction of the Mexborough Elective Orthopaedic Centre (MEOC), Bassetlaw Emergency Village (BEV), and Community Diagnostic Centre (CDC). MEOC was completed within the financial year, while the CDC and BEV schemes carried over into FY24/25. An additional £9.3m was invested in FY24/25 to complete these projects, representing a net year-on-year reduction in capital spend of £30.3m (-76%).

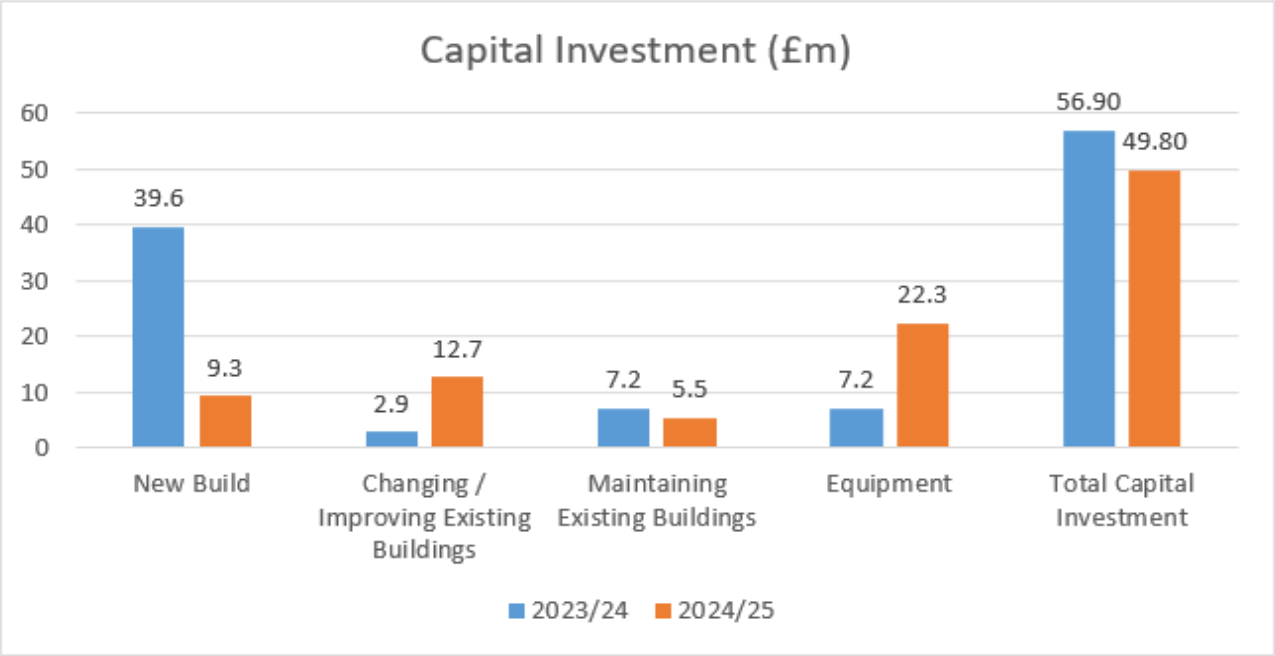
- **Changing/Improving Existing Buildings:** £12.7m in PDC funding was invested in changing or improving buildings in FY24/25, £10m of which was allocated for the relocation of Department of Critical Care (DCC) at DRI. This represents a £9.9m (253%) increase from the £2.8m invested in the previous year.

- **Maintaining Existing Buildings:** £5.4m of capital funding was allocated to maintaining existing buildings in FY24/25, representing a £1.7m (-33%) decrease from the £7.2m invested in FY23/24. This is in part because a higher level of investment was needed for electrical

infrastructure and fire safety in FY23/24 due to links to other projects within the capital programme. Additionally, further investment from the Trust's Capital Departmental Expenditure Limit (CDEL) allocation was needed to complete the BEV in FY24/25 as a pre-commitment, which further limited capital funding for building maintenance.

- **Equipment:** There has been a significant increase in equipment investment for FY24/25, totalling £22.3m (67%), compared to £7.3m in FY23/24. The FY24/25 investment included key acquisitions such as a CT scanner, SPECT CT, Pharmacy Robot, Da Vinci Robot, and Stroke Rehabilitation Robot. Additionally, £4.1m was spent on other medical equipment, alongside £10.7m invested in IT hardware and software, including the Electronic Patient Record (EPR) system. Funding for these investments was sourced from a combination of charity contributions, Public Dividend Capital (PDC), and the Trust's CDEL allocation.

Figure 2: Capital Investment Report for 2024/2025



4. Main ERIC Return Variances

Depreciation: Following revaluation/impairment, a decrease in the book value of fixed assets led to a reduction of £3.6m (-41%) at DRI, £0.9m (-30%) at BH and £0.6m (-44%) at MH in Q1 FY24/245.

Contribution to Costs: There was a reduction in income from contribution to costs from non NHS organisations by -£65k (-5%) compared to last year. This was because the Trust received non-recurrent income from an insurance claim related to building damage caused by a third party service provider at MH. Income from NHS organisations on the other hand increased by -£96k (299%) as a result of transferring pathology specimens from DBTH to Sheffield Teaching Hospital (STH) therefore increasing these contribution to costs for the reporting period.

Estates and Facilities Finance Costs: Finance costs have decreased by £3.9m (-24%) at DRI, £0.7m (-12%) at BH and £0.7m (-28%) at MH compared to last year. This is due to decreases in depreciation and a lower balance of loans reducing liabilities.

Interest on Capital: Interest charges have decreased by £45K (-17%) at DRI and £10k (-21%) at MH due to lower loan balances as loans are paid off, with BH remaining approximately the same as the previous reporting period.

Electro Bio Medical Equipment Maintenance: Costs have increased by £0.3m (301%) at MH due to the expansion of cardio respiratory and medical imaging on site, leading to a need for additional maintenance contracts. Conversely, costs reduced by £0.3m (-9%) at DRI and £0.1m (-16%) at BH.

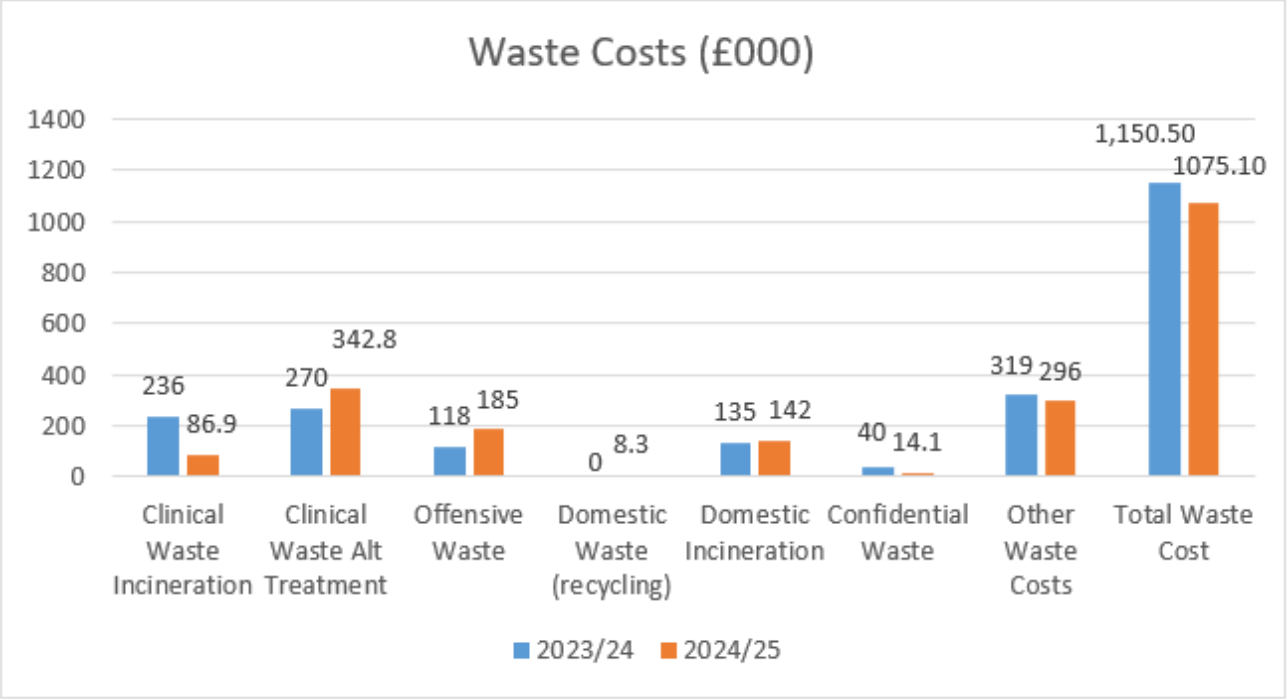
Energy: Lower energy tariffs as a result of a switch from a fixed to variable rate in FY24/25 resulted in reduced cost for both gas and electricity with usage remaining broadly flat. Electric costs decreased by £0.9m (-20%) at DRI, £0.6m (-33%) at BH and £60k (-32%) at MH. Natural gas costs decreased by £1.4m (-45%) at DRI, £0.4m (-43%) at BH and £0.3m (-58%) at MH.

Quality of Buildings: The proportion of the capital programme that includes elements of physical backlog removal totalled £16.5m in FY24/25, an increase of £4.2m (34%) on the previous reporting period.

Waste Management: Waste management costs reduced by £75.4k (-7%) compared to last year. This is primarily related to a change in the main waste management contract cost following a competitive exercise and changes in waste stream distribution. Figure 3 provides an overview of waste management cost for FY24/25 and the variance from the previous reporting period FY23/24.

One of the main factors leading to reduced costs is a reduction in the most expensive waste stream, clinical incineration, as a result of efforts to improve correct waste segregation at DBTH. While only a relatively small shift in volumes has been achieved so far, the financial impact is significant, and consequently this work will remain an area of focus for the year ahead in order to contribute to the 6.1% CIP target for Estates and Facilities Management (EFM).

Figure 3: Waste Management Variance Report for 2024/2025



5. Appendices

Appendix 1: ERIC Return Trust Level Report 2024/2025

Trust Profile	Unit	Value
Number of sites: General acute hospital	No.	3
Number of sites: Specialist hospital (acute only)	No.	0
Number of sites: Mixed service hospital	No.	0
Number of sites: Mental Health (including Specialist services)	No.	0
Number of sites: Learning Disabilities	No.	0
Number of sites: Mental Health and Learning Disabilities	No.	0
Number of sites: Community hospital (with inpatient beds)	No.	0
Number of sites: Other inpatient	No.	0
Number of sites: Non inpatient	No.	5
Number of sites: Support facilities	No.	0
Number of sites: Unoccupied	No.	0
Total number of sites	No.	8
Sites included above that are unreported	No.	0
Sites leased from NHS Property Services	No.	2
Sites occupied without charges	No.	0

Sustainability	Unit	Value
Estates Development Strategy	Yes/No	No
Energy managers	WTE	0.00
Does the trust have a waste reuse scheme	Yes/No	Yes
Waste re-use scheme: Cost savings	£	34,476
Waste re-use scheme: Carbon savings	CO2e (tonnes)	0.12
Waste managers	WTE	0.00
WEEE waste cost	£	18,952
WEEE waste weight	Tonnes	23.00
Estates and Facilities staff employed by an NHS wholly owned subsidiary company	WTE	0.00
Estates and facilities staff enrolled on an apprenticeship programme	No.	7

Finance	Unit	Value
Capital investment for new build	£	9,314,000
Capital investment for changing/improving existing buildings	£	12,685,354
Capital investment for maintaining (lifecycle) existing buildings	£	5,496,646
Capital investment for equipment	£	22,293,000
Private sector funding investment	£	0
Public sector funding investment	£	46,747,000
Charity and/or grant investment	£	3,042,000
Number of energy efficient schemes	No	0
Energy efficient schemes costs	£	
Carbon savings from investment in energy efficient schemes	CO2e (tonnes)	

Contribution to costs	Unit	Value
Contribution to costs from areas leased out for retail sales	£	-118,283
Contribution to costs from non NHS organisations	£	-1,125,860
Contribution to costs from NHS organisations	£	-128,475
Contribution to costs from local authorities	£	0
Income from car parking: patients and visitors	£	-976,264
Income from car parking: staff	£	-225,900
Total contributions	£	-2,574,782

Fire Safety	Unit	Value
Fires recorded	No.	1
False alarms: No call out	No.	74
False alarms: Call out	No.	37
Deaths resulting from fires	No.	0
Injuries resulting from fires	No.	0
Patients sustaining injuries during evacuation	No.	0

Medical Records	Unit	Value
Medical Records cost: Onsite	£	2,695,238
Medical Records cost: Offsite	£	76,174
Type of Medical Records	Select	3. Mixed
Medical Records service provision	Select	Hybrid

Appendix 2: ERIC Return Site Level Report 2024/2025

Facilities Management (FM) Services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Depreciation	£	2,103,817	5,152,308	795,902	0	0
Public Dividend Capital (PDC)	£	1,983,420	4,857,453	750,354	0	0
Public Dividend Capital (PDC): assets under construction	£	0	0	0	0	0
Leases and rent	£	146,991	268,117	36,423	90,606	229,277
Rates	£	661,896	1,426,906	215,876	0	0
Interest on Capital	£	53,970	132,173	20,417	0	0
Other Estates and Facilities finance costs	£	0	0	0	0	0
Indirect accommodation subsidies	£				0	0
Estates and property maintenance	£	1,487,311	3,794,827	359,765	0	
Grounds and gardens maintenance	£	14,427	36,956	5,316	0	
Electro Bio Medical Equipment maintenance	£	819,465	2,099,178	301,934	0	0
Other Hard FM (Estates) costs	£	505,787	1,323,354	186,358	0	
Other Soft FM (Hotel Services) costs	£	1,313,195	4,029,605	614,521	0	
Management (Hard and Soft FM) costs	£	183,763	482,585	43,836	0	
Estates and facilities finance costs	£	4,950,094	11,836,957	1,818,972	90,606	229,277

Areas	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Gross internal floor area	m²	42,454	108,754	15,642	1,157	2,045
Site heated volume	m³	118,648	275,670	38,832	4,393	5,177
Land area owned	Hectares	10.70	11.24	3.30	0.00	
Land area not delivering services	Hectares	1.51	0.16	0.57	0.00	
Private patient	m²	0	1,992	0	0	0
Pathology	m²	895	3,720	439	0	0
Clinical Sterile Services Dept. (CSSD)	m²	0	10	0	0	0
Clinical space: other	m²	26,146	66,176	8,797	688	1,797
Medical records	m²	869	1,977	238	0	0
Human Resources	m²	204	1,297	0	0	0
Information Technology	m²	78	490	76	0	0
General Administration	m²	1,148	1,972	885	0	0
Restaurants and cafés	m²	1,114	1,359	374	0	0
Staff Accommodation	m²	1,405	3,030	57	0	0
Non-clinical space: other	m²	5,700	14,466	3,404	469	126
Retail sales area: Commercial	m²	380	325	117	0	0
Internal floor area: unoccupied site	m²				0	
Buildings on site	No.	35	41	13	4	3

Function and Space	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Not functionally suitable: occupied floor area	m²	18,022	93,570	6,405	0	0
Not functionally suitable: clinical space	m²	11,045	66,560	4,697	0	0
Floor area: empty	m²	804	1,327	0	0	0
Floor area: under used	m²	0	131	0	0	0
Single bedrooms for patients with en-suite facilities	No.	32	117	19	0	0
Single bedrooms for patients without en-suite facilities	No.	29	93	3	0	0
Isolation rooms	No.	0	15	0	0	0

Quality of Buildings	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Cost to eradicate high risk backlog	£	8,795,281	6,666,129	366,371	0	
Cost to eradicate significant risk backlog	£	5,776,998	96,079,856	2,216,736	0	
Cost to eradicate moderate risk backlog	£	15,171,983	9,817,551	2,340,395	0	
Cost to eradicate low risk backlog	£	464,755	3,448,611	183,867	0	
Percentage of GIA surveyed using risk adjusted backlog guidance	Select	81 - 100%	81 - 100%	81 - 100%	Not Applicable	
Methodology used to review costs to eradicate backlog	Select	Formal 6 facet survey	Formal 6 facet survey	Formal 6 facet survey	Not Applicable	
Methodology used to review costs to eradicate backlog: Reason	Notes					
Formal survey year	Select	2025	2025	2025		
Review year	Select					

Quality of Buildings	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Investment to reduce backlog maintenance: Critical Infrastructure Risk	£	253,690	13,391,389	136,853	0	
Investment to reduce backlog maintenance: non Critical Infrastructure Risk	£	1,408,558	1,304,515	32,385	0	
Inflation element of the total cost to eradicate backlog maintenance	£	485,604	2,963,618	136,758	0	
Relevant occupied floor area	m²				0	

Age Profile	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Age profile: 2025 to 2034	%	0.00	0.00	0.00	0.00	0.00
Age profile: 2015 to 2024	%	4.17	0.25	3.91	0.00	0.00
Age profile: 2005 to 2014	%	5.90	0.13	14.29	31.05	0.00
Age profile: 1995 to 2004	%	12.92	3.42	25.76	20.55	23.26
Age profile: 1985 to 1994	%	35.44	9.45	22.71	0.00	0.00
Age profile: 1975 to 1984	%	28.54	0.00	0.81	0.00	0.00
Age profile: 1965 to 1974	%	2.25	49.15	15.75	26.56	64.06
Age profile: 1955 to 1964	%	1.07	24.17	3.00	0.00	0.00
Age profile: 1948 to 1954	%	0.00	0.00	0.00	0.00	0.00
Age profile: pre 1948	%	9.71	13.43	13.77	21.84	12.68
Age profile: total (must equal 100%)	%	100.00	100.00	100.00	100.00	100.00

CHP	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Fossil-fuel led CHP units operated on site	No.	0	1	1	0	
CHP unit/s size: electrical	kW		1,150	110		
CHP unit/s size: thermal	kW		4,900	177		
Fossil energy (Gas) input to CHP system/s	kWh		867,025	2,058,167		
Fossil energy (Other) input to CHP system/s	kWh		0	0		
Electrical energy output of CHP system/s	kWh		277,448	625,683		
Thermal energy output of CHP system/s	kWh		382,878	1,644,890		
Exported electricity	kWh		0	0		
Exported thermal energy	kWh		0	0		
Thermal energy discharged to waste	kWh		0	0		

Energy	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Electricity: green electricity tariff costs	£	1,299,564	3,449,277	131,399	0	
Electricity: green electricity consumed	kWh	5,056,366	12,637,040	1,786,255	0	
Electricity: trust owned solar costs	£	0	500	0	0	
Electricity: trust owned solar consumed	kWh	0	1,374,434	0	0	
Electricity: third party owned solar costs	£	0	0	0	0	
Electricity: third party owned solar consumed	kWh	0	0	0	0	
Electricity: other renewables costs	£	0	0	0	0	
Electricity: other renewables consumed	kWh	0	0	0	0	
Electricity: other costs	£	0	0	0	0	
Electricity: other consumed	kWh	0	0	0	0	
Electricity purchased from CHP costs	£	0	0	0	0	
Electricity purchased from CHP consumed	kWh	0	0	0	0	
Thermal energy purchased from CHP costs	£	0	0	0	0	
Thermal energy purchased from CHP consumed	kWh	0	0	0	0	

Gas costs	£	506,943	1,657,453	238,045	0	
Gas consumed	kWh	9,094,658	29,066,188	5,531,213	0	
Oil costs	£	0	0	0	0	

Energy	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA**	**DONCASTER ROYAL INFIRMARY RP5DR**	**MONTAGU HOSPITAL RP5MM**	**OTHER REPORTABLE SITES RP5ORS**	**RETFORD HOSPITAL RP5RE**
Oil consumed	kWh	0	0	0	0	
Non-fossil fuel: renewable costs	£	0	0	0	0	
Non-fossil fuel: renewable consumed	kWh	0	0	0	0	
Other energy costs	£	0	10,585	0	0	
Steam consumed	kWh	0	0	0	0	
Hot water consumed	kWh	0	0	0	0	
Solar electricity generated	kWh	0	0	0	0	
Maximum electrical demand	kW	939	2,121	438	0	
Available electrical capacity	kVA	900	4,400	2,000	0	
Number of primary heating gas boilers older than 10 years (100kW and above)	No.	22	4	2	0	0
Number of primary heating gas boilers older than 10 years (less than 100kW)	No.	9	6	2	0	0
Heat pumps installed on site	No.	4	0	8	0	0
Buildings with an electricity meter	No.	28	15	5	0	0
LED lighting coverage	%	80.00	26.00	73.00	0.00	0.00
Oil-led heating sources	No.	0	0	0	0	0
Fossil fuel heating replacement date	Select	No plan	No plan	No plan	No plan	
Heat decarbonisation plan	Select	No	No	No	No	Not Applicable
Relevant occupied floor area	m²				0	

Water Services	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA**	**DONCASTER ROYAL INFIRMARY RP5DR**	**MONTAGU HOSPITAL RP5MM**	**OTHER REPORTABLE SITES RP5ORS**	**RETFORD HOSPITAL RP5RE**
Water and sewerage cost	£	121,911	434,896	47,091	0	
Water volume (including borehole)	m³	33,167	143,189	15,650	0	
Buildings with a water meter	No.	9	8	4	0	0
Relevant occupied floor area	m²				0	

Waste	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Incineration (clinical waste) cost	£	18,764	58,881	9,326	27	
Incineration (clinical waste) weight	Tonnes	9.38	39.39	0.80	0.03	
Alternative Treatment (clinical waste) cost	£	72,455	247,056	23,370	0	
Alternative Treatment (clinical waste) weight	Tonnes	57.09	313.23	24.50	0.00	
Offensive waste cost	£	50,933	118,945	13,408	2,222	
Offensive waste weight	Tonnes	118.50	410.00	37.20	0.21	
Clinical waste (excluding incineration) processed on site cost	£	0	0	0	0	
Clinical waste (excluding incineration) processed on site weight	Tonnes	0.00	0.00	0.00	0.00	
Clinical waste processed at municipal waste plants cost	£	0	0	0	0	
Clinical waste processed at municipal waste plants weight	Tonnes	0.00	0.00	0.00	0.00	
Domestic waste (landfill) cost	£	0	0	0	0	
Domestic waste (landfill) weight	Tonnes	0.00	0.00	0.00	0.00	
Domestic waste (recycling) cost	£	7,189	1,174	0	0	
Domestic waste (recycling) weight	Tonnes	30.00	10.60	0.00	0.00	
Domestic waste (incineration) cost	£	30,885	98,917	12,077	225	
Domestic waste (incineration) weight	Tonnes	142.35	594.90	50.19	0.29	
Domestic waste (food) cost	£	0	0	0	0	
Domestic waste (food) weight	Tonnes	0.00	0.00	0.00	0.00	
Domestic waste (excluding incineration) processed on site cost	£	0	0	0	0	
Domestic waste (excluding incineration) processed on site weight	Tonnes	0.00	0.00	0.00	0.00	
Confidential waste cost	£	3,423	10,137	623	0	
Confidential waste weight	Tonnes	34.78	103.64	11.90	0.00	
Other waste costs	£	75,270	192,815	27,733	0	

Relevant occupied floor area	m²				0	

Car Parking	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Parking spaces available	No.	777	1,496	211	0	0
Car parking services cost	£	27,158	107,410	22,800		
Designated disabled parking spaces	No.	55	66	37		
Electric vehicle charging points	No.	0	0	0		
Average fee charged per hour for patient/visitor parking	£	1.43	1.43	1.43		
Average fee charged per hour for staff parking	£	0.14	0.14	0.14		
Is there a charge for disabled parking	Yes/No/None	No	No	No		

Cleaning services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Cleaning service provision	Select	In-house	In-house	In-house	Not Applicable	
Cleaning service cost	£	1,593,139	5,499,295	648,698		
Cleaning staff	WTE	51.48	200.18	21.20		
Relevant occupied floor area	m²					

Food Services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE

Food service provision	Select	Inpatient meals only	Inpatient meals only	Inpatient meals only	No meal provision	No meal provision
Inpatient food service cost	£	1,345,522	3,444,341	451,834		
Inpatient food ingredients cost	£	308,077	1,099,297	84,374		
Inpatient main meals requested	No.	189,819	677,994	52,020		
Food Services	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL** **RP5BA**	**DONCASTER ROYAL INFIRMARY** **RP5DR**	**MONTAGU HOSPITAL** **RP5MM**	**OTHER REPORTABLE SITES** **RP5ORS**	**RETFORD HOSPITAL** **RP5RE**
Inpatient food model type	Select	Cook-freeze pre-plated	Cook-freeze pre-plated	Cook-freeze bulk/buffet		
Inpatient meal preparation	Select	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider		
Inpatient meals ordered with a digital or electronic meal ordering system	%	100.00	100.00	100.00		
Other food services costs	£	0	0	0	0	
Meals provided to A&E and urgent care patients	No.	3,434	7,324	0		
Staff/visitor restaurant food model type	Select	Cook-freeze bulk/buffet	Cook-freeze bulk/buffet	Cook-freeze bulk/buffet		
Where are the staff/visitor main course options cooked	Select	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider		
Staff/visitor meals served	No.	16,275	49,649	2,975		
Catering staff	WTE	9.00	23.00	2.00		

Food Waste	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Total food waste (all destinations and EWC codes)	Tonnes	18.00	36.90	4.20		
Food waste generated from production	Tonnes	3.90	8.10	0.80		
Food waste generated from plate waste	Tonnes	1.30	3.60	0.40		
Food waste generated from unserved meals	Tonnes	1.60	3.30	0.40		
Food waste generated from spoilage	Tonnes	0.50	0.70	0.30		

Laundry & Linen	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Laundry and linen service provision	Select	Contracted – Full service	Contracted – Full service	Contracted – Full service	No service provision	
Laundry and linen (contracted full service) cost	£	417,990	1,053,461	179,783		
Laundry service cost	£					
Linen service cost	£					
Laundered pieces per annum	No.	750,710	2,478,090	251,525		
Bed linen replacement cost	£	8,675	14,458	5,783		
Other laundry and linen expenditure	£	0	0	0		
Onsite laundry	Select	No	No	No		
Relevant occupied floor area	m²					

Portering Services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Portering service provision	Select	In-House	In-House	In-House	No portering service	
Portering service cost	£	647,693	1,905,423	195,256		
Portering staff	WTE	21.55	64.31	6.19		
Portering job allocation method	Select	Digital System (App/ Hand-held Device)	Digital System (App/ Hand-held Device)	Digital System (App/ Hand-held Device)		
Relevant occupied floor area	m^2					

Safety	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Clinical service incidents caused by estates and infrastructure failure related to Critical Infrastructure Risk	No	4	5	3	0	0
Clinical service incidents caused by estates and infrastructure failure related to non-Critical Infrastructure Risk	No	2	2	1	0	0
Clinical service incidents caused by estates and infrastructure failure : other	No	0	4	0	0	0
Estates and facilities related incidents related to Critical Infrastructure Risk	No.	14	13	6	0	0
Estates and facilities related incidents related to Non-Critical Infrastructure Risk	No	1	33	2	0	0

Estates and facilities incidents related: other	No	32	29	15	0	0
Overheating occurrences triggering a risk assessment	No.	1	3	0	0	0
Estates and facilities RIDDOR incidents	No	0	3	0	0	0
Flood occurrences triggering a risk assessment	No	1	0	0	0	0

Safety - Incidents	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL** **RP5BA**	**DONCASTER ROYAL INFIRMARY** **RP5DR**	**MONTAGU HOSPITAL** **RP5MM**	**OTHER REPORTABLE SITES** **RP5ORS**	**RETFORD HOSPITAL** **RP5RE**
Most clinically impactful: Incident type	Select	Hot and cold water systems	Hot and cold water systems	Ventilation systems		
Most clinically impactful: Cost to rectify estates and infrastructure failure	£	50,000	100,000	56,000		
Most clinically impactful: Down time as a result of estates and infrastructure failure	Hrs	0	0	24		
Most clinically impactful: Lost clinical time as a result of estates and infrastructure failure	Hrs	0	0	24		
Most clinically impactful: Lost clinical income	£	0	0	0		
Most clinically impactful: Number of recurring incidents	No.	0	0	2		
Second most clinically impactful: Incident type	Select	Internal fabric and fixtures	Internal fabric and fixtures	Roofs		
Second most clinically impactful: Cost to rectify estates and infrastructure failure	£	40,000	50,000	50,000		
Second most clinically impactful: Down time as a result of estates and infrastructure failure	Hrs	0	0	0		

Second most clinically impactful: Lost clinical time as a result of estates and infrastructure failure	Hrs	0	0	0		
Second most clinically impactful: Lost clinical income	£	0	0	0		
Second most clinically impactful: Number of recurring incidents	No.	0	0	1		
Third most clinically impactful: Incident type	Select	Heating systems	Hot and cold water systems	Ventilation systems		
Third most clinically impactful: Cost to rectify estates and infrastructure failure	£	35,000	11,000	6,000		
Safety - Incidents	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA**	**DONCASTER ROYAL INFIRMARY RP5DR**	**MONTAGU HOSPITAL RP5MM**	**OTHER REPORTABLE SITES RP5ORS**	**RETFORD HOSPITAL RP5RE**
Third most clinically impactful: Down time as a result of estates and infrastructure failure	Hrs	0	0	0		
Third most clinically impactful: Lost clinical time as a result of estates and infrastructure failure	Hrs	0	0	0		
Third most clinically impactful: Lost clinical income	£	0	0	0		
Third most clinically impactful: Number of recurring incidents	No.	0	0	1		

2507 - F ASSURANCE & GOVERNANCE

11:45

2507 - F1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Executive Directors | 11:45

20 minutes

REFERENCES

Only PDFs are attached

F1 - Integrated Quality & Performance Report.pdf

F1 - Appendix IQPR May 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Integrated Quality & Performance Report**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	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:	IQPR – May 2025			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF3, BAF5			

Executive Summary – Key messages and Issues

Access

- Of 15 metrics. 6 were met for May 2025, 9 did not meet target.
- ED 4-hour performance was 74% for May 2025, only marginally over the target of 73.6%.
- Positively, RTT 18-week performance was 61.3% % for May 2025 against the target of 60.1%, on track against the trajectory which rises to 63.6% by March 2026
- Cancer 62 Day Combined Performance was comfortably above target at 76.7% for May 2025, but compliance against the 28 Day Faster Diagnosis Standard requires improvement at 76%

People

- Of 7 metrics, 7 were off track in May 2025.
- Work continues on medical job planning and medical appraisal performance, where great progress was made in 2024/25 achieving 82% and 100% respectively. Focus remains on ensuring improvements in both job plan sign-off rates and quality of job plans, along with continued high performance for medical appraisals.

Quality

- Of 27 metrics, 14 were met for May 2025, 13 did not meet target
- Continued focus on improving mortality performance against the Summary Hospital-level Mortality Indicator (SHMI), concentrating on clinical coding, patient pathways and Structured Judgement Reviews to ensure no lapses in care. The Sepsis 5-year strategy has recently been launched which outlines the plan for reducing sepsis-related morbidity and mortality for our patients.

Finance

- Of 10 metrics, 3 were met for May 2025
- The main focus is pay which is overspent by £1.8m YTD. Actions are in place via the Pay Efficiency and Workforce Planning workstreams and additional session controls.

Recommendations
The Board is asked to receive the report for assurance.

Healthier together – delivering exceptional care for all	
Patients	Regular review and assessment of Trust performance support the delivery of safe and effective services.
People	Regular review and assessment of Trust Performance, support our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships.
Pounds	Regular review and assessment of Trust Performance, supports delivery of the strategic priority to be sustainable and spend money wisely.
Health Inequalities	Health inequality data is not currently broken down in the IQPR .
Legal/ Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements
Partner ICB strategies	The document has no positive or negative impact on ICB Strategies.

Assurance Route	
Previously considered by - including date:	Contents shared with Finance & Performance Committee, Quality Committee and People Committee
Any outcomes/next steps / time scales	
Is this in line with Current risk appetite **N/A**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust





Integrated Performance Report

May 2025

We care

Contents

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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

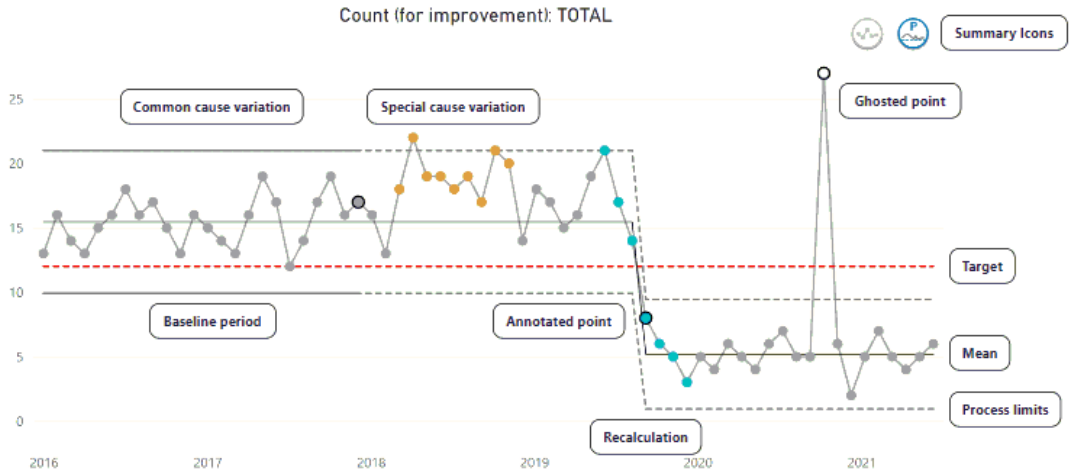
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

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.

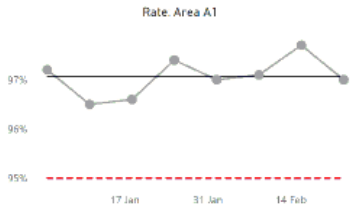
Annotations

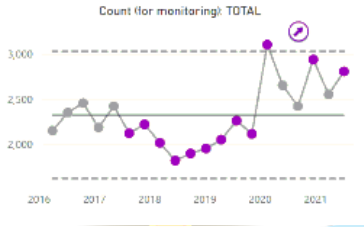
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



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.
(common cause)	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.
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↗				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

	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 Planned Vs Actual CHPPD RM	NICE Guidance % Non & Partial Compliance Time to Hire Completed SET Training MSA 31 day combined		Number of Complaints Not Signed Off in Agreed Timeframe Severe harm falls
No significant change.	Planned Vs Actual CHPPD Total	12 hours in department Ambulance handovers - 60 minutes VTE Faster Diagnosis Standard 62 day combined MRSA Cases Reported in Month COHA & HOHA C.Diff cases in month % Over 18 in-hospital deaths scrutinised by Medical Examiner Team Cancelled Operations Never Events PSIIs in Month HAPU Cat 4 Sickness Absence	Ambulance handovers - 15 minutes Ambulance handovers - 30 minutes Diagnostic waiting times FFT (% positive) – Trust SEPSIS 1 Hour Screening SEPSIS 1 Hour Antibiotics Consultants Signed off Job Plans Overall Sickness Absence % patients waiting less than 18 weeks from referral to treatment 4 hour Performance	Severe harm falls Number of Complaints Received in Month Claims CNST (patients) - new in month Claims LTPS - (staff) new in month
Concerning variation (High or Low).				
Variance where up or down is may not be improving or concerning.				

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				
Section	Metric	Standard/ threshold	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
UEC	4 hour ED	78% by March 2025	May-25	73.6%	74.0%	0.4%	72.6%	73.8%	1.2%	F	
UEC	12 hours in department	No more than 2%	May-25	2.0%	2.8%	0.8%	2.0%	2.5%	0.5%	?	
UEC	Ambulance handovers - within 15 minutes	65%	May-25	65.0%	48.2%	-16.8%	65.0%	45.4%	-19.6%	F	
UEC	Ambulance handovers - within 30 minutes	95%	May-25	95.0%	82.7%	-12.3%	95.0%	82.3%	-12.7%	F	
UEC	Ambulance handovers - over 45 minutes	0%	May-25	0.0%	7.1%	7.1%	0.0%	6.7%	6.7%		
UEC	Ambulance handovers - over 60 minutes	0%	May-25	0.0%	3.2%	3.2%	0.0%	3.0%	3.0%	?	
Diagnostics	Diagnostic waiting times *	DM01 99% / Operational guidance 95%	May-25	66.7%	81.6%	14.9%	66.7%	81.6%	14.9%	F	
Elective Care	% patients waiting less than 18 weeks from referral to treatment *	92%	May-25	60.1%	61.3%	1.2%	60.1%	61.3%	1.2%		
Elective Care	52 weeks *	< 1% by March 2026	May-25	1.0%	2.9%	1.9%	1.0%	2.9%	1.9%		
Elective Care	Percentage of patients waiting no longer than 18 weeks for a first appointment *	72% by March 2026	May-25	67.7%	70.0%	2.3%	67.7%	70.0%	2.3%		
Cancer	Faster Diagnosis Standard	80% by March 2026	Apr-25	83.7%	76.0%	-7.7%	83.7%	76.0%	-7.7%	?	
Cancer	31 day combined	96%	Apr-25	96.0%	97.2%	1.2%	96.0%	97.2%	1.2%	?	H
Cancer	62 day combined	>= 75% by March 2026	Apr-25	73.3%	76.7%	3.4%	73.3%	76.7%	3.4%	?	
Elective Care	Cancelled Operations Not Rebooked within 28 Days	0	May-25	0	3	3	0	8	8	?	
Access	Mixed Sex Accommodation - nationally reported breaches in month	0	May-25	0	2	2	0	2	2	?	L

Key performance indicators - Quality

				Current month			Year to date				
Section	Metric	Standard/ threshold	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Mortality	SHMI (12 month Rolling)	<100	Feb-25	100	114.3	14.3	100	114.3	14.3		
Mortality	SHMI (Monthly)	<100	Feb-25	100	115.9	15.9	100	115.8	15.8		
IPC	Hospital Acquired MRSA (Colonisation) Cases Reported in Month		May-25	1.2	4	2.8	1.3	7	5.7		
IPC	Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0	May-25	0	0	0	0	0	0		
IPC	Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month		May-25	3.5	12	8.5	7	19	12		
IPC	Number of Community Onset Healthcare associated (COHA) C.Diff cases in month										
IPC	Hospital Acquired Pressure Ulcers (HAPU) Cat 4		May-25	0.0	0	0	0	0	0		
IPC	e.coli		May-25	8.3	8	-0.3	16.5	19	2.5		
IPC	MSSA		May-25	0	6	6.0	0	13	13.0		
IPC	Klebsiella		May-25	2.8	3	0.3	5.5	3	-2.5		
IPC	Pseudomonas		May-25	1.4	2	0.6	2.8	5	2.2		
Falls	Severe harm falls	0	May-25	0	1	1	0	3	3		
Complaints	Number of Complaints Received in Month		May-25	0	59	59	0	133	133		
Complaints	Number of Complaints Not Signed Off in Agreed Timeframe		May-25	0	0	0	0	0	0		

Key performance indicators - Quality

				Current month			Year to date				
Section	Metric	Standard/ threshold	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Claims	Claims CNST (patients) - new in month		May-25	0	5	5	0	12	12		
Claims	Claims LTPS - (staff) new in month		May-25	0	0	0	0	0	0		
FFT	Friends & Family Response Rates - Trust		May-25	95%	88.8%	-6.2%	95%	88.90%	-6.1%	F	
Audit & Effectiveness	% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%	May-25	100%	100.0%	0.0%	100%	100.0%	0.0%	?	
Audit & Effectiveness	VTE - % of patients having a VTE Risk Assessment	95%	May-25	95%	96.4%	1.4%	95%	96.9%	1.9%	?	
Nice Guidance	NICE Guidance Response Rate Compliance	90%	May-25	90%	97.6%	7.6%	90%	97.3%	7.3%	P	H
Nice Guidance	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%	May-25	10%	9.0%	-1.0%	10%	8.5%	-1.5%	?	L
CHPPD	Planned Vs Actual CHPPD RM	90%	May-25	90%	99.0%	9.0%	90%	99.0%	9.0%	P	
CHPPD	Planned Vs Actual CHPPD RN	90%	May-25	90%	100.0%	10.0%	90%	100.0%	10.0%	P	
CHPPD	Planned Vs Actual CHPPD Total	90%	May-25	90%	91.0%	1.0%	90%	90.0%	0.0%	?	
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%	May-25	90%	47.3%	-42.7%	90.0%	44.7%	-45.3%	F	
Sepsis	Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	90%	May-25	90%	55.6%	-34.4%	90.0%	64.2%	-25.8%	F	
Patient Safety	Never Events - Reported in month	0	May-25	0	0	0	0	1	1	?	
Patient Safety	PSIIs reported in month		May-25	0	0	0	0	1	1	?	

Key performance indicators - Finance

Metric	Standard/threshold 24/25	Latest month reported	Current month				Year to date (YTD)			
			Plan £'000	Actual £'000	Variance £'000		Plan £'000	Actual £'000	Variance £'000	
YTD distance from financial plan I&E	No variance to plan	May-25	315	321	6	A	1,790	1,781	-9	F
ERF position	Month 11 FOT 2024-25	May-25	10,125	10,318	193	F	18,615	19,116	501	F
CIP delivery -vs Plan	No variance to plan	May-25	2,503	2,503	0	F	3,340	3,340	0	F
Total pay spend against plan		May-25	34,001	35,010	1,009	A	68,807	70,641	1,834	A
Reduction in Additional sessions	24/25 spend - 40% reduction	May-25	774	1,375	601	A	1,548	2,931	1,382	A
Reduction in Bank pay	24/25 spend - 10% reduction	May-25	1,346	1,459	113	A	2,692	2,887	194	A
Reduction in Agency pay	24/25 spend - 40% reduction	May-25	671	1,249	578	A	1,342	2,266	924	A
Capital position YTD versus plan	No variance to plan	May-25	5,023	621	-4,403	F	10,047	1,195	-8,852	F
Cash balance	No variance to plan	May-25	24,914	20,903	-4,011	A	24,914	20,903	-4,011	A
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	May-25	95.0%	74.3%	-20.7%	A	95.0%	74.5%	-20.5%	A

Key performance indicators - People

				Current month			Year to date				
Section	Metric	Standard/ threshold	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
People	Consultants with Signed Off Job Plans in EJP	90%	May-25	90.0%	74.0%	-16.0%	90.0%	74.7%	-15.3%		
People	Employee Turnover	10%	May-25	10.0%	10.6%	0.6%	10.0%	10.1%	0.1%		
People	Overall Sickness Absence	5%	May-25	5.0%	5.9%	0.9%	5.0%	5.9%	0.9%		
People	Time to hire (from TRAC authorisation - unconditional offer) A4C posts only	47 days	May-25	47	62.3	15.3	47	62.3	15.3		
People	Completed SET Training	90%	May-25	90.0%	89.2%	-0.8%	90.0%	89.6%	-0.4%		
People	Completed Appraisals *	90% end July	May-25	90.0%	41.5%	-48.5%	90.0%	41.5%	-48.5%		
People	Medical Appraisals completed	90%	May-25	90.0%	86.0%	-4.0%	90.0%	86.0%	-4.0%		

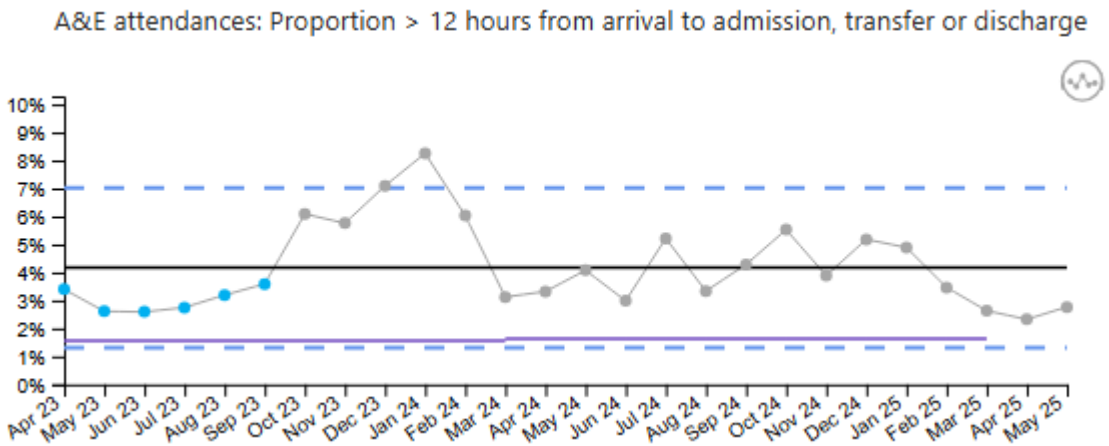
				Current month		
Metric	Standard/ threshold 24/25	Available	Latest month reported	Local target	Actual	Variance
Flu vaccination for all colleagues		In development (data)	Mar-24	75%	41.10%	-33.90%

Theme	DBTH 2021 Score	National Sector Average 2021	DBTH 2022	National Sector Average 2022	DBTH 2023	National Sector Average 2023	DBTH 2024	National Sector Average 2024
We are compassionate and inclusive	7.2	7.2	7.3	7.2	7.41	7.41	7.3	7.22
We each have a voice that counts	6.7	6.7	6.7	6.6	6.82	6.7	6.71	6.68
We are always learning	5.2	5.2	5.6	5.4	5.9	5.61	5.84	5.69
We are a team	6.4	6.6	6.6	6.6	6.81	6.75	6.72	6.74
Staff Engagement	6.7	6.8	6.8	6.8	6.94	6.91	6.74	6.85

Assurance report

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

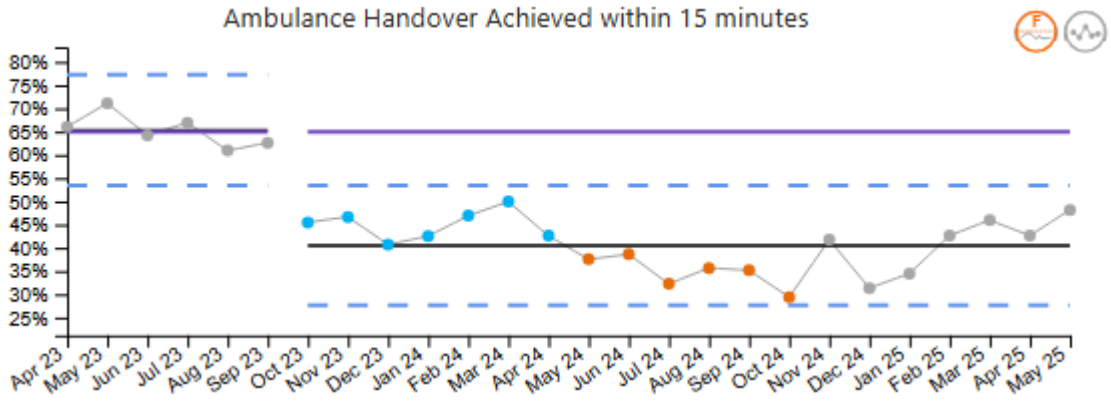
Summary of challenges & risks	In May 2025, 2.8% of patients were in the Emergency Department > 12 hours from arrival, against the national standard of no more than 2% Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will FALL BELOW the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	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 Weekly MDT review of longest patients with decision to admit from previous week to identify learning and opportunities for improvement
Action timescales and assurance group or committee	Improvement trajectory to be agreed. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

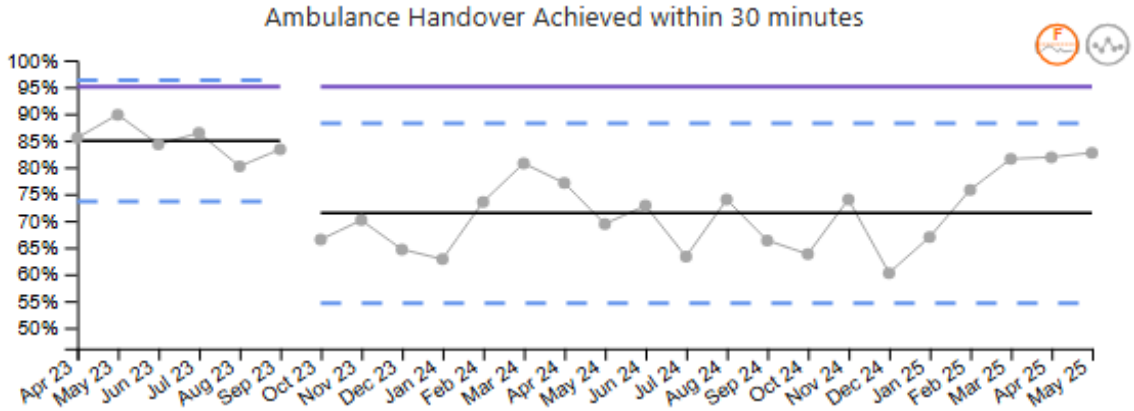


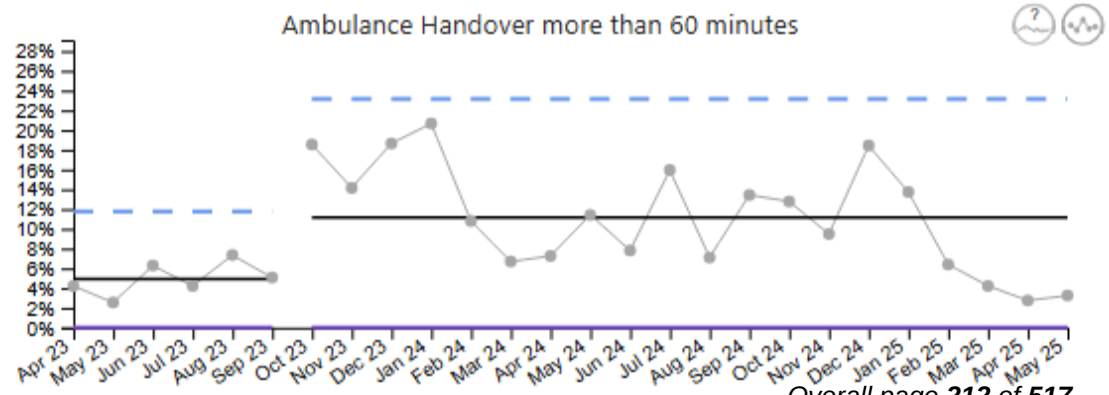
Assurance report

Ambulance Handover within 15/30/45/60 mins

Summary of challenges & risks	In May 2025, 48.2% of ambulance handovers took place within 15 minutes against the standard of 65%, 82.7% took place within 30 minutes against the standard of 95%, and 96.8% took place within 60 minutes against the standard of 100%. 92.9% were within 45 minutes. **Ambulance Handover 15 and 30 minutes** Common cause variation, NO SIGNIFICANT CHANGE. This process is not capable and will FALL BELOW the target without process redesign. **Ambulance Handover 60 minutes** 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 in October 2023 as the volume of ambulance arrivals increased
Actions to address risks, issues and emerging concerns relating to performance and forecast	Significant improvement for <30mins handover time at Bassetlaw since Bassetlaw Emergency village (BEV) opened in February. 62.69% Pre BEV opening compared to 80.14% in May. Continued ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. Utilisation of the escalation area at times of peak demand to create additional capacity for handover Joint improvement plan in place with the ambulance service to eliminate handover waits > 45 minutes from August 2025. Actions include a review of capacity and demand and joint escalation process.
Action timescales and assurance group or committee	Eliminating handovers > 45 minutes from August 2025. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care



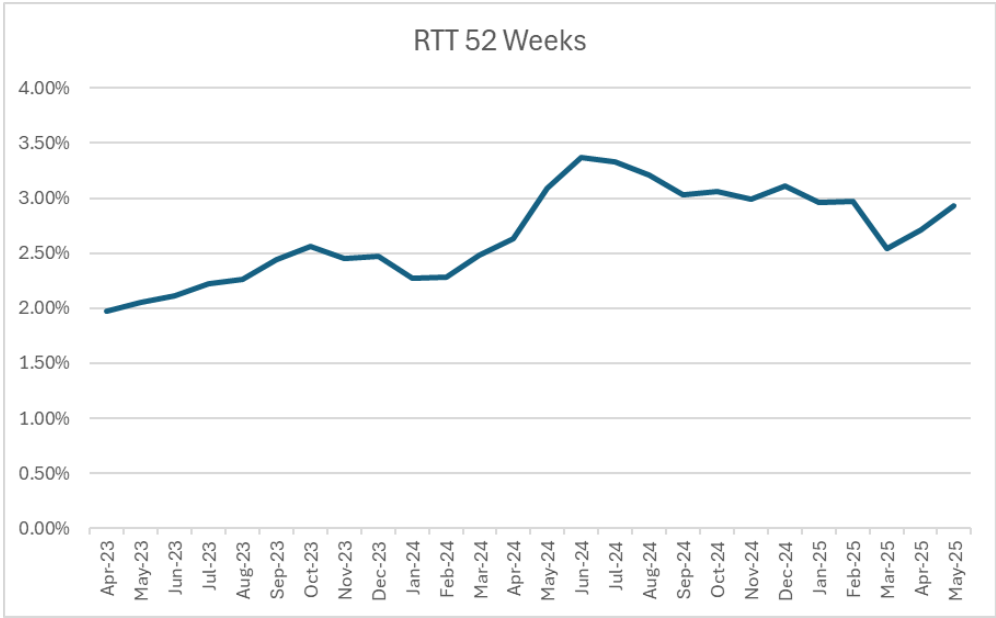




Assurance report

RTT % waits over 52 weeks for incomplete pathways

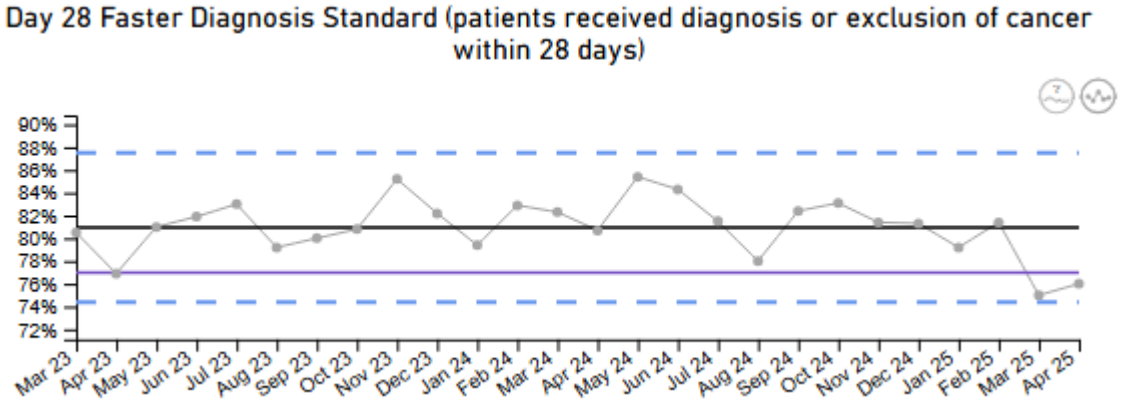
Summary of challenges & risks	In May 2025 2.9 % of the patients on an incomplete pathway have been waiting for more than 52 weeks against the standard of no more than 1% by March 2026. The majority of specialties are on track to deliver the standard by March 2026, the exceptions to this are T&O and ENT.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The Elective Improvement Support Team are working with the Trust to develop improvement plans for T&O and ENT. Demand and capacity modelling has been completed for ENT and is due to commence in June for T&O.
Action timescales and assurance group or committee	Improvement trajectory to be agreed. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



Assurance report

Cancer Faster Diagnosis Standard

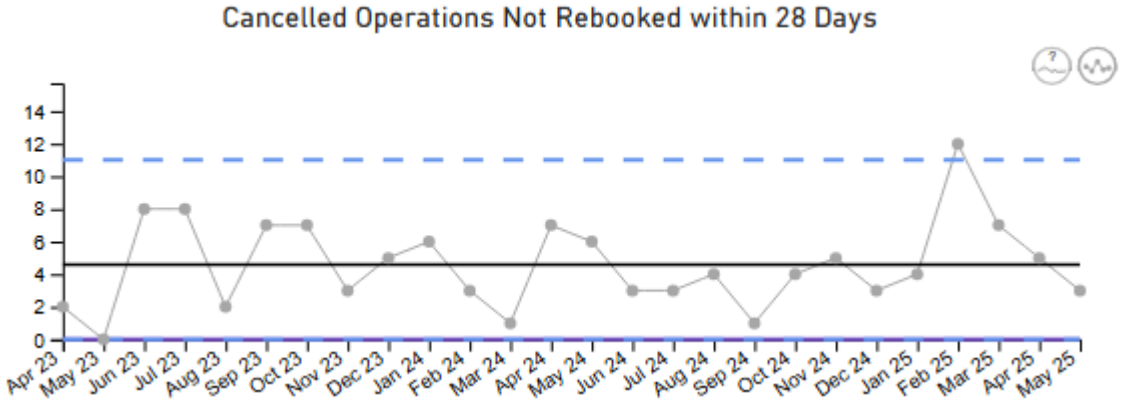
Summary of challenges & risks	In April 2025, 76% of patients received a diagnosis or exclusion of cancer within 28 days against the trajectory of 81.6%. The main driver of the underperformance in month was the increase in referrals. The Trust plan forecast 1,525 referrals in April and received 1,848. The 3 specialties impacting on the performance are: **UGI** – whilst an improvement has been seen in month UGI is still significantly behind target due to staffing shortfalls. **LGI** – 6% reduction due to delays within the straight to test pathway and increased number of referrals **Breast** – 5% reduction in month due to complex pathways with multiple investigations Common cause variation, **NO SIGNIFICANT CHANGE.** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Review of the straight to test pathway within LGI with cancer services and division. Escalation process requires a rereviewed with Cancer Team and Division Forecast improvement in May performance
Action timescales and assurance group or committee	Monthly trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	N/A



Assurance report

Cancelled operations not rebooked within 28 days

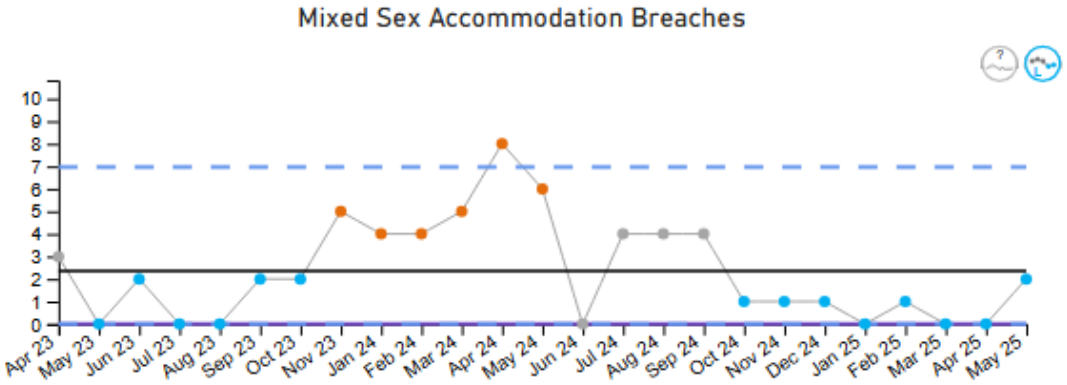
Summary of challenges & risks	There were 3 breaches of the 28-day guarantee in May 2025. 1 x General Surgery, equipment couldn't be sourced within 28 days 2 x ENT., both patients required pathology input at STH Common variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	As part of the Theatre Improvement Programme for 2025/26 the escalation process for on the day cancellations is being reviewed to ensure the Divisional Leadership Team is aware of any potential cancellations prior to cancellation so actions can be taken to avoid where possible. Within the Division of Surgery, the monitoring process for re-booking any patients within 28 days is also being reviewed to ensure operational oversight and escalation where a patient is not re-booked within 28 days.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



Assurance report

Mixed sex accommodation

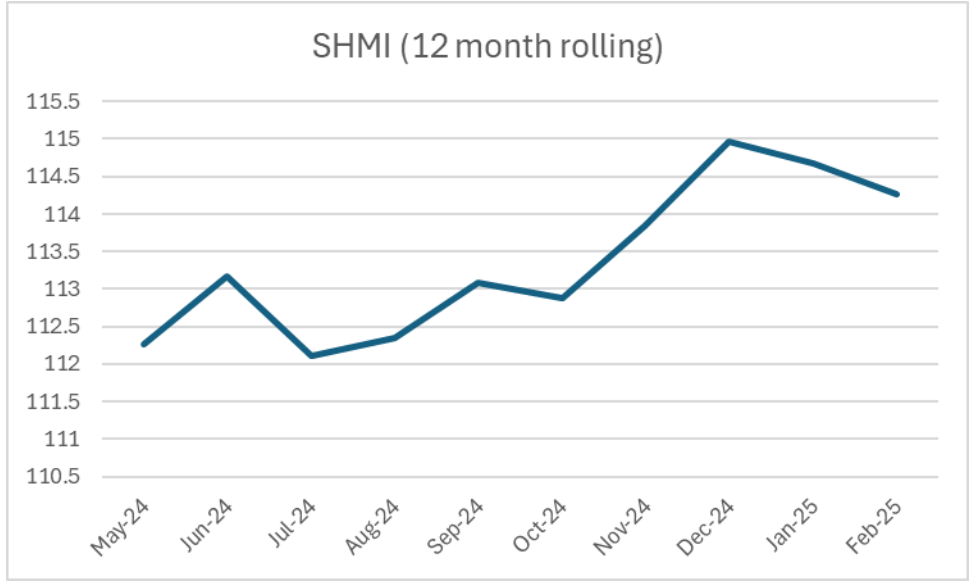
Summary of challenges & risks	There were 2 mixed sex accommodation breaches in May 2025. 1 x due to a delay in step down from Critical Care 1 x due to a delay in step down from CCU. Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER.** This process will not 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	The Site Team has oversight of all patients requiring step down from critical care and coronary care, this includes the timescales in which this must take place. The Site Team monitor this through the 3 x daily Patient Flow meetings, liaising with Divisional teams to create base ward capacity within the agreed timescales.
Action timescales and assurance group or committee	Monthly reporting to the Divisional Performance Review Meeting
Risk register	N/A

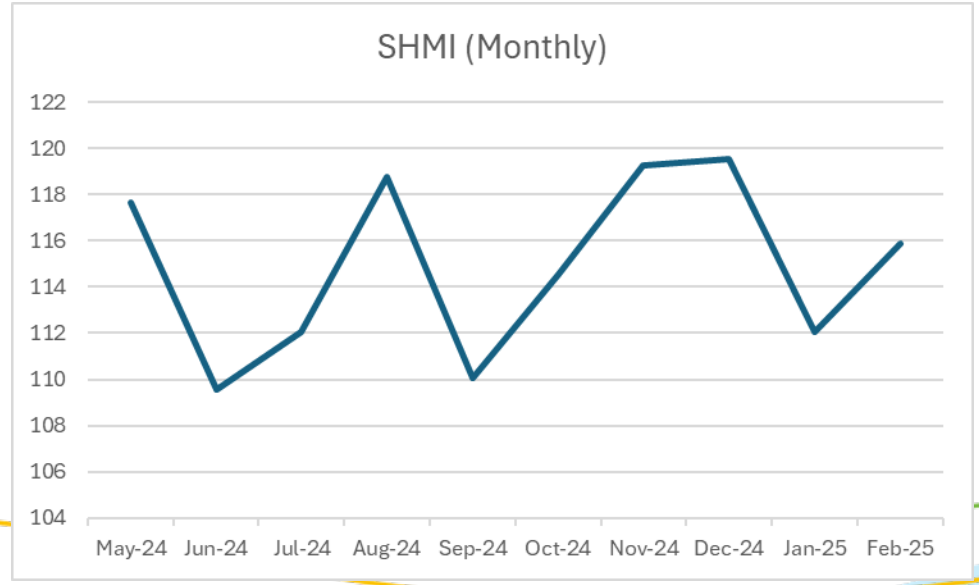


Assurance report

SHMI

Summary of challenges & risks	The 12 month rolling SHMI in February 2025 was 114.3. Monthly SHMI in February 2025 was 115.9.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Performance data is showing a downward trend. A jump can be seen in 2024 which is the point when Covid deaths began to be included in figures. Work continues to deliver the action plan to improve mortality governance focussing on: - Clinical coding/depth of coding - Increasing the number of Structured Judgement Reviews undertaken to ensure no lapses in care - Review of admission pathways to understand number of consultant transfers per episode of care - Review the recording and coding of elective and non-elective pathways Both the Mortality Governance and Mortality Data Assurance Improvement Groups ensure review of outliers is undertaken. Medical Examiners are providing a 7 day service scrutinising 100% of adult deaths in acute and community settings in line with Learning from Deaths national framework, reporting to Regional and National Chief Medical Examiners
Action timescales and assurance group or committee	Ongoing improvement work – reporting into Mortality Governance and Patient Safety Committee
Risk register	



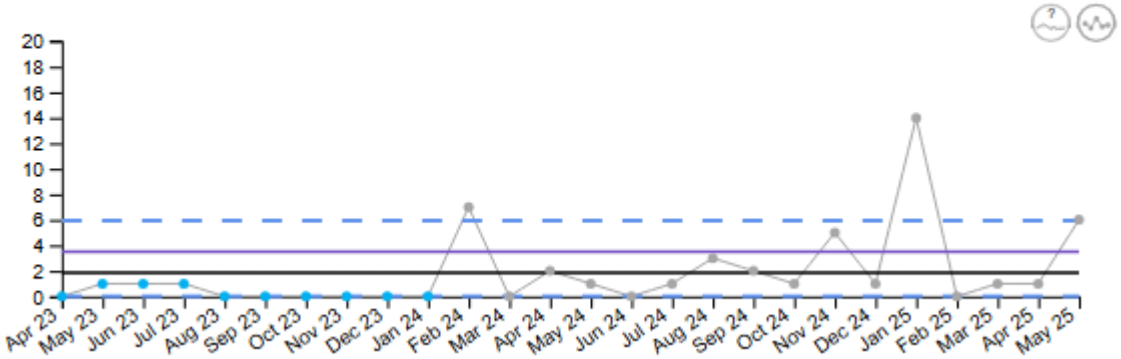


Assurance report

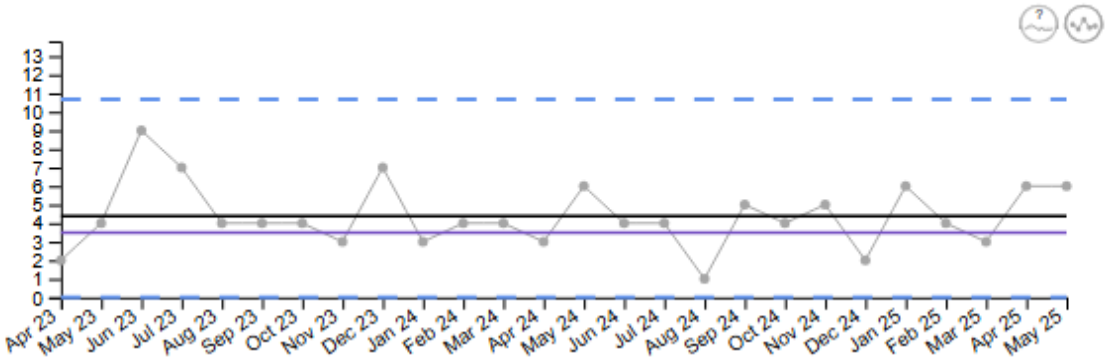
Number of C.Diff cases in month

Summary of challenges & risks	In May 2025 there were 12 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	The IPC team continue to follow up all CDiff patients and GDH patients three times per week. Snapshot audits are completed weekly to ensure that appropriate IPC precautions to minimise transmission are in place. The IPC team have commenced follow up of patients in the community with GDH or CDiff to optimise management with the aim of addressing the rising numbers of cases (nationally) as a system. Antimicrobial stewardship Nurse is currently working with the antimicrobial lead and antimicrobial pharmacist on improving standards of antimicrobial stewardship. Deep clean programme is in place Antimicrobial stewardship is a joint quality priority for 2025/26 and will bring about a programme of work. Ongoing acute federation work to review processes with other trusts.
Action timescales and assurance group or committee	Ongoing and constantly reviewed. Monitored via IPC strategic group which feeds into patient safety group
Risk register	3517

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



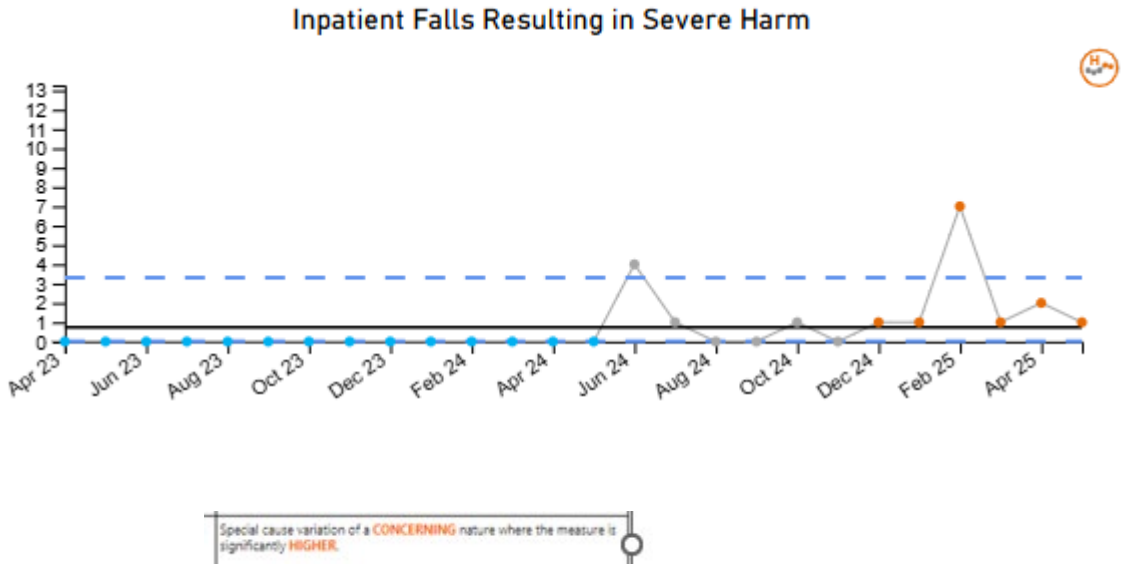
Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month



Assurance report

Inpatient falls

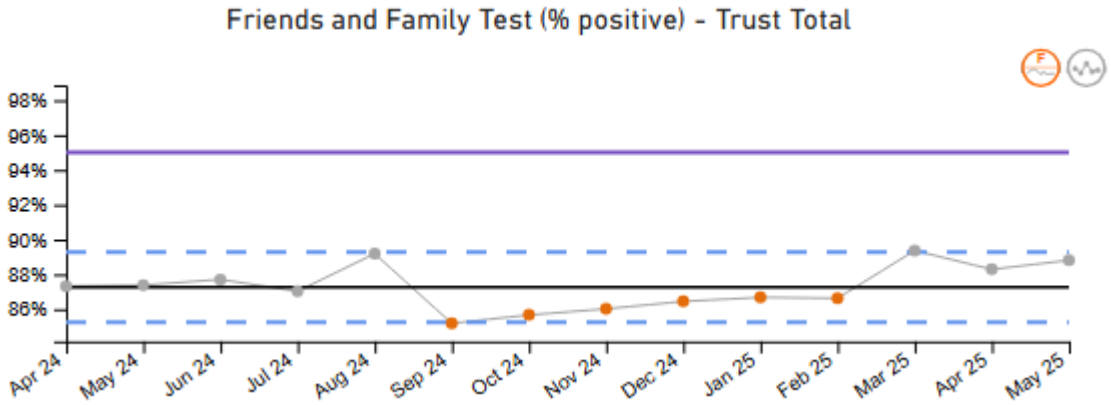
Summary of challenges & risks	There was one fall resulting in severe harm in May 2025. Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. Assurance cannot be given as there is no target
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Falls activity monitored through Trust Incident reporting system & Quality dashboard to ensure national and local standards and policies are being maintained • Falls Improvement Plan in Place and shared Trust wide for Local Implementation • Patient Safety Incident Response Framework (PSIRF) process utilised for all post fall review meetings and outcomes extracted for shared learning • Local learning action plan shared immediately with the ward staff as identified in the swarm huddle PIRF process
Action timescales and assurance group or committee	A Monthly Falls Report is presented at Patient Safety Review Group Monthly review at Trust Falls Learning Group of all falls resulting in moderate harm and above
Risk register	N/A



Assurance report

Friends & Family response rate – Trust

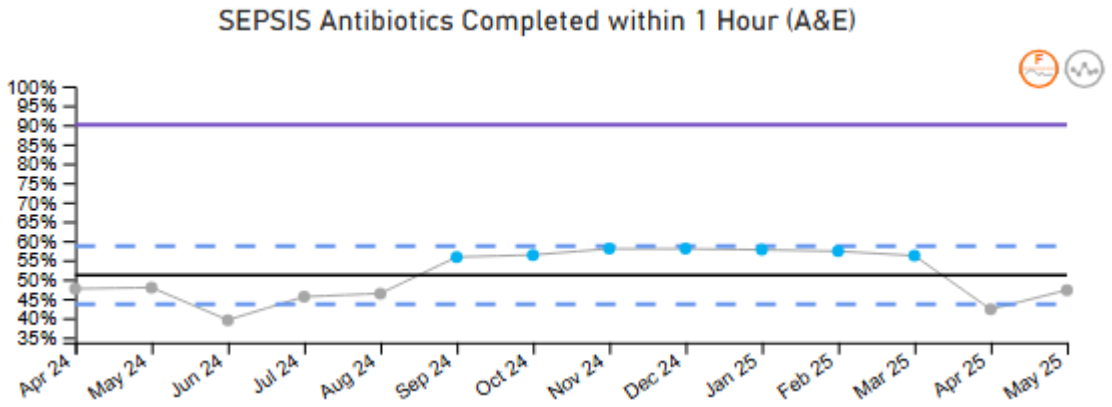
Summary of challenges & risks	The Trust position was 88.8% for May 2025. Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	To monitor weekly reports of positive response rates by ward/service, to quickly identify and respond to downward trends or service areas with persistent low scores. Carry out reviews in areas with declining or consistently low FFT positive responses, to understand root causes through data indicating themes from comments and complaints etc. Ensure visible "you said we did " boards are in place in all patient areas. Ensure wards are not photocopying the forms as these get rejected and then require to be manually inputted therefore affecting response rates as these cannot be recorded automatically. Digital devices being procured to increase digital submission.
Action timescales and assurance group or committee	Ongoing and monitored via the patient experience and involvement group. Reports into Caring Group
Risk register	n/a

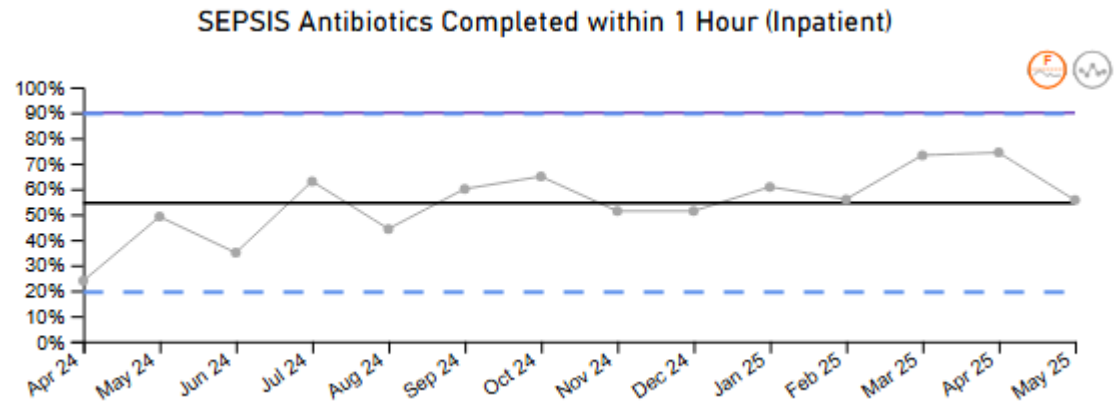


Assurance report

Sepsis Antibiotics Completed within 1 Hour

Summary of challenges & risks	For May 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 in A&E was 47.3% 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 (March 25). This may require a discussion regarding re-baselining. For May 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 as an Inpatient was 55.6% 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	Launch of DBTH 5 Year Sepsis Strategy 2025, which includes recognition and rapid response: - Mandatory sepsis screening (NEWS2) Hospital wide - 'Real-time' Sepsis alerts in AMU Tracker and ED 'Live' Sepsis Tracker - New Surgical and Orthopaedic Trackers ready to introduce imminently. - Pathology alerts for neutropenic sepsis to Medical Registrar - Standardised care- - Updated Sepsis Guidelines for ED/inpatient settings - Integrated with Symphony/Nervecentre The aim: is to provide automated performance feedback, enabling a culture of continuous improvement
Action timescales and assurance group or committee	Ongoing improvement work as outlined in the 5 year Strategy Sepsis Action Group reports into Mortality Governance and Patient Safety Committee
Risk register	





Assurance report

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

Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,294	6,088	-206	F	-229	F
Ambulance staff						
Apprenticeship Levy	131	126	-4	F	-9	F
Allied health professionals	2,915	2,835	-80	F	-123	F
Healthcare science staff	21	16	-5	F	-11	F
Medical and dental	10,614	11,081	467	A	1,568	A
Non Medical Non Clinical				A		A
Nursing & midwifery	12,987	13,028	42	A	300	A
Comprising:						
Registered nursing	9,638	9,333	-306	F	-447	F
Unregistered nursing	3,346	3,696	350	A	748	A
Scientific, therapeutic and tech	815	856	41	A	111	A
Reserves	1,403	979	-423	F	-1,411	F
CIP Target	-1,177		1,177	A	1,638	A
Total Trust	**34,001**	**35,010**	**1,009**	A	**1,834**	A

Assurance report

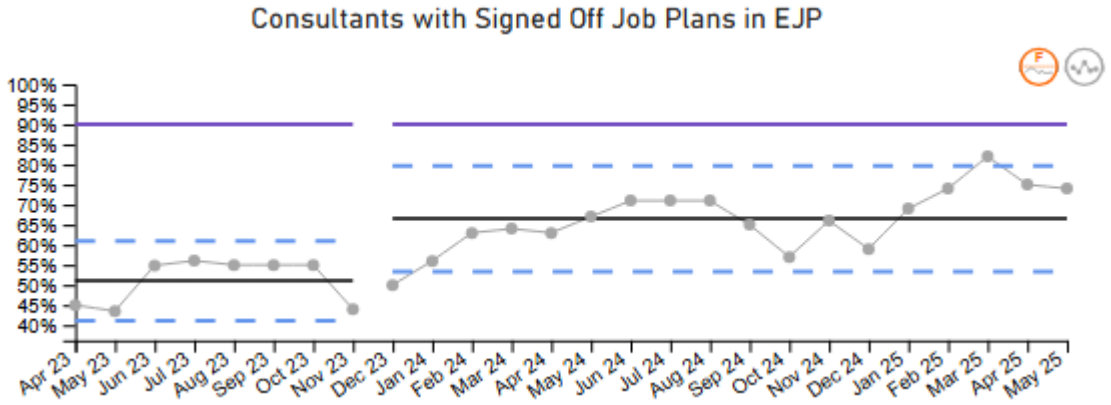
Pay spend against plan including substantive, additional sessions, bank and agency continued

Summary of challenges & risks	Pay is overspent by £1.8m YTD
Actions to address risks, issues and emerging concerns relating to performance and forecast	**A. CIP Pay Efficiency Workstream** in place for 25/26. Within the workstream there are x5 key projects supporting the reduction of agency and bank volumes and price:- (1) Medical Recruitment - Review recruitment activity and provide support through a series of initiatives to have more substantive colleagues in post and reduce reliance on temporary workers. This will include visibility that vacant roles are proactively recruited to, and plans are in place. (2) Medical Agency & Bank - Review rates paid for agency and bank workers with the aim of reducing these holistically. Identifying and managing escalation rates and out of policy bookings should be done through grip and control meetings. This should also include a review of the current controls in place e.g. sign off thresholds and that they are effective and proportionate. (3) Nursing, Midwifery & AHP Agency & Bank - Review rates paid for agency and bank workers with the aim of reducing these holistically. This includes a review of the current controls in place e.g. G&C, sign off thresholds and that they are effective and proportionate. (4) Sickness Absence - Support the reduction in sickness across the Trust through identification of hotspots and ensuring plans are in place to support increased attendance, monitor compliance with policies and through the wider health and wellbeing agenda. (5) Effective Rostering - Ensure our people are deployed as effectively as possible by monitoring compliance with rostering best practice e.g. roster sign off period, compliance with Annual Leave and Sick Leave thresholds, use of “additional bricks” and owed hours. **B. Additional Session** funding is held centrally in reserves and only allocated once the COO has approved the sessions to be undertaken, this is considerable step change to previous years where funding was within divisional budgets with limited challenge. **C. CIP Workforce Planning Workstream** in place for 25/26. Within the workstream there are x3 key projects plus a number of ad hoc findings supporting the reduction of medical spend:- (1) Unpredictable on call emergency work - In line with the Consultant contract and recommendations from NHS Employers and BMA, during 2025/2026 the Medical Director’s office are planning to review the demands of unpredictable emergency work for those teams of senior medical staff who participate in an on-call rota. (2) Sessional Delivery Tracking - The aim of the sessional delivery tracking is to ensure that as far as possible clinical activity is being delivered as planned, for 25/26 the focus will be Outpatient and Theatres activity only. (3) Standardisation of Travel Time in Job Plans (4) Ad Hoc - RRP payments, review of annual and bank holiday entitlements for part time staff
Action timescales and assurance group or committee	UEC Rota review wef August 25 to reduce need for temporary staffing Sessional delivery pilot to commence July 25 then full roll out by Q3 Divisional action plans to address the pay overspends being discussed at PRMS Detailed cash flow monitoring in place and being reviewed Q1 detailed I&E forecasts including impact of efficiency plans Executive Team meetings reviewing CIP progress SYICB/NHSE Efficiency Opportunities Reviewed and Plans in development
Risk register	

Assurance report

Consultants with Signed Off Job Plans

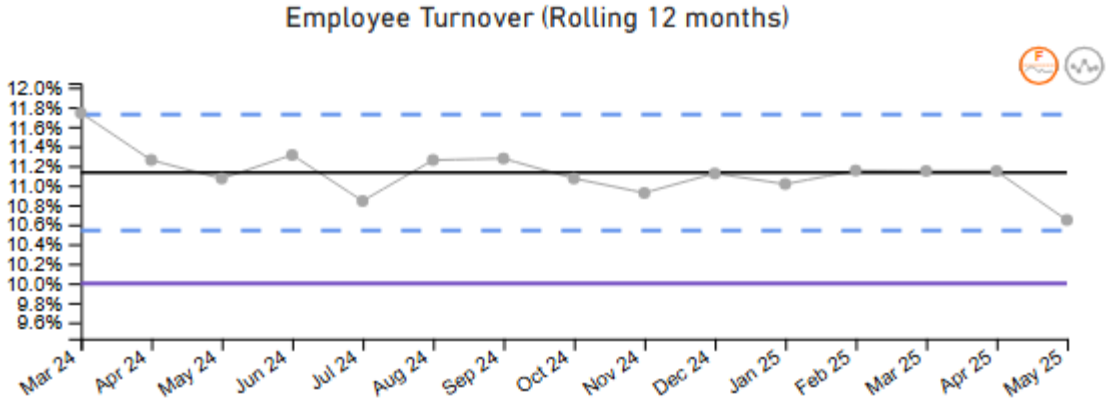
Summary of challenges & risks	For May 2025 74.0% of Consultants had a signed off job plan Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign Re-basing has taken place December 2023 as job planning completion was linked to CEA programme
Actions to address risks, issues and emerging concerns relating to performance and forecast	MD Team continue to support the robust job planning process: - sending reminders of job plan review due dates, contacting individual clinicians and their clinical managers and recording individual job plan sign off dates. - ensuring quality job plan documents are produced, through full completion of job plan templates which include all activities, SPA time, objectives and contract information Job Plan Policy developed, currently progressing through approval process
Action timescales and assurance group or committee	Working towards a trajectory of 90% achievement by the end of quarter 2.
Risk register	



Assurance report

Employee Turnover (Rolling 12 months)

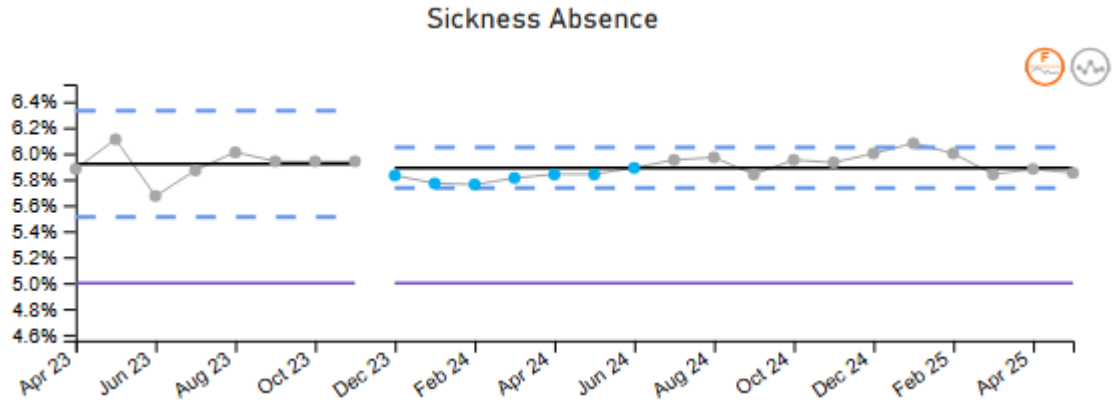
Summary of challenges & risks	For May 2025 Employee turnover was 10.6% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Learning from leavers project to improve the response rates of exit interviews and feedback from those leaving the Trust to enable improved thematic analysis • Leavers Policy drafted and being reviewed • Improved appraisal process complemented by Scope for Growth conversations and succession planning discussions. Recommunicated to support appraisal season 2025 (Q1/2)
Action timescales and assurance group or committee	• Leavers policy planned to go to Policy Formulation Group meeting in Q2 (timeline postponed due to other priority policies) • Monitor improvements in relation to learning from leavers project in Q2/3 – review at Workforce & Education Group
Risk register	16, 2554



Assurance report

Overall sickness

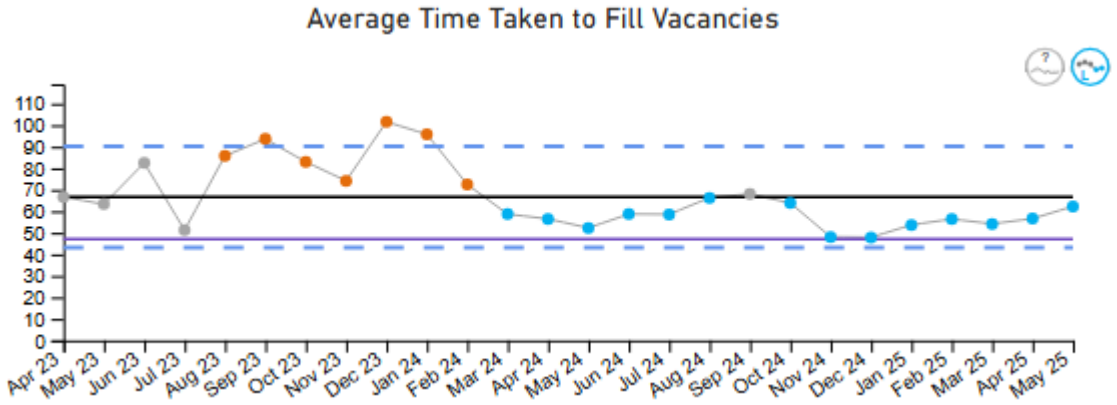
Summary of challenges & risks	In May 2025 the overall sickness was 5.9% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Actions identified from post implementation review (PIR) of the sickness absence policy together with learning from another trust • Sickness absence policy to be further revised as a result including refocusing on supporting attendance at work • Learning to be considered from another trust identified from national Chief People Officers (CPO) network (Q2) • Focus and data analysis on further specific groups – Estates & Facilities and Admin & Clerical (Q1/2) • Offer of additional support and training from the People Business Partner Teams • Identification of patterns of absence and appropriate actions that can be taken in line with the policy • Improvement work ongoing supporting absence management for medical colleagues with feedback, input and support from Clinical Directors
Action timescales and assurance group or committee	• All actions in relation to improving attendance and sickness absence management are tracked on Monday.com and monitored through the Pay Efficiency workstream with monthly steering group meetings, chaired by the CPO • Actions have timeframes and deadlines throughout 2025/26
Risk register	2554



Assurance report

Average time taken to fill vacancies

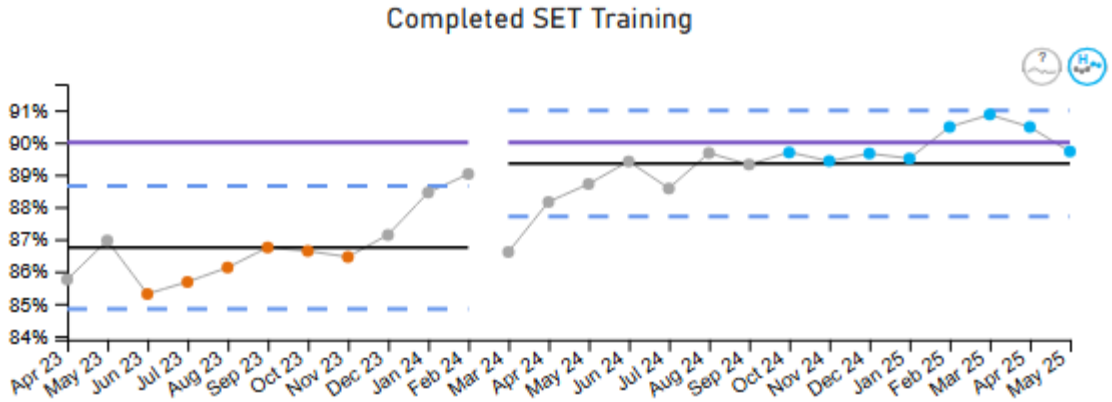
Summary of challenges & risks	The Trusts time to hire is 62 days for May 2025 Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Additional training and support offered by the recruitment team • Improvements made to the internal transfer register and plans to pilot the process for clinical admin and clerical roles (postponed until Q2 2025/26) – anticipated to have a positive impact on reduction of number of vacancies • Collaborative work with system trusts on improving time to hire continues, including reviewing processes for pre-employment checks • Recruitment administrative model to be reconsidered in 2025/26
Action timescales and assurance group or committee	• Support actions and training offer are ongoing • Collaborative work is ongoing throughout 2025/26 • Workforce & Education Group reports (bi-annual) • People Committee bi-annual reports (bi-annual) • Internal transfer for admin and clerical posts expected to be piloted in Q2 (if appropriate leads can be identified to support)
Risk register	16 (linked)



Assurance report

SET training

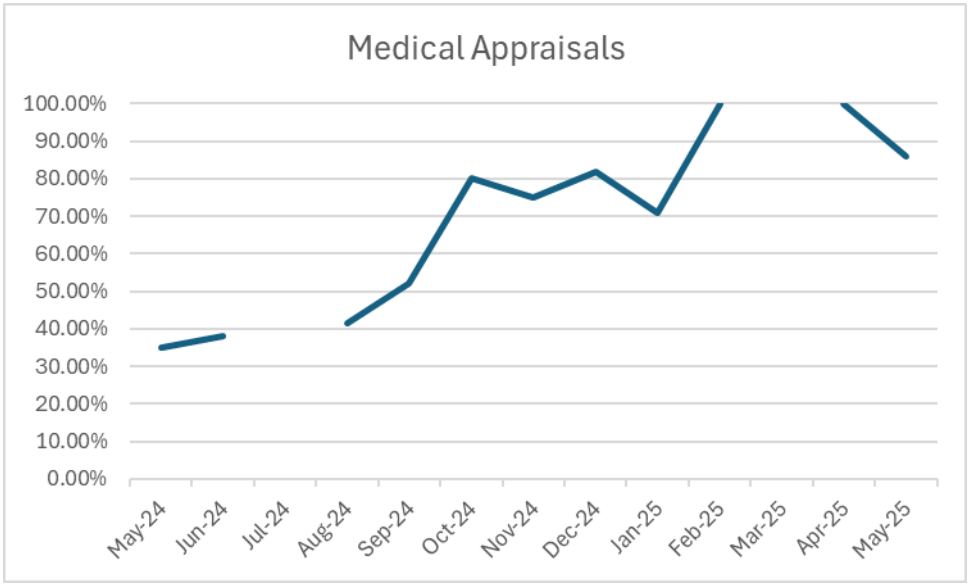
Summary of challenges & risks	SET training compliance in May 2025 was 89.2% Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits. Re-baselining took place on this metric in December 2023
Actions to address risks, issues and emerging concerns relating to performance and forecast	• 90% achieved in 2025 for two consecutive months prior to returning to over 89% in last two months. Trust focus on '3 steps to success' on SET compliance supported this increase. • Work continues on NHSE national statutory and mandatory training project and is on track • NHSE Memorandum of Understanding effective from May 2025 to support passporting between trusts of statutory and mandatory training • Prioritisation exercise taking place to support completion of role-specific training (ReST), which complements SET
Action timescales and assurance group or committee	• NHSE project work in line with national timescales during 2025/26. Progress report to Executive team and Workforce & Education Group in June 2025 • Further review of frequency of training for one SET topic in line with national approach (Q2) • People Committee reports – every meeting
Risk register	3005



Assurance report

Medical Appraisals

Summary of challenges & risks	Medical appraisals completed for May 2025 was 86%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In line with Royal Colleges and GMC guidelines, the annual medical appraisal process is continuous throughout the year, with achievement measured nationally at the end of March. At March 2025 100% of medical appraisals were completed, with exceptions for long term sickness, sabbatical, maternity leave etc. The MDs medical appraisal process is embedded as business as usual and working well.
Action timescales and assurance group or committee	On track to achieve 100% by the end of March 2026.
Risk register	



Metrics in development

- Medical Appraisals completed – *Back dated forms not yet 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*
- Vacancies (specific staff groups) – *Additional data required in extracts provided This is being investigated*
- Turnover – *reviewing logic*
- Severe harm falls per 1000 bed days – *Further development required following testing results*
- No urgent operation to be cancelled for a second time – *Further investigation required*
- Combining of COHA & HOHA – *Further development required following testing results*

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2507 - F2 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK REGISTER

Decision Item | Zara Jones, Deputy Chief Executive | 12:05

Executive Directors
20 minutes

REFERENCES

Only PDFs are attached

F2 - Board Assurance Framework inc. Trust Risk Register.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	1 July 2025
Report Title/ Ref:	**Board Assurance Framework inc. Trust Risk Register**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance Tracy Evans-Philips, Trust Risk Manager			
Appendices:	Appendix 1: Risk Report and Trust Risk Register Appendix 2: BAF Risk 1 - 7			
Purpose of the report	**Assurance**	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	Compliance to the Risk Policy and Board Assurance Framework impacts the effectiveness of the Board to monitor the Trusts Strategic risks			

Executive Summary – Key messages and Issues

This report presents the Board Assurance Framework (BAF) for 2025/26 up to and including reviews into June 2025. The Board Assurance Framework and Trust Risk Register are presented to the Board of Directors for further discussion and assurance.

Background

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 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 3 lines of defence in line with the agreed risk appetite and tolerance levels for the Trust. Whilst risk cannot be eliminated completely, the Trust understands the importance of managing risk effectively to reduce any likelihood of a negative impact to the Trust, its people, and the patients we care for.

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

2.7 The Board of Directors should carry out a robust assessment of the trust's emerging and principal risks.
2.8 The Board of Directors should monitor the trust's risk management and internal control systems.

The Partnership BAF Risk was discussed at length in the Board development session in June 2025, and the amendments made there will be updated and agreed on the BAF at the next session. This has moved out of sync slightly as this was previously discussed through confidential board. It now a standing agenda item for the board development session. The results of any updates will be reflected in the September BAF that will come to the public board for assurance.

The BAF reflects the changes and updates to the strategic risks of the organisation. These are updated by the lead executive and monitored through the responsible committees. All risks and action plans are discussed in line with the risk policy. To note that following a discussion at the People Committee, the decision was made to keep the target risk score as 12, given the national context, the strategic ambitions and the risk appetite which is now 'seek'.

The June Finance and Performance Committee received BAF risks 3 and 7 for discussion, and will discuss BAF Risks 4 and 5 in their July meeting.

The 'clean version' of the Board Assurance Framework is enclosed in appendix 2 for Board review, discussion, and assurance, this has had all the changes updated that were shared within the committee and agreed. The BAF will continue to mature in line with the developing strategy and identified milestones.

Operational risks that influence any strategic risk are documented within the corresponding BAF risk and are continuously managed through the monthly Risk Management Group. These are shown within the Trust Risk Register that is managed through the Datix System. The report is taken at a specific point in time and therefore any updates or amendments that happen after this time will not be reflected here.

Recommendations

The Board of Directors are asked to:

- Receive the report.
- Approve the current BAF risk content and take assurance this enables the Board to fulfil its duty to monitor its highest strategic risks.
- Note that the BAF and Trust Risk Register is a live document, which will be reviewed and updated regularly throughout the year.

Healthier together – delivering exceptional care for all

Patients	Regular review and assessment of the risks to patient care support the delivery of safe and effective services.
People	Regular review and assessment of strategic risks, support our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships, however, may identify areas of risk as part of a triangulated approach to risk management.
Pounds	Regular review and assessment of the financial risks, support delivery of the strategic priority to be sustainable and spend money wisely. Regular review may identify areas of financial or resource risk as part of a triangulated approach to risk management.
Health Inequalities	All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities
Legal/ Regulation	It is a regulatory requirement as part of the NHS Code of Governance for the Board of Directors to have mechanisms in place to manage and address risk throughout the organisation.
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies

Assurance Route

Previously considered by - including date:	Quality Committee People Committee Finance and Performance Committee Confidential Board of Directors
Any outcomes/next steps / time scales	To be approved by the Board of Directors on 01 July 2025 To be reviewed and updated in subsequent committees of the Board
In line with Current risk appetite **Yes**	**Risk Appetite levels: -** highlight only if this report is outside of Board Assessment

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Board Assurance Framework and Trust Risk Register Review

BAF Summary of Changes:

- Assurance levels on actions and controls have been agreed by respective lead committees – see highlight reports from each committee. These state the emerging risks as presented in the Trust Risk Register relevant to each committees' BAF risks, plus the assurance around the mitigating actions described therein.
- 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.

Trust Risk Register (Appendix 1)

Summary of data extracted from Datix Risk Management System 09 June 2025
Author: Tracy Evans-Phillips, Risk Manager.

Introduction

This report provides an update to the Board of Directors following an ongoing review of all risks within the Trust. It highlights overarching operational risks that are directly linked to the strategic risks outlined in the Board Assurance Framework (BAF). Each overarching operational risk identifies any dependent risks rated 15 or above. These risks have received approval at the Divisional/Directorate level and the Risk Management Group, with the exception of new risks yet to be reviewed by the Risk Management Group. The report begins with a summary outlining the relationship between Strategic Risks (BAF) and Operational Risks, followed by the comprehensive Trust Risk Register.

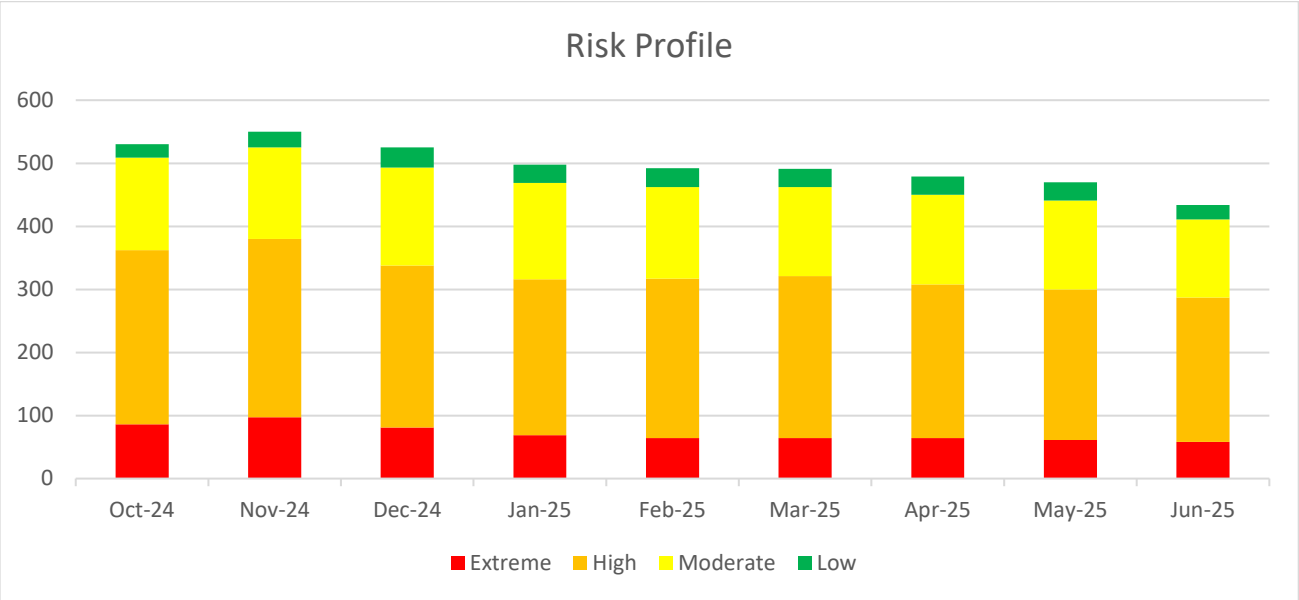
Please note: The information provided is based on the date the reports were compiled. Specific figures are subject to change throughout the month as updates occur.

Trust Risk Profile

Since May, there has been an 7.7% reduction in the number of risks on the full risk register, decreasing from 470 to 434 by June as a result of risk reduction. Compared to the peak in November 2024, this represents a 21.1% reduction.

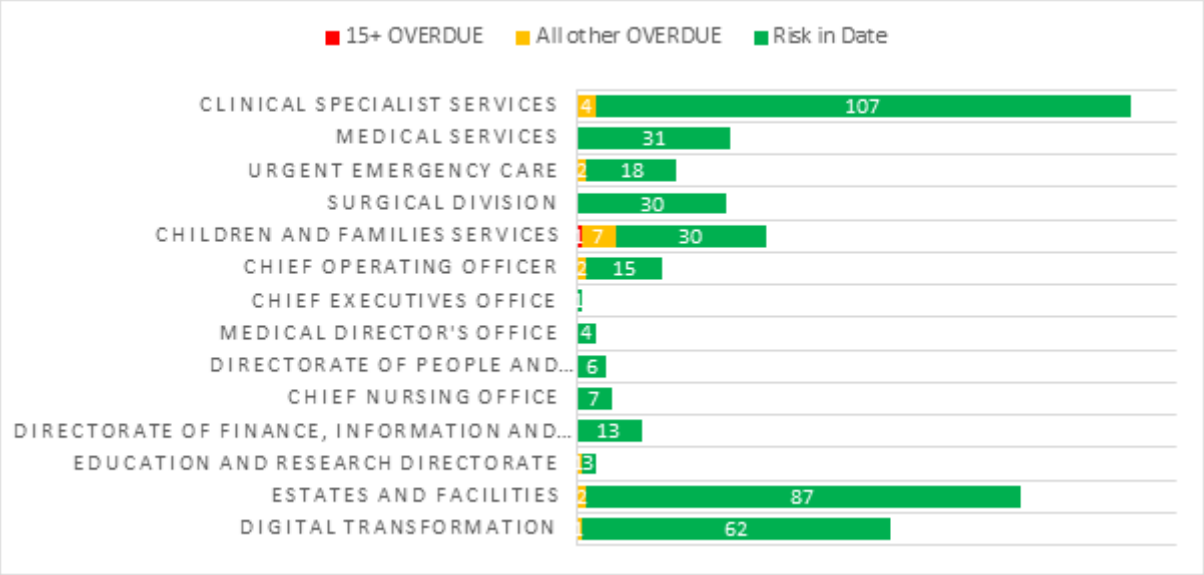
Between March and June:

- 13 new risks were raised (3 with an extreme rating, 15 or higher)
- 48 risks were archived, including two that had been opened during the same period
- There was also movement of risks between different risk grading



Risk Review Dates

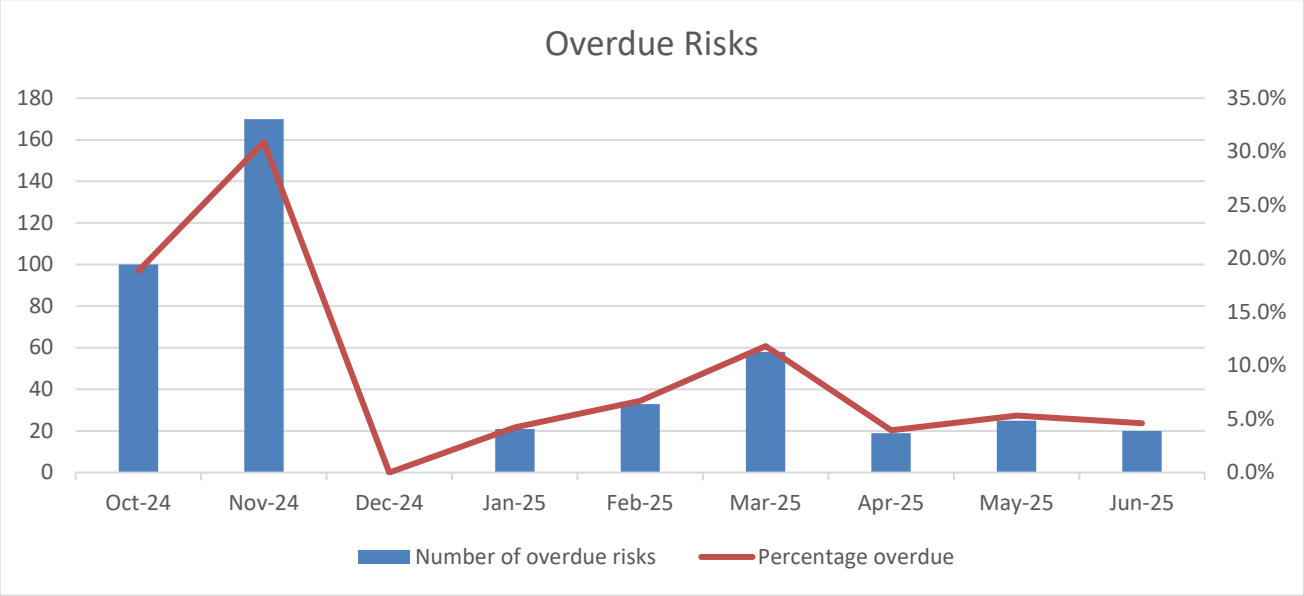
The chart below presents all risk recorded across the Trust, included those classified as “Extreme” (scoring 15 or higher), broken down by Division and Directorate. June data shows that 20 risks (representing 4.6% of the total risk register) were overdue, including one extreme-rated risk; this is an improvement on 58 risks (12%) reported in May.



The above chart shows the 434 Trust Risks, which include 58 extreme risks.

To assist Divisions and Directorates with their ongoing risk planning and reviews at governance forums, the Risk Manager delivers a monthly report detailing overdue risks and actions. Additionally, all risks scheduled for review in the current month are highlighted to support the development of a forward-looking risk evaluation plan.

Overdue Risk over time

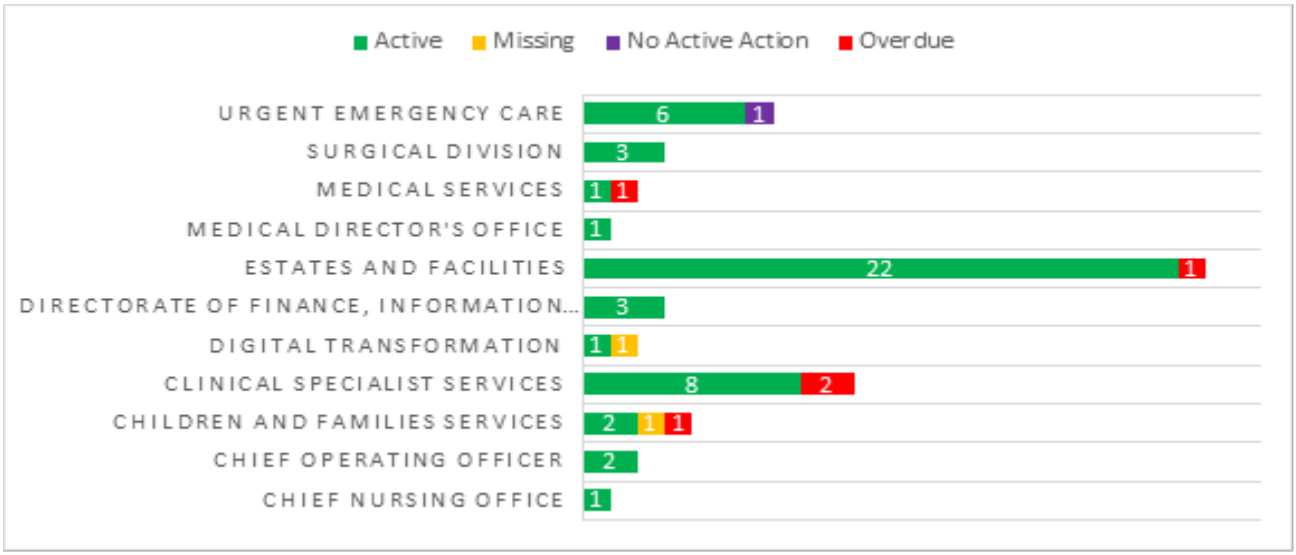


From April to June 2025, the number of overdue risks remained relatively stable (between 20 and 30), with the percentage overdue fluctuating between 5% and 7.5%. As of June, there were 20 overdue risks, accounting for approximately 4.6% of the total risk register. The data suggests a more stable but not fully compliant state, with room for improvement. All overdue risks are reviewed monthly at the Risk Management Group each month to reinforce the importance timely and consistent risk reviews.

Risk Action Plans

All active risks should contain remedial action plans to improve the management of risk and achieve the desired level. Once a risk reaches its target rating, remedial actions may no longer be required.

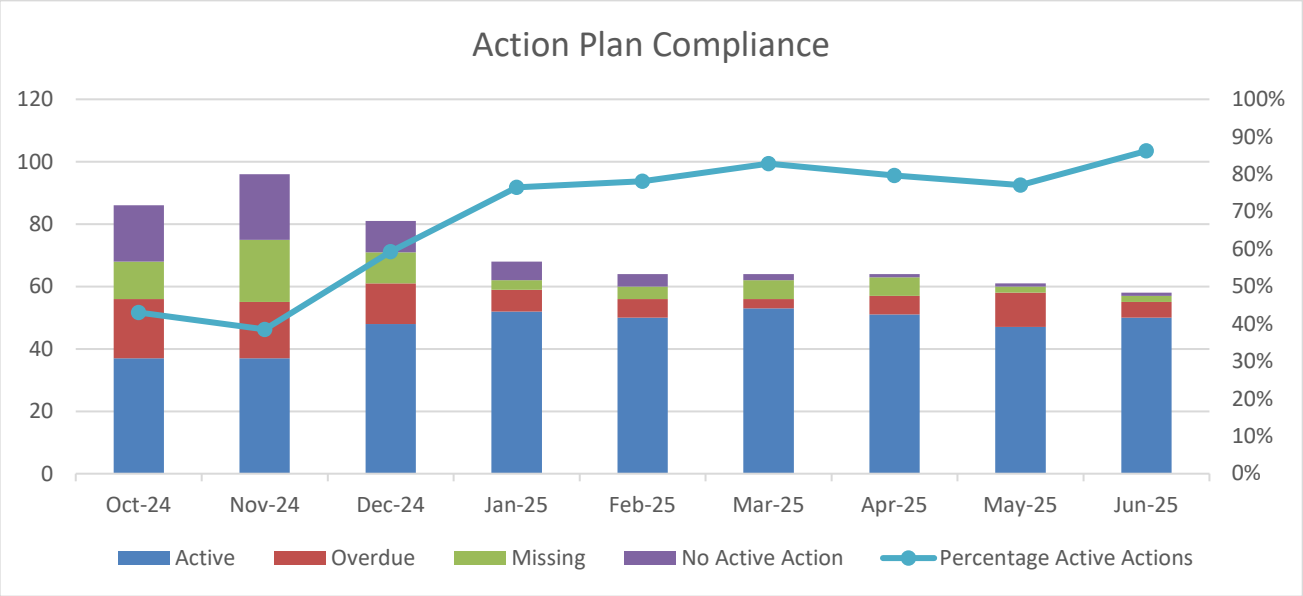
The chart below outlines the status of action plans for all risks rated 15 and above, categorised by Division or Directorate. It highlights active actions, overdue actions, and actions missing from Datix entries – the two missing in the chart below are new and are scheduled for Governance discussion for agreement of actions. While some risks have undergone remedial action, this has not always resulted in achieving the agreed target level. One risk on the chart below has no active action and requires discussion at the next Governance meeting to agree a remedial action plan.



The above chart shows the action summary of 58 Extreme risks (15+).

The Risk Management Group reviews and discusses risks categorised as having "no active action" to determine whether further action is required beyond the responsibility of the risk location. A reduction in the number of risks requiring remedial action has been observed. The Risk Manager is working with the Divisions and Directorates to ensure implementation of action plans to ensure good practice of this aspect of risk management.

Action Compliance over time



The chart above demonstrates the improvement in the number of mitigating action plans added onto Datix, relating to the highest rating risks (15+), the compliance has risen from 43% in October to 86% in June.

Risk Management Group and eLearning

As of the end of March 2025, the Risk Management eLearning module was established as a core competency within the Electronic Staff Record (ESR) system and made mandatory for relevant staff. The module provides foundational knowledge of risk management, with a particular focus on accurately scoring risks in alignment with Trust-wide objectives rather than departmental goals. This approach supports consistency in risk score moderation across the risk register.

A compliance target of 90% over three years was set for this training. By the end of May 2025, the compliance rate stood at 55.31%.

Changes to Trust Risk Register

Following an instigated review of risks that have remained at the same risk rating for over 2 years and risk moderation at Risk Management Group of extreme risks, nine risks were downgraded and no longer appear on the Trust Risk Register, and five risks have been closed. Details below:

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

- **RISK 1246 Conformity to critical ventilation**
  Likelihood of infection reduced due to settle plate testing
- **RISK 3209 Patient Tracking System**
  The Patient Pathway System is live in six areas, thereby reducing the likelihood of the risk
- **RISK 3323 Vascular capacity issues**
  Following deep dive investigation, likelihood of risk reduced
- **RISK 3460 Junior Out of Hours cover**

Locum cover secured

- **RISK Audiology equipment and estate standards**
  Significant progress against standards, estate work and technology procurement
- **RISK 3542 Audiology best practice, training and guidance**
  Increase in training compliance and guidance in development
- **RISK 3600 Water ingress through ceiling**
  Works completed reduced likelihood of occurrence
- **RISK 3607 Database storage capacity**
  Funding allocated for hardware to mitigate
- **RISK 3616 eReconciliation compliance**
  Additional controls have reduced likelihood of risk

Risks closed.

- **RISK 3175 24/25 Cost Improvement Plans**
  Replaced with risk for 25/26 RISK 3634
- **RISK 3439 Mexborough Elective Orthopaedic Centre Theatre Capacity**
  Reached the target of 85% theatre utilisation
- **RISK 3480 24/25 Statutory regulations for Emergency Planning Resilience Response**
  Replaced with risk for 25/26 RISK 3627
- **RISK 3601 Alertive location name changes**
  Alertive have updated location names
- **RISK 3614 Oncologist shortages**
  Risk belongs to Sheffield

New Risks

Eight new risks have been added to Datix with a 15+ rating. Two risks have not been presented at Risk Management Group and are currently going through the divisional governance process before it is moderated in this forum and are therefore here for awareness only.

- **RISK 3621 Risk to neuro-rehabilitation outcomes due to service capacity**
  Triage of patients, daily re-evaluation of caseload and reallocating of colleagues from stroke workforce to maintain care plans
- **RISK 3624 Unidentified mental capacity issues during pregnancy**
  Quality workstreams with Safeguarding teams
- **RISK 3627 Compliance with statutory Emergency Preparedness Resilience Response 2025/26**
  Governance and Accountability Framework, oversight and escalation of risks, time-bound action plans, multi-agency exercises, participation in local forum, board member briefings
- **RISK 3632 Compliance with 2025/26 financial plan**
  Scrutiny and monitoring of finance processes and budget holder meetings
- **RISK 3634 Delivering if 2025/26 Cost Improvement Plans**
  Target setting, transformation plans/schemes, provider savings
- **RISK 3637 Insufficient Cash Funds for 2025/26**
  Break –even plans for 25/26, work ongoing to develop achievable, cash releasing schemes
- **RISK 3652 NHS Mail issues affecting Alertive use**
  Additional phones as resilience (interim) measure with emergency teams list as back up Communication with NHS Mail
- **RISK 3657 Delayed surgical review for abdominal patients**
  Monitor use of Children Appendicitis Score (CAS) to ensure timely escalation for surgery

The individual risks that relate to the relevant BAF are presented to the responsible committees where further discussion and assurance is provided.

Appendix 1 Trust Risk Register

Subsequent to the review of the risks within the Board Assurance Framework, some of the risks no longer have an overarching status are directly linked to the relevant BAF Strategic Risk; resulting in a larger 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	Rachel Wilson	Risk of patient harm as a result of unavailability and supplies of medicines	08/10/2025	15	11 Months	6	0	No	No
BAF 1	3197	Simon Brown	There is a risk of regulatory action and patient harm due to reduced safeguarding team capacity and compliance to SAAF	11/08/2025	9	4 Months	6	0	No	No
BAF 1	3209	Denise Smith	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	17/06/2025	12	2 Months	6	0	No	Yes Overdue
BAF 1	3246	Simon Brown	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	20/06/2025	15	27 Months	9	1	Yes Duration	No
BAF 1	3290	Karen Jessop	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	01/12/2025	10	25 Months	6	0	Yes Duration	No
BAF 1	3449	Simon Brown	Risk of harm to patients due to pressure ulcers due to numbers of patients on under prescribed mattress	30/06/2025	9	7 Months	6	0	No	No
BAF 1	3454	Nicholas Mallaband	If there is a deterioration in services we will be unable to deliver high-quality care which may result in regulatory action	30/06/2025	16	15 Months	8	5	Yes Duration	No
BAF 1	3627	David Harvey	Increased risk of consequences resulting from incidents due to failure in statutory (EPRR) contractual obligations	31/07/2025	20	3 Months	16	0	No	No
BAF 2	16	Zoe Lintin	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	27/06/2025	12	12 Months	9	3	No	Yes Overdue
BAF 2	19	Zoe Lintin	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	01/10/2025	8	7 Months	8	0	No	No
BAF 3	3434	Ben Vasey	Timely access to diagnostic services - Demand, Capacity & Flow	30/06/2025	12	16 Months	12	5	Yes Duration	No
BAF 3	3435	Ben Vasey	Timely access to elective care - Demand, Capacity & Flow	30/06/2025	12	16 Months	12	1	Yes Duration	No
BAF 3	3436	Lesley Barnett	Timely access to cancer services - Demand, Capacity & Flow	29/07/2025	12	12 Months	12	0	No	No
BAF 3	3437	Suzanne Stubbs	Timely access to emergency care - Demand, Capacity & Flow	30/06/2025	16	16 Months	12	5	Yes Duration	No
BAF 4	12	Howard Timms	Failure to ensure that estates infra-structure is adequately maintained and upgraded in line with current legislation	28/11/2025	25	3 Months	10	12	No	No
BAF 4	1083	Mathew Gleadall	Risk of electrical failure due to age and condition of HV/LV infrastructure	28/11/2025	15	83 Months	10	1	Yes Duration	No
BAF 4	1412	Howard Timms	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	30/06/2025	15	51 Months	10	6	Yes Duration	No
BAF 4	1807	Mathew Gleadall	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	30/06/2025	16	3 Months	8	2	No	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	8 Months	10	2	No	No
BAF 5	3632	Sam Wilde	Failure to achieve compliance with financial performance and achieve 2025/26 financial plan	12/06/2025	16	3 Months	8	0	No	No
BAF 5	3629	Sam Wilde	25/26 Risk of Fraud, Bribery and Corruption against the Trust through criminality by exploitation of control measures.	08/10/2025	12	3 Months	8	0	No	Yes Missing
BAF 5	3630	Angela Lawson	25/26PMO1 Lack of engagement/capacity from operational services to deliver project objectives/CIP schemes not delivering savings	14/07/2025	9	3 Months	6	0	No	No
BAF 5	3628	Angela Lawson	25/26 PMO2 Financial services don't complete financial analysis of identified schemes within agreed timescales delaying schemes	14/07/2025	6	3 Months	6	0	No	No
BAF 5	3634	Yasmin Ahmed	Failure to deliver 25/26 Cost Improvement Plans impact on the Trust's deliver of financial targets	12/06/2025	16	3 Months	9	0	No	No
BAF 5	3635	Yasmin Ahmed	Failure to deliver 25/26 Capital Programme including inability to meet Trust's needs for capital investment	12/06/2025	9	3 Months	6	0	No	No
BAF 5	3636	Yasmin Ahmed	Non-delivery of 25/26 activity targets impacting on levels of income received by the Trust	12/06/2025	12	3 Months	6	0	No	No
BAF 5	3637	Yasmin Ahmed	Insufficient cash funds in 25/26 to pay staff, suppliers and replace/invest in capital	12/06/2025	16	3 Months	8	0	No	No
BAF 5	3631	Angela Lawson	25/26 PMO3 - Monday.com system failure resulting in the loss of project information	14/07/2025	10	3 Months	10	0	No	No
BAF 6	3507	Sam Debbage	Failure to meet MHRA research inspection standards	16/06/2025	12	12 Months	4	0	No	No
BAF 7	1410	David Linacre	Failure to protect digital assets, risk of a cyber-attack which may result in the Trust being non-operational	30/10/2025	15	3 Months	10	0	No	No
BAF 7	3384	Dan Howard	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	30/06/2025	8	7 Months	8	2	No	No
BAF 7	2727	Virendra Pandare	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	30/06/2025	9	15 Months	3	0	Yes Duration	No
BAF 7	3184	Dan Howard	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	30/06/2025	8	17 Months	4	0	Yes Duration	No

BAF 7	1663	Dan Howard	Failure of the HSCN, Internet, or VOIP telephony external network connections	31/07/2025	8	7 Months	4	0	No	No
BAF 7	3474	David Linacre	(AIP) VMware ELA - expire 31/03/2025 Significant financial pressure	10/06/2025	4	3 Months	4	0	No	No
BAF 7	2736	David Linacre	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & DR	30/06/2025	9	40 Months	6	0	**Yes** Duration	No

Appendix 2: Board Assurance Framework

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: Cautious	3209; 3454; 3627; 3449; 3197; 3290; 3246 1517
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Last reviewed (by on behalf of Lead Director)	May 2025	Risk Rating	**16**		**12**			
Last Changed (By Lead Committee)	December 2024	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	Divisional performance monitored at Performance Review Meetings with Exec oversight, (monthly) (1) CQC Action plan update to QC (June 25) (2) CQC Action plan assurance presentation to Integrated Quality Improvement Group (March & April 25) (3) CQC Quarterly Engagement Meetings (3) CARE Accreditation Process review oversight at TLT (1) Maternity, Neonatal Quality and safety Group (1) IQPR (2) Internal Audit of Patient Safety Incident Response Framework 25/26 plan (3)		**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) Skill mix paper considered by Executive team and included in current annual planning (1) AHP update provided to People Committee (2)		**Significant Assurance**
Clinical Audit Programme and monitoring.		Report to Quality Committee June 2025 (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 following 360 Assurance Audit	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	Internal Audit Complaints Handling Policy (Oct 24) (3) (Moderate **Assurance)** Infection Prevention Control Steering Group (1)	**GA3** Lack of visibility of resuscitation activity and RESPECT compliance	**Moderate Assurance** **Limited Assurance**

	GC9 High numbers of Clinical policies are out of date **GC10**: Antimicrobial Stewardship Procedures not consistently applied in all areas	Internal Audit- Medicines Management (**Significant Assurance)** Risk Management Group (1) Internal Audit Risk Management *follow-up* (**Limited Assurance)**	**GA4:** Implementation of recommendations for medicines management Internal Audit **GA5)** Internal Audit follow-up recommendations for risk management	**Significant Assurance** **Limited 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) Patient Safety report to QC (June 25) (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 (Apr 25) (3) CNST divisional oversight group highlight reports (1) Maternity, Neonatal Quality and safety committee (2) Maternity safety champions visits and meeting (2) Maternity and Neonatal Board report (May 25) (2) Maternity and Neonatal Single delivery plan update to QC (April 25) (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**
GA2) Effectiveness Group receive divisional highlight reports to check compliance with actions for clinical governance recommendations	March 26	EMD	All activities monitored through Monday.com and standardised templates for reporting through local governance, audit and effectiveness and Effective Committee.
GA3) Education Team working with EMD office to establish baseline for understanding required actions for RESPECT and resuscitation.	July 25	EMD	Audit review will come to Quality Committee once completed with next steps to address the gaps. Will be a priority area of focus in 2025/26, will check on the expected timescale for this action with the education team and update the committee.
GA4) Medicines management Implementation of Internal Audit 2 moderate recommendations.	October 2025	CN	Plans are in place to complete the recommendations; progress towards completion will be reported to Trust leadership team.
GA5) Follow up- recommendations for Internal Audit risk management	April 2025	DCEO	All follow-up actions now completed and reported through to the Risk Management Group and monitored through Audit and Risk Committee. This supports the correct risk scoring and monitoring of clinical risks across the Trust. Action complete
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.
GC2) Business case under development to embed required skill mix based on quality risks	August 25	CN	Once developed Business Case 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	May update – Individual AHP speciality reviews underway led by the CN. draft safe staffing paper being revised following further comments from executives and will be presented to People Committee in June
GC4) SJR plan in place to address current gaps	July 25	EMD	Phase 3 is now ongoing training following identification of consultants once they come forward to be involved in the SJR process. Trajectory to be agreed and target number will be monitored through the mortality governance and learning from deaths report
GC5) Recruitment to Learning From Deaths Manager	April 25	EMD	June 25 update: Interim Manager in post supporting 4 days a month flexibly for the remainder of this financial year. Current recruitment issues have impacted on the substantive recruitment to this role.

GC6) Mortality Governance Group Action Plan in place	Nov 25	EMD	All actions from the 360 Assurance Audit are now in place, Action Complete
GC7) Implement actions from IA complaints policy	May 25	CN	Report on actions to come to Quality Committee Report on June QC agenda
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	DCEO	Process established for all policies on Monday.com for monitoring, Next stage of review to understand where policies are approved, who signs them off and ensuring this requirement is understood by the named policy Author. Executives continue to receive reports on outstanding policies within their portfolios.
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.

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: Seek Regulatory: Cautious	
Initial Date of Risk Assessment	July 2023	**Impact**	3		3	Risk Treatment Strategy	Treat	**16;19**
Risks Last reviewed (by on behalf of Lead Director)	May 2025	**Risk Rating**	**12**		**12**			
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 IA Bank and Agency processes	**GC1:** Additional actions identified to support return to work and reduce sickness absence.	Chief People Officer Senior Leadership meeting (1) Reports assurance at People Committee (2) IA Bank and Agency (3)All recommendations implemented. IA Pay and expenditure (3) **Significant Assurance** IQPR to Board (2)	**GA2:** IA Pay and Expenditure recommendations.	**Significant Assurance** **Significant 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) Internal Audit eRostering (3) Moderate/Limited *Internal Audit Absence Management 2025 – 26 Audit plan (3)*	**GA3:** Internal Audit e rostering recommendations. Split assurance of Moderate and Limited	**Significant Assurance** **Limited Assurance** **Moderate Assurance**
Equality Diversity & Inclusion Improvement Plans		EDI Forum reports bimonthly (1) People Committee Biannually (2) WRES and WDES data reporting to Board (3) *Internal Audit Strategy 2023-2027 Equality Diversity and Inclusion 2025-*26 Audit Plan (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 Forum (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
GA2: Implementation of IA Pay and Expenditure recommendations for people directorate	June 25	Chief People Officer	All remaining actions on track to complete
GA3: Implementation of Internal Audit e-rostering recommendations	September 2025	Chief People Officer	Progress report to be provided at June 2025 People Committee. All remaining actions on track to complete
GC1: The Workforce workstream reviewing identified actions for improvements, reporting Executive team	March 26	Chief People Officer	Policy implementation review of refreshed sickness absence policy completed. The recommendations and learning from this and benchmarking with another trust have now been collated and improvements agreed for implementation. The deep dive data analysis has been completed on additional groups. All actions are managed internally on Monday.com and monitored at steering group meetings.
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	Preferred option for data capture on exit interviews to be further detailed for implementation.
GC3: Network refresh and relaunch project	March 26	Chief People Officer	Progress monitoring and reporting will be through to EDI Forum. Executive Sponsorship of networks now in place for the two active networks as part of the refresh work over Feb and March 2025. Further networks are expected to launch in May and June 2025
GC4: Design of holistic leadership development modules into an overarching leadership programme	March 27	Chief People Officer	The second annual DBTH Leadership Conference was held in April 2025, face-to-face in the education centre, with guest key-note speaker. Workshops were hosted by DBTH leads on a variety of topical subjects. Positive feedback received from attendees. Content can be used again and will be banked as resources going forward.

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: Cautious	**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) Internal Audit of Data Quality, Cancer metrics 25/26 Plan (3)	**GA1)** Operational Delivery Group (Monthly) to be set up **GA2)** Inconsistently applied Divisional Governance arrangements **GA5)** Internal Audit: Outpatients appointments	Partial Assurance **Limited 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) Internal Audit of Patient Flow 25/26 Plan (3)	**GA3)** No current specific reporting on demand management	Partial Assurance
Efficiency GIRFT Programme Outpatient improvement programme Theatres improvement programme Urgent Emergency Care improvement programme	**GC11)** Review of impact of current GIRFT programme **GC12)** Improved reporting of the improvement programmes, using SPC charts as the standard	Performance Review Meetings monthly report (1 Doncaster Place UEC board (monthly) (3) Outpatient improvement programme meeting (1) Theatre improvement programme meeting (1) Model Health reporting system (3)	**GA4)** No current specific reporting on efficiency	Partial 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: SMART Actions	**Timescale**	**Lead**	**Progress update**
GC1) Initiate and embed a Trust wide Access Group (executive led)	June 2025	COO	Operational Delivery Group established, first meeting 27 June 2025
GC2) Embed consistent use of Urgent Emergency Care (UEC) escalation process	April 2025	COO	Escalation process implemented. Further work in progress with YAS / EMAS to revise the ambulance handover process
GC3) Review Trust Validation Process with national best practice and initiate new process	September 2025	COO	Initial discussion with COO / CFO / COO taken place. The Trust is participating in the NHSE 'DQ Sprints' during 2025/26
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 complete. Divisions of Medicine and Surgery developing the model of care in line with the national service specification
GC11) Current GIRFT programme review	June 2025	COO / EMD	Links to GA4) as part of a fundamental strategic decision and review. Discussion with the Elective Improvement Support Team took place in June to consider a support programme for the Trust for elective care / GIRFT improvement
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. Implemented for some of the access standards.
GA1) Operational Delivery Group (Monthly) Chaired by the COO	July 2025	COO	Group established, first meeting 27 June 2025
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	Elective Care Improvement Support Team to work with the Trust to develop the expertise internally
GA4) Efficiency reporting plan	June 2025	COO / EMD	Part of the wider Trust discussion on the GIRFT resources
GA5) Implementation of Internal Audit recommendations for Outpatients Appointments	March 2026	COO	

Strategic Risk 4 (Cause – Event-impact)	***If DBTH cannot maintain and improve the 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 / Regulatory	Links to Significant strategic Risks on Trust Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	5		4	Risk Appetite	Finance: Open Quality: Cautious Regulatory: Cautious	**12; 1412; 1807; 3348; 1083**
Initial Date of Risk Assessment	July 2023	**Impact**	4		4	Risk Treatment Strategy	Manage	
Risk Last reviewed (by / on behalf of Lead Director)	May 2025	**Risk Rating**	**20**		**20**			
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)		**Partial 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**

GC1a: Confirm the funding availability for estates maintenance based on the findings of the estates review and associated business case by the end of quarter 1 of FY2025/26	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
GC1b : Once funding is confirmed, align the estates maintenance strategy to funding availability, adopting an approach that mitigates risk and regulatory non-compliance as far as reasonably practicable within any funding constraints that may remain.	September 2025	Head of Estates	Dependant on GC1a progress
GC1c : Assess remaining gaps in compliance after the maintenance strategy is reviewed, complete a risk assessment and record the findings on the E&F risk register.	October 2025	Head of Estates	Dependant on GC1a progress
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

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 Finance Officer	**Likelihood**	4		4	Risk Appetite	Finance: Open Regulatory: Cautious	**3629; 3630;3628; 3681; 3632;3634; 3635; 3636; 3637; 3639**
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risk Last reviewed (by / on behalf of Lead Director)	April 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 Estates procurement and Contract management	**GC3:** Outstanding actions from IA of Bank and Agency spend **GC5**: Embedding of Medical rostering **GC7:** Completion of actions from IA of Accounts Payable	Internal Audit Bank and Agency Spend (3) (Limited 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) Internal Audit of Accounts Payable (3) [Significant Assurance] Internal Audit of Estates Procurement and Contract Management 25/26 plan(3)		**Limited Assurance** **Significant 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 • Weekly Non-pay review	**GC6:** Specific control measures within the performance assurance framework 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**
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 Vs target CIPs to be used within the PRM setting to track achievement earlier.	May 2025	CFO	Dashboard to presented at May PRMS for month 1 reporting
GC2: Don't currently have a rolling 3-year CIP programme	July 2025	CFO	The Trust currently has multi-year cross cutting CIP schemes. Rolling 3 year CIP Programme to be developed as part of the Trust's medium tern finance plan
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. Deputy CPO confirmed all actions complete
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 as part of the assurance performance framework.	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
GC7: Implementation of all Internal Audit recommendations for Accounts Payable	August 2025	CFO	4 agreed actions with deadlines between end May 2025 and end August 2025
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

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	Seek	
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Manage	3507
Risk Last reviewed (by on behalf of Lead Director)	June 2025	Risk Rating	**8**		**6**			
Score Last Changed (By Lead Committee)	March 2025	Inherent Score	4x4=16					

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 being assessed for priorities to talk forward	Reporting through to each Board on activities from the CEO report (1) The DGH Collaboration Opportunities Report (3)		**Partial Assurance**
Best Care Environment Ambition: 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**
Tacking Health Inequalities Ambition Trust and Place level HI Activities. Health Inequalities considered on each Board and Committee paper explicitly		Health Inequalities reported through to Finance and Performance Committee on progress(2) Presentation to Board Development Session February 2025 (2) *Internal Audit of Partnership arrangements due in April 2025 24/25 Audit plan*(3)		**Significant Assurance**
Pathology Partnership		Pathology Partnership Board (2) *Internal Audit of Partnership governance arrangements - Pathology 25/26 Audit plan* (3)		***To review***
Full DBTH engagement in any emerging Collaborative Opportunities in the South Yorkshire and Bassetlaw areas	**GC4:** Not all partner governor positions are filled or actively engaged	Board of Directors (2) Board to Board meetings (3) Partner Governor arrangements (2)		
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.	September 25	CEO	DGH opportunities report received and shared at Board of Directors of all DGHs. Working through the options to increase collaboration for delivery of strategic aims.
GC2: Engagement in Acute Federation workstreams to drive change and improvements.	March 26	DCEO	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. Briefing to the Board in April around the partnership working,
GC4: Increase the range of Partner Governors and review the engagement as part of the wider membership project	Dec 25	DCEO	Membership project to commence in June 25. Reach out to key partners to be governors – action commenced and waiting responses back
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

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: Cautious Quality: Cautious	1410; 3384; 2727; 3184; 1663 3474;2736
Initial Date of Risk Assessment	January 2025	**Impact**	5		4	Risk Treatment Strategy	Treat	
Last reviewed (by / on behalf of Lead Director)	June 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)		**Partial Assurance**
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 *Internal Audit of Data Security and Protection Toolkit 2025-26 Audit Plan (3)*	**GA1**: DSPT Action Plan	**Significant Assurance**
Data quality improvement plan.	**GC6:** Unsupported and out of data core systems or systems running unsupported versions of Microsoft Server	Digital Maturity Assessment (3)		**Partial Assurance**
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) *Internal Audit of Cyber Security Governance 2025-26 Audit Plan (3)*	**GA2**: Cyber Assurance Framework Action Plan	**Partial Assurance**
EPRR and business continuity arrangements	**GC7**: Check resilience of EPRR disaster recovery and business continuity plans	Reported to Audit and Risk Committee (2)		**Partial Assurance**

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	Complete: 25/26 digital plan has been shared and agreed. Plan subject to onward monitoring and review by TLT and F&P.
GC2: Universal digital performance reporting action plan	August 2025	CIO	Draft KPIs are in place and were reported on at the last Digital Performance Group (March 25). They were further refined ~~by~~ in June 25.
GC3: Agree Digital Strategy 2025-2030	October 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. Deadline updated to October to allow full engagement with all relevant internal and external stakeholders.
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 was reviewed by F&P in March and F&P recommended its approval to Trust Board, Trust Board (private) approved the FBC in March 2025. It has since been submitted onwards for regional and national approval by NHSE and then Cabinet Office. The Change Control Notice is being finalised and the FBC is proceeding through its approval route in parallel, and as expected with no delays. The forward timeline is a) CCN approval by STH, DBTH and FD – June 2025 b) Fundamental Criteria Review by FD team – July 2025 c) EPRIB sign off, final FD FBC approval and Order Generation – August 2025 No concerns or delays to escalate.
GC5: Replace all end of Windows 10 life desktop hardware (desktops, laptops)	September 25	CIO	Orders have been placed for devices and the replacement programme is underway.
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. Tabletop business continuity exercise took place in June 25 which was a simulated exercise of multiple core systems being unavailable. Lessons learnt and feedback from the session will be incorporated into BC procedures.
GA1: DSPT Action plan recommendations	March 25	CIO	The audit ahead of our 2025 DSPT submission has taken place. While we are yet to receive the formal management report, the verbal feedback was very positive and suggested only a small number of minor recommendations will be made in the audit report.
GA2: Agree Cyber Assurance Framework Action Plan and complete actions	May 25	CIO	Monitored by Audit and Risk Committee. All actions to mid-June 2025 complete with the exception of CS3 (device compliance for third party remote connections) and CS5 (device hardening – making more resilience to an attempted cyber security attack). Both outstanding actions will be complete by end of June 25.

Three Lines of Defence		
First Line of Defence – operational management, examples include:		
	Budgets; Risk assessments; Work programmes of groups / committees;	Planning exercises when, who, relevance; Training needs assessments.
Second Line of Defence – Corporate oversight, examples include:		
	Performance/Quality monitoring in place and at what level, how and when; Action monitoring reports Complaints and Compliments / Incident monitoring;	National returns; Training compliance monitoring; Routine reporting of key targets together with any necessary contingency plans.
Third Line of Defence - Independence assurances example include:		
	External audit; External inspection bodies, such as the Care Quality Commission and Royal Colleges; Systems of accreditation	Mandatory reporting systems; Internal Audit; Health and Safety Executive.

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 management actions are not considered vital to achievement 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 have been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operational weaknesses have been recognise. Existing performance presents an unacceptable 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 accepted as urgently required.
External - Third Line of Defence - Internal Audit (360 Assurance)	
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.