Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING

BOARD MEETING

7 January 2025

09:30 GMT Europe/London

Virtual - MS Teams

Join the meeting now

AGENDA

2501 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 7 January 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 7 January 2025 at 09:30
Via MS Teams

		Purpose	Page	Time
A	**OPENING ITEMS**			**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair of the Board* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting.*			10
A2	Actions from previous meeting *Suzy Brain England OBE, Chair of the Board*	*Review*		
A3	Chair's Report *Suzy Brain England OBE, Chair of the Board*	*Information*		10
A4	Chief Executive's Report *Richard Parker OBE, Chief Executive*	*Information*		10
B	**STRATEGY, PLANNING & PARTNERSHIPS**			**10:00**
B1	Trust Strategy Update Report *Zara Jones, Deputy Chief Executive*	*Discussion*		10
C	**ASSURANCE & GOVERNANCE**			**10:10**
C1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
C2	Financial Position Update *Jon Sargeant, Chief Financial Officer*	*Note*		10

C3	Audiology Service Update *Zara Jones, Deputy Chief Executive*	*Discussion*		10
BREAK 10:50 – 11:00				
C4	Board Assurance Framework including Trust Risk Register *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Assurance*		20
C5	Chair's Assurance Log – Finance & Performance Committee *Mark Day, Non-executive Director*	*Assurance*		5
C6	Chair's Assurance Log – Quality Committee *Jo Gander, Non-executive Director*	*Assurance*		5
C7	Chair's Assurance Log – People Committee *Mark Bailey, Non-executive Director*	*Assurance*		5
C8	Chair's Assurance Log – Charitable Funds Committee *Hazel Brand, Non-executive Director*	*Assurance*		5
C9	Standing Financial Instructions, Standing Orders and Scheme of Delegation *Jon Sargeant, Chief Financial Officer*	*Approve*		10
C10	The Insightful Provider Board & DBTH Reporting *Zara Jones, Deputy Chief Executive*	*Note*		5
D	**STATUTORY & REGULATORY**			**11:55**
D1	Maternity & Neonatal Update - Bi-annual Workforce Report *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery*	*Assurance*		15
D2	Year 6 Clinical Negligence Scheme for Trusts Board Declaration *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery & Tomas Barani, Clinical Director*	*Approval*		10
E	**INFORMATION**			**12:20**
E1	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-
F	**CLOSING ITEMS**			**12:20**
F1	Minutes of the meeting held on 5 November 2024 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
F2	Pre-submitted Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
F3	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10

F4	**Date and time of next meeting:** **Date:** Tuesday 4 March 2025 **Time:** 9:30 **Venue:** MS Teams	*Information*		
F5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair of the Board*	*Note*		
G	**MEETING CLOSE**			**12:45**

***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

2501 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

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

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

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

REFERENCES

Only PDFs are attached

A1 - Register of Interests & FPP (2.1.2025).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

Mark Day , Non-Executive Director

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

(as at 2 January 2025)

Hazel Brand , Non-Executive Director
Councillor, Bassetlaw District Council (independent) In this role, member of the Council's Appointments and Audit & Governance Committees
Parish Councillor, Misterton

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

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

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

Jon Sargeant, Chief Financial Officer
Director, Doncaster and Bassetlaw Healthcare Services Ltd

Sam Wilde, Chief Financial Officer Designate
Member of NHS Benchmarking Network and Co-Chair of the Network's Steering Group, which oversees its operation

Zoe Lintin, Chief People Officer
Trustee on the Board of The Diocese of Sheffield Academies Trust

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

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

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

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

The following have no relevant interests to declare:

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

(as at 2 January 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 2 January 2025)

2501 - A2 ACTIONS FROM PREVIOUS MEETING

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

10 minutes

REFERENCES

Only PDFs are attached

A2 - Board of Directors Action Log - 5 November 2024.pdf

Action notes prepared by: Angela O'Mara
Updated: 23 December 2024

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	5 November 2024

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P24/05/D1**	**L2P Medical Appraisal system** – to provide post implementation feedback to the Board of Directors	**NM**	**November 2024**	**Update 30/10/2024 –** paper appended to the action log. Action closed
2.	**P24/07/D3**	**Immediate Safety Concerns Exception Reports** To incorporate an update on the immediate safety concerns reported in July in the next Guardian of Safe Working Report to Board.	**MK**	**November 2024**	**Update 30/10/2024** - included within the Guardian of Safe Working Report @ agenda item E1. **Update 5/11/2024** – action closed
3.	**P24/11/D5**	**Strategic Risk 2 – Board Assurance Framework** To consider the risk and mitigating actions in place related to sickness absence.	**ZL**	**January 2025**	**Update 16/12/2024 –** BAF updated to include sickness absence and reviewed by the People Committee on 17/12/2024. Action to be closed

Action notes prepared by: Angela O'Mara
Updated: 23 December 2024

No.	Minute No.	Action	Responsibility	Target Date	Update
4.	**P24/11/E4**	**<u>Emergency Preparedness, Resilience & Response Compliance against the National Core Standards</u>** To report the Trust's compliance following completion of the ICB's assessment.	**DS**	**January 2025**	**Update 23/12/2024 -** no change to the previously declared level of compliance (31%) following review by the ICB. Action to be closed.

2501 - A3 CHAIR'S REPORT

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

10 minutes

REFERENCES

Only PDFs are attached

A3 - Chair's Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**A3**
Report Title:	**Chair's Report**		
Sponsor:	Suzy Brain England OBE, Chair of the Board		
Author:	Katie Michel, PA to the Chief Executive and Chair		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

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

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

Healthier together – delivering exceptional care for all

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

Implications

Relationship to Board assurance framework:			
		BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	x	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
		BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions

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

NHS Providers – Care Quality Commission (CQC) Chairs Roundtable

This roundtable, chaired by NHS Providers' chair Ron Kerr, and led together with CQC's chair, Ian Dilks, provided an opportunity to discuss the regulator's next steps as it looks to rebuild its processes and reputation with the health and care sector. It was also an opportunity for trust leaders to share their recent regulatory experiences, including in relation to the findings of the Dash Review and Sir Mike Richards' report, and to discuss how the CQC could best support providers.

NHS Providers Annual Conference & Exhibition

This year, over 800 senior leaders from NHS trusts, system partners and key stakeholders were in attendance at the event in Liverpool. The theme was "*Next Generation"*, which focused on collective efforts to maximise the social and economic value of the NHS, ensuring it remains responsive, effective, and centred on patient and community needs.

We delved into critical topics essential for building the future of healthcare:

- **Leadership for the future**: Supporting inclusive and visionary leaders who can navigate and inspire in a rapidly evolving healthcare landscape.
- **Digital innovation and AI**: Leveraging cutting-edge technologies to enhance healthcare delivery and patient outcomes.
- **Reducing inequalities**: Addressing disparities to ensure equitable healthcare for all.
- **Sustainability and productivity**: Exploring financial sustainability in challenging times and sharing how trusts and their staff have improved productivity while sustaining high quality care.
- **Improving care for children and young people**: Working together to enhance the health and wellbeing of the younger population.

The conference provided an opportunity to engage with senior leaders from within and outside of the NHS as we shared insights, discussed challenges, and built a path for a stronger, more resilient health service.

NHS 10 Year Plan Regional Engagement Event - North East and Yorkshire

In November Chairs and Chief Executives from across the region were invited to join a discussion on the 10-year plan for health as part of the national programme of engagement to shape thinking. The session was hosted by Tom Riordan from the Department of Health and Social Care and Lauren Hughes from NHS England. At a local level, the Lead Governors from the Nottingham and Nottinghamshire Integrated Care System have collated a governor response and on 31 January 2025 a workshop facilitated by the Deputy Chief Executive and Head of Quality Improvement & Innovation will seek executive, non-executive, and governor input.

Alongside this there have been a range of national webinars including the evolving NHS Operating Model, winter preparedness and attracting and developing aspirant chairs from diverse backgrounds and with diverse experience.

Colleague Engagement

Since my last board report I have had the pleasure of meeting with Sam Wilde who has recently joined the Trust. Sam joins us from Lincolnshire Community Health Services NHS Trust, where he served as Director of Finance and Business Intelligence since 2018. Sam will take up the role of Chief Financial Officer following Jon Sargeant's retirement on 31 January 2025.

I would also like to take this opportunity to place on record my personal thanks and those of the Board of Directors, at what will be Jon's last Board meeting. Since joining the Trust in 2016 Jon has made a significant contribution; navigating and providing leadership to ensure the delivery of challenging efficiency programmes, ambitious financial plans, and capital projects. The Board of Directors wish you the very best in your future endeavours Jon!

Long Service Afternoon Tea 2024

This year's event brought together 70 colleagues from Doncaster Royal Infirmary, Bassetlaw, and Montagu Hospitals, each having served between 10 and 50 years in the NHS. Hosted by members of the Trust's Board of Directors, the event celebrated colleagues' exceptional service and commitment. The event was funded by proceeds from the Trust's internal staff lottery, money which is raised with the express purpose of supporting reward and recognition schemes.

Volunteers Christmas Lunch

The Trust is enormously grateful for the support provided by 120 volunteers across its three hospital sites. To say a special thank you, a festive lunch was arranged in recognition of the vital role volunteers fulfil assisting patients, visitors and colleagues.

The annual Bassetlaw League of Friends' Carol Service took place the evening of 16 December and it was my pleasure to give a reading and join in the celebration. The week prior to this, the Trust hosted its first Virtual Ward Carol Concert at Doncaster Royal Infirmary. Organised by Mandy Tyrrell, Virtual Ward Manager and Staff Governor the service allowed those patients receiving hospital level care in their home to watch the concert, where a local brass band performed.

Governor Engagement

Shortly after November's Board meeting the Council of Governors met. Governors received their usual updates from the Lead Governor, Chair, Non-executive Committee Chairs and the Chief Executive. In addition, the Associate Director of Strategy, Partnerships & Governance presented papers on the appraisal process for

the Chair and Non-executive Directors, recruitment and succession planning and a proposal for future Council of Governor and Annual Members meetings.

To progress some of this work governors were invited to express an interest in joining working groups and in December governors came together to consider future ways of working and specific schemes of work with the Associate Director of Strategy, Partnerships & Governance. Afterwards governors were joined by the Chair, Non-executive Directors, and colleagues from the Trust Board Office for a festive buffet.

Partner Engagement

Launch of Doncaster Health and Education Strategic Alliance

For many years, the Trust and Doncaster College have worked in close partnership to widen access to rewarding careers in the health and care sectors, ultimately fostering better health outcomes for our communities. This alliance formalises our shared vision, paving a simplified career pathway across our region and removing barriers to learning, while generating innovative opportunities in health education.

I attended this launch on 5th December to celebrate this milestone and to discuss the Alliance's potential to expand opportunities for people from all backgrounds. It was clear to see that, together, as an anchor institution and a premier education provider in the region, we are dedicated to exploring new ways to develop the next generation of healthcare professionals.

I continue to work closely and collaboratively with partner organisations, including my role as Chair of the Acute Federation Board and across the South Yorkshire and Nottingham and Nottinghamshire Integrated Care Systems.

Non-executive Director (NED) Champion Roles & Activity

In her capacity as the non-executive Freedom to Speak Up Champion, Hazel Brand attended the Freedom to Speak Up (FTSU) forum in November. The Thirlwall Inquiry was discussed, set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby. In the terms of reference, the effectiveness of NHS management and governance structures and processes, and consideration of NHS culture, are included. In a list of supplementary questions, the role of FTSU is mentioned: "Were existing processes and procedures for raising concerns used, including whistleblowing and freedom to speak up guardians? Were they adequate?" This is an aspect that the Thirlwall Inquiry will examine.

The Health Services Safety Investigations Body (HSSIB) will be investigating the risk of fatigue in healthcare and its impact on patient safety. In other safety-critical industries, fatigue is monitored and routinely considered as a potential contributory factor in safety incidents. In healthcare, there is limited evidence that staff fatigue is considered as part of patient safety incident investigations.

At the quarterly FTSU 'catch-up' with the Chief People Officer and FTSU Guardians, Paula Hill and Jon Ginever, the issue of detriment was discussed; one of the biggest barriers to speaking up is a fear of reprisals. Regional FTSU networks have developed a best practice guide to help FTSU Guardians respond consistently when colleagues verbalise these experiences.

Non-executive Wellbeing Champion, Lucy Nickson is currently engaging with a national forum for executive and non-executive Health and Wellbeing Champions/Guardians. As part of this engagement, Lucy's initial assessment is that the Trust's thinking and health and wellbeing offer are well advanced compared to its peers.

2501 - A4 CHIEF EXECUTIVE'S REPORT

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

10 minutes

REFERENCES

Only PDFs are attached

A4 - Chief Executive's Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2024	**Agenda Reference:**	**A4**
Report Title:	**Chief Executive's Report**		
Sponsor:	Richard Parker OBE, Chief Executive		
Author:	Emma Shaheen, Director of Communications & Engagement		
Appendices:			

Report Summary				
Purpose of the report & Executive Summary The report provides an overview of areas of interest and focus at a local, system and national level connected to the work of the Trust and aligned to its four strategic priorities.				
Recommendation:	The Board is asked to note the report.			
Action Required:	~~Approval~~	~~Review and discussion~~	~~Take assurance~~	**Information only**

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

Implications			
Relationship to Board assurance framework:	**x**	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	x	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
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		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term

	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**		
Legal/ Regulation:	N/A		
Resources:	N/A		
Assurance Route			
Previously considered by:	N/A		
Date:			
Any outcomes/next steps			
Previously circulated reports to supplement this paper:			

Chief Executive Board Paper

January 2025

This report present updates categorised under our four strategic priorities.

- Patients - We deliver 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*

Overnight and extended paediatric stays available at Bassetlaw

From November 2024 the Children's Assessment Unit (CAU) at Bassetlaw Hospital has been able to support children requiring extended and overnight stays.

This improvement, made possible through the successful recruitment of additional nursing colleagues, means that more young patients will now receive treatment closer to home, reducing the need for transfers to Doncaster Royal Infirmary (DRI).

Since 2017, the CAU has operated from 9am to 9pm, with the last admission at 7pm, and any patients needing care beyond these hours were transferred to the Children's ward at DRI. The reintroduction of overnight inpatient care has remained a high priority for DBTH, to secure the required number of specialist nursing staff to safely operate the service.

The move to open the CAU for longer will also free provision at DRI creating more capacity to care for children across the region – something which will be particularly helpful during the winter months.

DBTH earns Silver NJR Quality Data Award

Doncaster and Bassetlaw Teaching Hospitals has been recognised as a Silver National Joint Registry (NJR) Quality Data Provider for 2024, highlighting the organisation's commitment to patient safety and data excellence.

The NJR Quality Data Provider scheme publicly acknowledges hospitals that achieve exceptional standards in supporting patient safety through compliance with the mandatory NJR data submission quality audit process.

By meeting these stringent requirements, Doncaster and Bassetlaw Teaching Hospitals has demonstrated its dedication to maintaining the highest standards of care.

To achieve this accolade, hospitals must meet best practice targets, promote engagement and awareness of quality data collection, and embed the ethos that thorough and accurate data is integral to improving patient outcomes.

Quality data collection plays a vital role in enhancing patient safety, driving continuous improvement, and fostering innovation by enabling healthcare providers to make evidence-based decisions and identify areas for

advancement. This recognition underscores Doncaster and Bassetlaw Teaching Hospitals' consistent efforts in these areas.

Audiology update
In the last Board meeting we updated on the current challenges faced by our audiology services, and a further update is included in today's agenda.

The update highlights that during the paediatric audiology review of historical cases a small number have been identified with low or moderate harm caused. On behalf of the Trust, I am sorry to those affected children and their families. We are ensuring these children get the treatment and support they need.

People - *We are supportive, positive and welcoming*

Celebrating Long Service and our volunteers
As highlighted in the Chair's report, the Long Service Awards took place in December. More than 70 colleagues attended a celebratory afternoon tea, to honour some of our long-serving colleagues, recognising outstanding contributions to healthcare and the NHS.

We also celebrated our volunteer colleagues at our Christmas luncheon. Over 120 volunteers support our three hospital sites and we are extremely grateful for all the support they provide to the Trust.

Recognising talent
We were proud to be nominated as part of the Doncaster Business Awards in the Apprentice of the Year category, with Luke Staton representing DBTH. While he didn't win this time, the nomination serves as a testament to the remarkable talent and potential we have here at DBTH.

Excellence in Midwifery
Lucy Williams, one of DBTH's newest midwives, is already making waves with her innovative research on yoga as a potential intervention for gestational diabetes mellitus (GDM). Her critical review, which showcased promising results, was presented at an international conference in Germany, supported by the Trust. Lucy's work has earned her academic recognition and reflects DBTH's commitment to fostering talent and embedding research into practice.

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

DBTH honoured with University Campus Doncaster Community Award
DBTH has been awarded the first, inaugural University Campus Doncaster Community Award at Doncaster College's annual graduation ceremony.

This special accolade recognises the Trust's outstanding contributions to education, community service, and healthcare across South Yorkshire and North Nottinghamshire.

In presenting the award, John Rees, Principal and Chief Executive Officer of DN Colleges Group, praised DBTH's exceptional impact on the local community: "Doncaster and Bassetlaw Teaching Hospitals were the clear choice, alongside Club Doncaster Sports College, to be the recipients of our first-ever Community Award.

“Their contributions to education, community service, and healthcare provision make them a vital part of our region. Their unwavering commitment to supporting our students, alongside their dedication to advancing healthcare and training opportunities, exemplifies the spirit of community engagement that this award was created to celebrate.”

DBTH Charity launch new lottery

In December 2024 Doncaster and Bassetlaw Teaching Hospitals launched their new lottery. Every penny raised through the lottery will be reinvested into improving care and services at our hospitals, ensuring that your participation directly benefits the community.

The first draw will take place in February and membership costs £5 per month.

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

Investing in pioneering therapy technology

A £700,000 investment in advanced technology will enhance stroke rehabilitation services at Montagu Hospital. Funded by the DBTH Charity, supported by the Fred and Ann Green Legacy, cutting-edge equipment will be introduced to improve rehabilitation for patients at the Mexborough site’s Rehabilitation Centre and those receiving care at home.

This latest investment, combined with additional staffing, will significantly enhance the hospital’s stroke and rehabilitation services, increasing capacity and improving care.

The Tyromotion Robotic Rehabilitation Suite, the first of its kind in the NHS, will be introduced, offering tools to aid mobility, limb functionality, and cognitive recovery.

2501 - B STRATEGY, PLANNING & PARTNERSHIPS

2501 - B1 TRUST STRATEGY UPDATE REPORT

Decision Item | Zara Jones, Deputy Chief Executive | 10:00

10 minutes

REFERENCES

Only PDFs are attached

B1 - Trust Strategy update Board.pdf

Report Cover Page			
Meeting Title:	**Board of Directors - Public**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**B1**
Report Title:	**Trust Strategy update report**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance		
Appendices:	Appendix 1 : Summary of the Strategy Development		

Report Summary

Purpose of the report

This is a progress paper for the Board of Directors which updates on the actions taken following the Board Development Session on 5 December 2024, when the strategic priorities and approach was discussed.

Background

The Board has agreed on the 4P's framework, Patients, People, Pounds, and Partnerships. We have used these to frame the discussions with our key stakeholders including governors, partners, and colleagues, on what should be the Trusts priorities over the next 1-3 years.

As well as the detail on what was important for them, the feedback included the aspiration that the strategy should be a dynamic document, able to resiliently flex and adapt to a changing external environment. A live strategy that is relevant to everyone working in our Trust so they can clearly see the contribution they make to the achievement of the Trust's strategic ambitions.

Priorities overview

The Board of Directors discussed the proposed priorities and agreed in principle that these should be built around:

- Health inequalities, to include how decisions are made through the lens of health inequalities and how we capture this information about our patients and population, supporting services to intervene earlier and moving to a preventative approach to healthcare. This aligns to the national priority.
- Becoming a digitally mature organisation, including the implementation of an electronic patient record system, and all of the additional workstreams that will be required in order to maximise the benefit of digital for patients and our people. This aligns to the national priority.
- Having a fit for the future Estate, including the ability to deliver healthcare where it most needed, which is not always within the hospital setting, but in community locations away from the hospital site. This aligns to the national priority.
- Developing our education and research offer, aligned to progressing with our ambition to become a university teaching hospital, which supports the wider people plan of attracting and retaining the best people and embedding a learning culture within the Trust.

Next steps

These principle priorities will be further refined, discussed, and finalised within the board development session in February 2025. It will then be presented to the March 2025 Board of Directors for formal approval. The details of oversight, management and reporting will be agreed through the board committee structures and mapped across to the Board Assurance Framework where applicable. Although this work commenced before the general election, the DBTH proposed priorities align to the national direction of travel for the NHS (The Darzi report).

Conclusion The Trust has engaged with colleagues and partners in the development of the Trust's strategy and priorities over the last 6-9 months. There has been recognition throughout this process that the Trust is not able to deliver everything and an approach on focussing on fewer aligned priorities has been the collective preference. There is ongoing work to articulate these priorities into the 25/26 planning process and to map the progress monitoring of these through committees and board.				
Recommendation:	The Board is asked to take significant assurance on the progress of the agreed actions following the BDS in December 2024.			
Action Required:	~~Decision~~	~~Review and discussion~~	**Take assurance**	~~Information only~~
Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS** ***We deliver safe, exceptional, person-centred care.***	**PEOPLE** ***We are supportive, positive, and welcoming.***	**PARTNERSHIP** ***We work together to enhance our services with clear goals for our communities.***	**POUNDS** ***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications			
Relationship to Board assurance framework:	x	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	x	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
	x	BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
	x	BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
	x	BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES**		
Legal/ Regulation:	The Boards strategic ambitions should inform the strategic priorities, and align to the decision making framework for the Trust.		
Resources:			
Assurance Route			

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

Trust Strategy development – recap and key activities

- Commitment to developing a refreshed strategy for the Trust
- Refresh of vision (Healthier Together) and underpinning priorities (4 Ps)
- Assurance process for 4 P delivery agreed for Board-level reporting
- February and June Board development sessions
- Governors briefing and engagement session
- Framework agreed – flexible and live, linking strategic direction to enabling plans internally and stakeholder strategies
- Trust Leadership Team refined the strategy areas of focus in October and approved them in November for sharing with the Board in December.

Wider Engagement

- Summer 2024 – stakeholder and colleague surveys
- 400 individual responses and 7 organisational / partner submissions
- Details of responses in accompanying paper. The outputs will support both the strategy development and focus of our annual operational plans
- We are seeking to engage in the Government's ten year plan consultation and will use outputs from this exercise to further refine our strategy development
- The benefit of developing more of a flexible strategy framework is that we can keep building in feedback to test and challenge our thinking and direction as a Board and wider organisation.

Next steps?

- Board Development in February 2025 - finalising the key priorities
- Aligning the DBTH planning process to the priority areas
- Defining the monitoring and reporting framework to support delivery
- Articulating the key risks and controls that will support managing delivery

2501 - C ASSURANCE & GOVERNANCE

2501 - C1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Executive Directors | 10:10

20 minutes

REFERENCES

Only PDFs are attached

- C1 - Integrated Perfomance Report.pdf
- C1 - Integrated Performance Report Presentation.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	07 January 2025	**Agenda Reference:**	**C1**
Report Title:	**Board Integrated Performance report November 2024**		
Sponsor:	Zara Jones, Deputy Chief Executive		
Author:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr N Mallaband, Acting Executive Medical Director Jon Sargeant, Chief Financial Officer Denise Smith, Chief Operating Officer		
Appendices:			

Report Summary

Purpose of the report & Executive Summary

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

84 metrics have been identified based on their significance to be presented within the IQPR report to the Trust board. Of these 11 require further development to report (summarised on slide 47). Of the 73 metrics reported 5 are pending national / local thresholds or have no applicable target and data was not provided by cut off for 3 metrics. For the remaining 65 metrics included in this document against an applicable standard 18 are currently meeting or exceeding the standard and 47 are not, this is broken down as follows:

Access – 25 metrics. 6 being met, 18 not meeting target (1 no applicable target)

Quality – 31 metrics, 8 being met, 16 not meeting target, (3 data missed cut off, 4 awaiting target confirmation)

People – 7 metrics monitored monthly, 1 being met, 6 not meeting target. One annual target not met

Finance – 10 metrics, 3 being met, 7 not meeting target

The Trust has continued to have challenges in meeting expected standards for urgent and emergency care in November. Improvement work undertaken to date has however had a positive impact in 24/25 with a statistically significant increase in 4 hours performance. This change, although positive, is not sufficient to meet expected target levels so further interventions will be required. Ambulance handovers completed within 15 minutes has seen a statistically significant deterioration since April so will also require further support. Overall UEC demand is driving significant financial pressures and over-spends on pay in the organisation due to the opening of escalation beds.

The Trust continues to deliver significantly less activity than planned in 2024/25. This is creating a significant income risk on Elective recovery funding and is also a contributory factor in the number of long waiters not reducing in line with expectations. The run rate of activity has also not been increasing as

anticipated in line with elective recovery planning and long waiters are trending upwards specifically in the 78 week + cohort.

Both urgent and emergency care and elective recovery are also impacted by sickness and vacancy rates being higher than planned for. There has however been statistically significant improvements in vacancy rates, turnover, and time to recruit but these remain below target levels. Electronic job planning has shown a significant improvement over the last 2 years but this has stalled in the last 12 months. Work has recommenced following transition to L2P but significant additional work is required to hit the expected standard.

The Trust has positive trends in performance for reducing MRSA infections and increasing the proportion of >18 deaths scrutinised by the medical examiner. There are however several metrics which without further intervention will not consistently achieve target levels. HSMR continues to be significantly higher than target with action plans in place to improve clinical coding/depth of coding and Structured Judgement Reviews (SJRs) to improve the learning from deaths process. The Sepsis Action Group are also reviewing all incidences of sepsis and SJRs are being undertaken where disease level mortality data highlights areas of concern.

Work is ongoing with executive directors to re-baseline several metrics to support more meaningful analysis of trends. A number have been enacted in this report with further metrics planned for the January report.

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

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

Implications			
Relationship to Board assurance framework:	**X**	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	X	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
	X	BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
		BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss

			opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	N/A		
Legal/ Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements		
Resources:	N/A		
Assurance Route			
Previously considered by:			Contents shared with Finance & Performance Committee, QEC and People committee
Date:			
Any outcomes/ next steps			
Previously circulated reports to supplement this paper:			

NHS 75

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Board Integrated Performance report

November 2024

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision is:

Healthier together – delivering exceptional care for all.

Our four strategic priorities are:

We care

Contents

Executive Summary

Overview	84 metrics have been identified based on their significance to be presented within the IQPR report to the Trust board. Of these 11 require further development to report (summarised on slide 47). Of the 73 metrics reported 5 are pending national / local thresholds or have no applicable target and data was not provided by cut off for 3 metrics. For the remaining 65 metrics included in this document against an applicable standard 18 are currently meeting or exceeding the standard and 47 are not, this is broken down as follows: Access – 25 metrics. 6 being met, 18 not meeting target (1 no applicable target) Quality – 31 metrics, 8 being met, 16 not meeting target, (3 data missed cut off, 4 awaiting target confirmation) People – 7 metrics monitored monthly, 1 being met, 6 not meeting target. One annual target not met Finance – 10 metrics, 3 being met, 7 not meeting target The Trust has continued to have challenges in meeting expected standards for urgent and emergency care in November. Improvement work undertaken to date has however had a positive impact in 24/25 with a statistically significant increase in 4 hours performance. This change, although positive, is not sufficient to meet expected target levels so further interventions will be required. Ambulance handovers completed within 15 minutes has seen a statistically significant deterioration since April so will also require further support. Overall UEC demand is driving significant financial pressures and over-spends on pay in the organisation due to the opening of escalation beds. The Trust continues to deliver significantly less activity than planned in 2024/25. This is creating a significant income risk on Elective recovery funding and is also a contributory factor in the number of long waiters not reducing in line with expectations. The run rate of activity has also not been increasing as anticipated in line with elective recovery planning and long waiters are trending upwards specifically in the 78 week + cohort. Both urgent and emergency care and elective recovery are also impacted by sickness and vacancy rates being higher than planned for. There has however been statistically significant improvements in vacancy rates, turnover, and time to recruit but these remain below target levels. Electronic job planning has shown a significant improvement over the last 2 years but this has stalled in the last 12 months. Work has recommenced following transition to L2P but significant additional work is required to hit the expected standard. The Trust has positive trends in performance for reducing MRSA infections and increasing the proportion of >18 deaths scrutinised by the medical examiner. There are however several metrics which without further intervention will not consistently achieve target levels. HSMR continues to be significantly higher than target with action plans in place to improve clinical coding/depth of coding and Structured Judgement Reviews (SJRs) to improve the learning from deaths process. The Sepsis Action Group are also reviewing all incidences of sepsis and SJRs are being undertaken where disease level mortality data highlights areas of concern. Work is ongoing with executive directors to re-baseline several metrics to support more meaningful analysis of trends. A number have been enacted in this report with further metrics planned for the January report.

At a Glance

Assurance

Variation

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

Key Performance Indicators - Access

				Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
UEC	4 hour ED	78% by March 2025	Nov-24	75.1%	72.9%	-2.2%	75.7%	72.0%	-3.7%		
UEC	12 hours in department	No more than 2%	Nov-24	2.0%	3.9%	1.9%	2.0%	2.7%	0.7%		
UEC	Number of arrivals		Nov-24	16573	17516	943	137467	138496	1029	N/A	
UEC	Ambulance handovers - 15 minutes	65%	Nov-24	65%	41.8%	-23.2%	65%	37.0%	-28.0%		
UEC	Ambulance handovers - 30 minutes	95%	Nov-24	95%	74.0%	-21.0%	95%	70.2%	-24.8%		
UEC	Ambulance handovers - 60 minutes	0%	Nov-24	0%	9.5%	9.5%	0%	10.9%	10.9%		
UEC	Average ambulance handover times - YAS		Nov-24	23	00:29:22	00:06:22	18	0:30:22	00:12:22		
Diagnostics	Diagnostic waiting times	DM01 99%/ Operational guidance 95%	Nov-24	87.2%	75.0%	-12.1%	87.2%	75.0%	-12.1%		
Diagnostics	Diagnostic activity against plan (including NOUS & CT IR)		Nov-24	18821	18987	166	150878	151011	133	N/A	
Elective Care	% patients waiting less than 18 weeks from referral to treatment	92%	Nov-24	92.0%	58.6%	-33.4%	92.0%	58.6%	-33.4%		
Elective Care	65 weeks	0 by September 2024	Nov-24	0	201	201	0	201	201		
Elective Care	78 weeks	0	Nov-24	0	41	41	0	41	41		
Cancer	Faster Diagnosis Standard	77% by March 2025	Oct-24	82.4%	83.1%	0.7%	80.1%	82.0%	1.9%		
Cancer	31 day combined	96%	Oct-24	96.0%	92.1%	-3.9%	96.0%	93.2%	-2.8%		
Cancer	62 day combined	70% by March 2025	Oct-24	74.8%	81.3%	6.5%	73.6%	73.5%	-0.1%		

				Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Activity against plan	Day Case Activity against Plan		Nov-24	4498	3872	-626	35441	31592	-3849	N/A	
Activity against plan	Inpatient Elective Activity against Plan		Nov-24	651	621	-30	5308	5029	-279	N/A	
Activity against plan	Outpatient New Activity against plan		Nov-24	14492	14432	-60	118436	117209	-1227	N/A	
Activity against plan	Outpatient Follow Up Activity against plan		Nov-24	30215	29786	-429	249127	235541	-13586	N/A	
Stroke	Proportion directly admitted to a stroke unit within 4 hours of clock start	75%	Sep-24	75.0%	58.6%	-16.4%	75.0%	58.6%	-16.4%		
Stroke	Proportion of patients scanned within 1 hour of clock start	48%	Sep-24	48.0%	56.9%	8.9%	48.0%	56.9%	8.9%		
Stroke	Percentage of eligible patients given thrombolysis	90%	Sep-24	90.0%	100.0%	10.0%	90.0%	100.0%	10.0%		
Stroke	Percentage treated by a stroke skilled Early Supported Discharge Team	>24%	Sep-24	24.0%	56.9%	32.9%	24.0%	56.9%	32.9%		
Stroke	Percentage discharged given a named person to contact after discharge	80%	Sep-24	80.0%	46.6%	-33.4%	80.0%	46.6%	-33.4%		
Elective Care	Cancelled Operations Not Rebooked within 28 Days	0	Nov-24	0	5	5	0	33	33		

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	£2.4m year-end deficit (Revised)	Nov-24	1,042	1,568	526	A	1,043	2,278	1,235	A
ERF position		Nov-24	9,709	9,020	-689	A	78,798	72,983	-5,815	A
CIP delivery -vs Plan	£21.2m year-end CIP target	Nov-24	2,193	1,398	-795	A	10,747	8,850	-1,897	A
Substantive pay spend against plan		Nov-24	31,491	29,942	-1,550	F	239,510	225,572	-13,938	F
Additional sessions pay spend against plan		Nov-24	780	1,334	554	A	6,295	10,120	3,824	A
Bank pay spend against plan		Nov-24	15	1,303	1,288	A	134	11,289	11,155	A
Agency pay spend against plan		Nov-24	858	910	52	A	5,266	8,739	3,473	A
Capital position YTD versus plan	£48.8m year-end plan	Nov-24	2,586	1,422	-1,164	F	12,266	11,967	-299	F
Cash balance		Nov-24	14,955	41,031	26,076	F	14,955	41,031	26,076	F
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	Nov-24	95.0%	67.9%	-27.1%	A	95.0%	85.5%	-9.5%	A

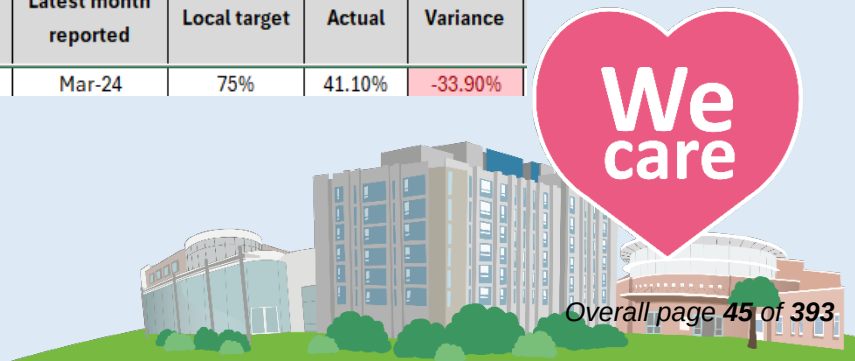
Key Performance Indicators - People

Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Consultants with Signed Off Job Plans in EJP	90%	Nov-24	90.0%	66.0%	-24.0%	90.0%	66.6%	-23.4%		
Employee Turnover	10%	Nov-24	10.0%	10.8%	0.8%	10.0%	10.8%	0.8%		
Overall Sickness Absence	5%	Nov-24	5.0%	5.9%	0.9%	5.0%	5.9%	0.9%		
Overall Vacancies		Nov-24	5.0%	5.6%	0.6%	5.0%	5.0%	0.0%		
Time to hire (from TRAC authorisation - unconditional offer) A4C posts only	47 days	Nov-24	47	48.1	1.1	47	48.1	1.1		
Completed SET Training	90%	Nov-24	90.0%	88.9%	-1.1%	90.0%	88.8%	-1.2%		
Completed Appraisals	90% end July	Nov-24	90.0%	93.3%	3.3%	90.0%	93.3%	3.3%		

Annual metrics

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

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



Key Performance Indicators - Quality

				Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Mortality	Hospital Services Mortality Rate (HSMR): (rolling 12 Months - Combined)	<100	Sep-24	100	109.1	9.13	100	109.1	9.13	F	
Mortality	Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months)	<100	Sep-24	100	123.6	23.59	100	123.6	23.59	F	H
Mortality	Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months)	<100	Sep-24	100	109.0	8.97	100	109.0	8.97	F	
IPC	Hospital Acquired MRSA (Colonisation) Cases Reported in Month		Nov-24	1.2	2	0.8	9.3	10	0.7	?	
IPC	Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0	Nov-24	0	0	0	0	0	0	?	L
IPC	Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month		Nov-24	3.5	10	6.5	28	47	19	?	
IPC	Number of Community Onset Healthcare associated (COHA) C.Diff cases in month		Nov-24							?	
IPC	Overall Number of HAPUs / 1000 bed days		Nov-24	0	2	2	0	2	2	N/A	
IPC	Hospital Acquired Pressure Ulcers (HAPU) Cat 4		Nov-24	0	0	0	0	1	1	?	
Falls	Severe harm falls	0	Nov-24	0	0	0	0	6	6		
Complaints	Number of Complaints Received in Month		Nov-24		53	53		427	427		
Complaints	Number of Complaints Not Signed Off in Agreed Timeframe		Nov-24	0	0	0	0	68	68		
Claims	Claims CNST (patients) - new in month		Nov-24		6	6		69	69	?	
Claims	Claims LTPS - (staff) new in month		Nov-24		2	2		12	12	?	

				Current month			Year to date				
Section	Metric	Standard/ threshold 24/25	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
FFT	Friends & Family Response Rates - Trust		Nov-24	95%	86.0%	-9.0%	95%	90.7%	-4.3%		
FFT	Friends & Family Response Rates - ED		Nov-24	95%	67.0%	-28.0%	95%	70.5%	-24.5%		
FFT	Friends & Family Response Rates - Inpatient		Nov-24	95%	94.2%	-0.8%	95%	93.8%	-1.2%		
FFT	Friends & Family Response Rates - Outpatient		Nov-24	95%	87.7%	-7.3%	95%	91.4%	-3.6%		
FFT	Friends & Family Response Rates - Maternity		Nov-24	95%	82.8%	-12.2%	95%	94.2%	-0.8%		
Audit & Effectiveness	Mixed Sex Accommodation - nationally reported breaches in month	0	Nov-24	0	1	1	0	28	28		
Audit & Effectiveness	% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%	Nov-24	100.00%	100.00%	0.0%	100%	100.0%	0.0%		
Audit & Effectiveness	VTE - % of patients having a VTE Risk Assessment	95%	Nov-24	95.00%	93.48%	-1.5%	95%	95.5%	0.5%		
Nice Guidance	NICE Guidance Response Rate Compliance	90%	Nov-24	90.00%	96.42%	6.4%	90%	96.0%	6.0%		
Nice Guidance	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%	Nov-24	10.00%	10.70%	0.7%	10.00%	11.6%	1.6%		
CHPPD	Planned Vs Actual CHPPD RM	90%									
CHPPD	Planned Vs Actual CHPPD RN	90%									
CHPPD	Planned Vs Actual CHPPD Total	90%									
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%	Nov-24	90.00%	57.0%	-33.0%	90.00%	49.8%	-40.2%		
Sepsis	Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic reatment within 1 hour of diagnosis	90%	Nov-24	90.00%	74.3%	-15.7%	90.00%	54.4%	-35.6%		
Patient Safety	Never Events - Reported in month	0	Nov-24	0	0	0	0	5	5		
Patient Safety	PSIIs reported in month		Nov-24	0	1	1	0	11	11		
Patient Safety	Number of incidents over 48 hours in the holding area		Nov-24		11	11		11	11		

What is an SPC chart

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

Recalculations

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

Baselines

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

Summary icons

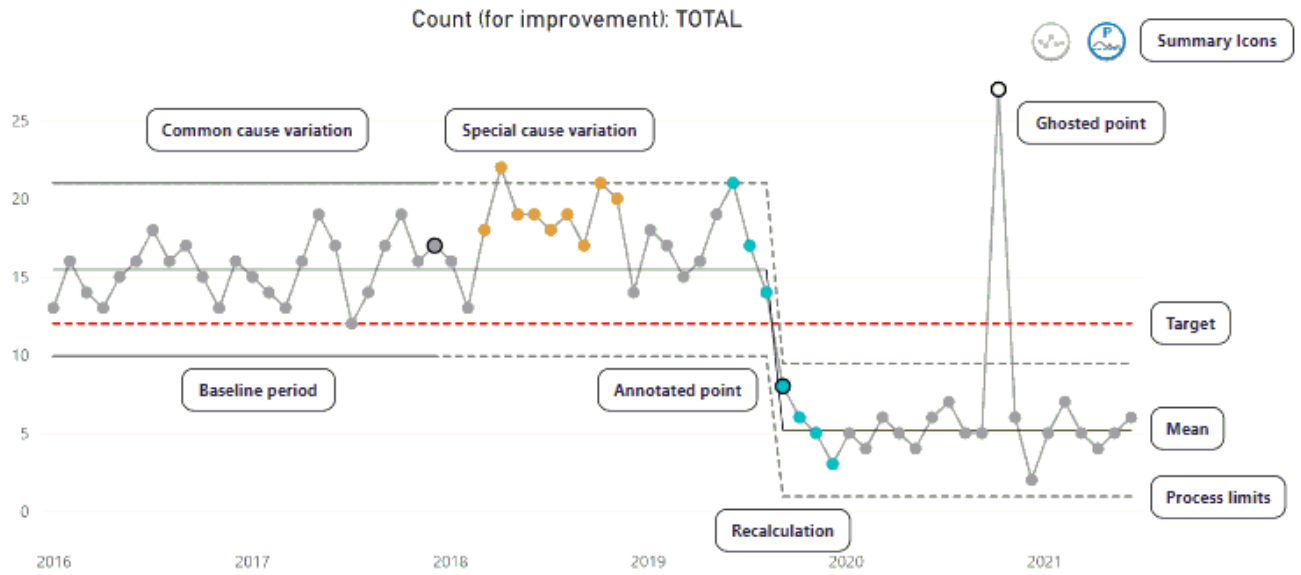
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

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

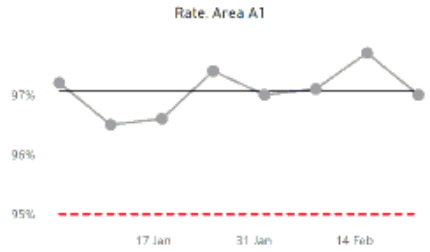
Annotations

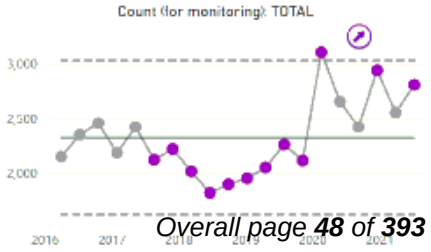
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



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

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





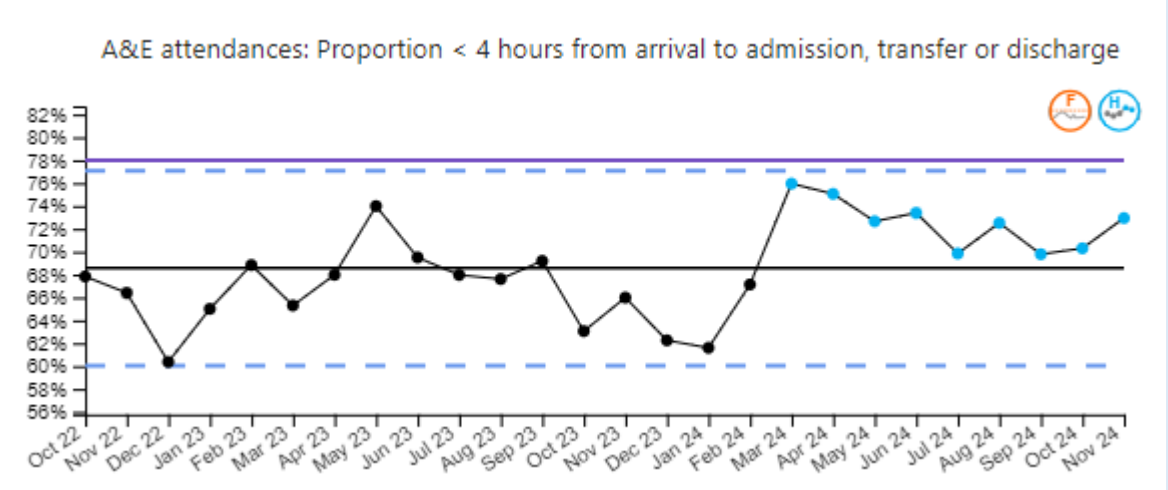
Icon descriptions

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

Assurance report

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

Summary of challenges & risks	Performance in November 2024 was 72.9%, against the trajectory of 75.1%. ED attendances for the month were 17516 which was above the plan of 16573. Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER.** This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	New medical rota to allow capacity to meet peak in demands over 24hr period. Touchpoint Meetings 3 x Per Day between FCMS, ED, YAS and MSDEC. Introduction of Integrated Care Coordination Centre - YAS Senior Clinical Advisor within the Ops Hub Productivity tool has been agreed within the Division and will be implemented from December 2024.
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

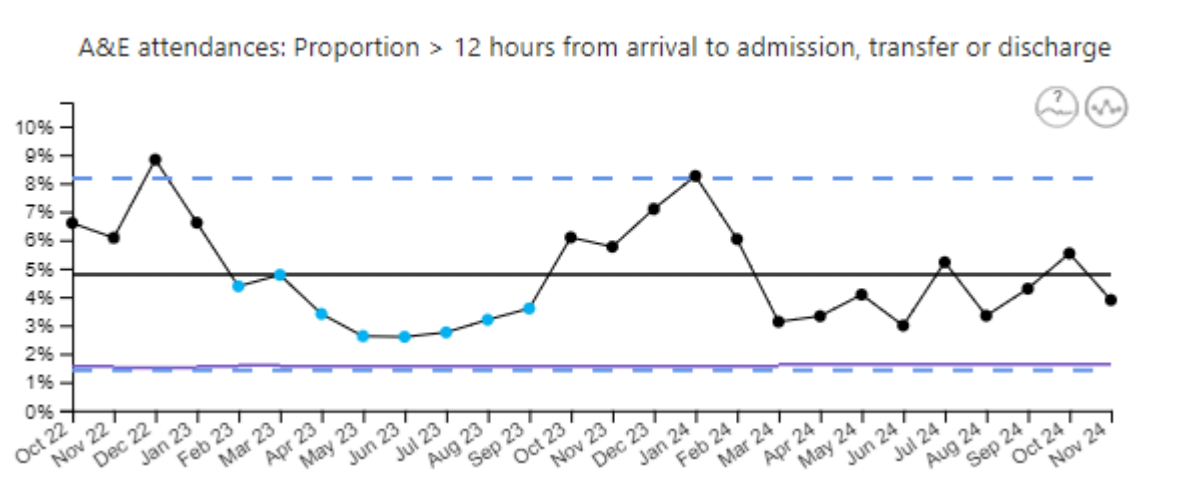


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	In November 2024, 3.9% of patients were in the Emergency Department > 12 hours from arrival, against the national standard of no more than 2% Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Review of the urgent and emergency care improvement plan to ensure appropriate actions in place, across the Trust, to improve access to emergency care prior to winter Surge actions in place to redistribute clinical team during peaks in demand
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

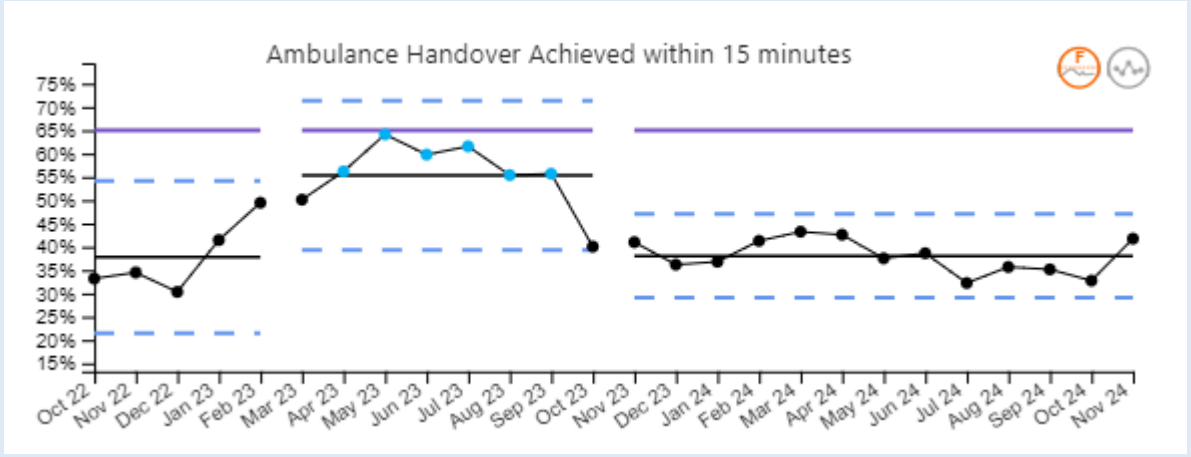


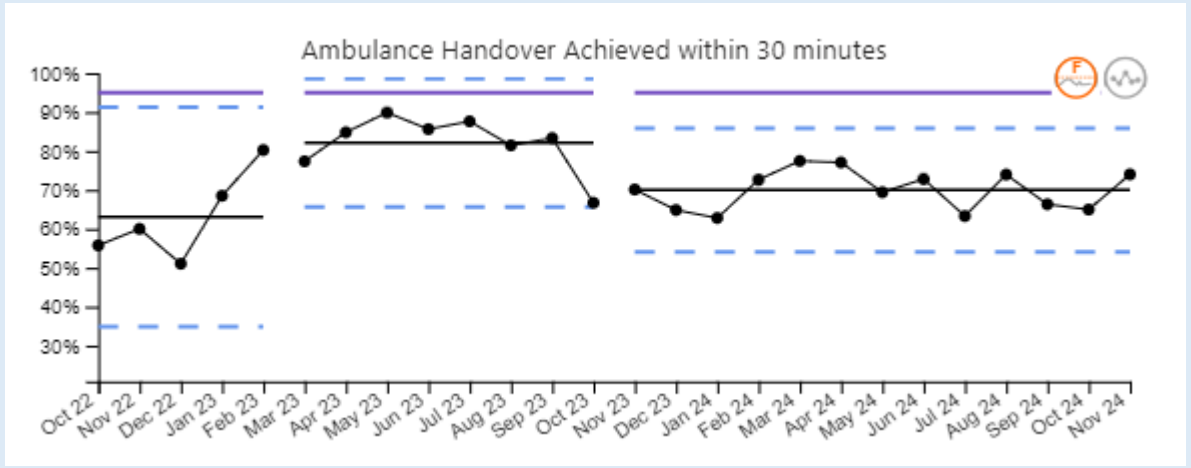
Source DBTH_IQPR_Dashboard_November_2024

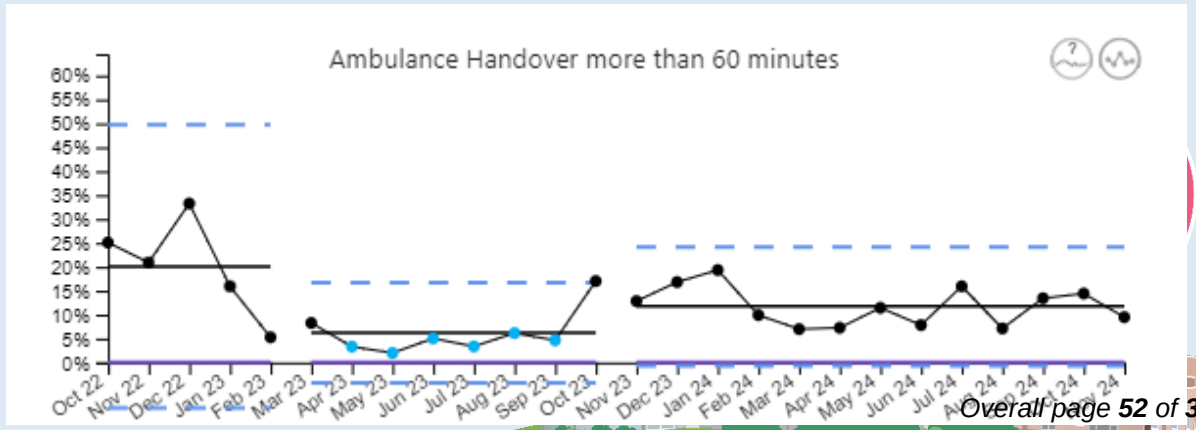
Assurance report

Ambulance Handover within 15/30/60 mins

Summary of challenges & risks	In November 2024, 41.8% of ambulance handovers took place within 15 minutes against the standard of 65%, 74.0% took place within 30 minutes against the standard of 95%, and 90.5% took place within 60 minutes against the standard of 100%. <u>Ambulance Handover 15 and 30 minutes</u> Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. <u>Ambulance Handover 60 minutes</u> Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits. Re-basing has taken place February 2023 as ESA was expanded and in October 2023 as the volume of ambulance arrivals increased
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. Utilisation of the escalation area at times of peak demand. Proactive capacity preparation to create capacity for forecast peaks in demand. Introduction of Integrated Care Coordination Centre - YAS Senior Clinical Advisor within the Ops Hub. Missed opportunity audit with DBTH, YAS and Place partners undertaken in December.
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care



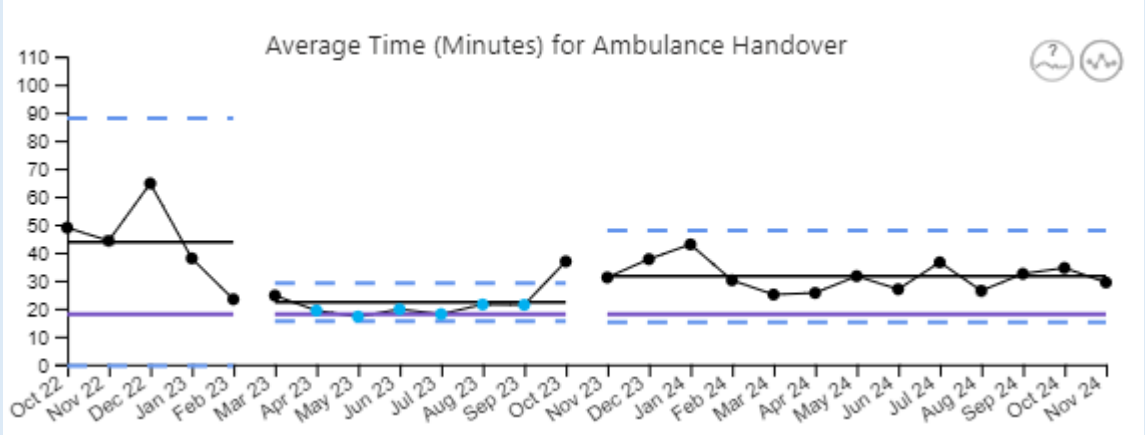




Assurance report

Average Ambulance Handover Times

Summary of challenges & risks	Average handover time for YAS in November 2024 was 29:22 compared to the trajectory of 23:00 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	Ambulance service focus on reducing the number of conveyances to DRI, maximising see and treat and utilising all available alternatives to conveyance. Utilisation of the escalation area at times of peak demand. Proactive capacity preparation to create capacity for forecast peaks in demand. Introduction of Integrated Care Coordination Centre - YAS Senior Clinical Advisor within the Ops Hub. Missed opportunity audit with DBTH, YAS and Place partners undertaken in December.
Action timescales and assurance group or committee	Improvement trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

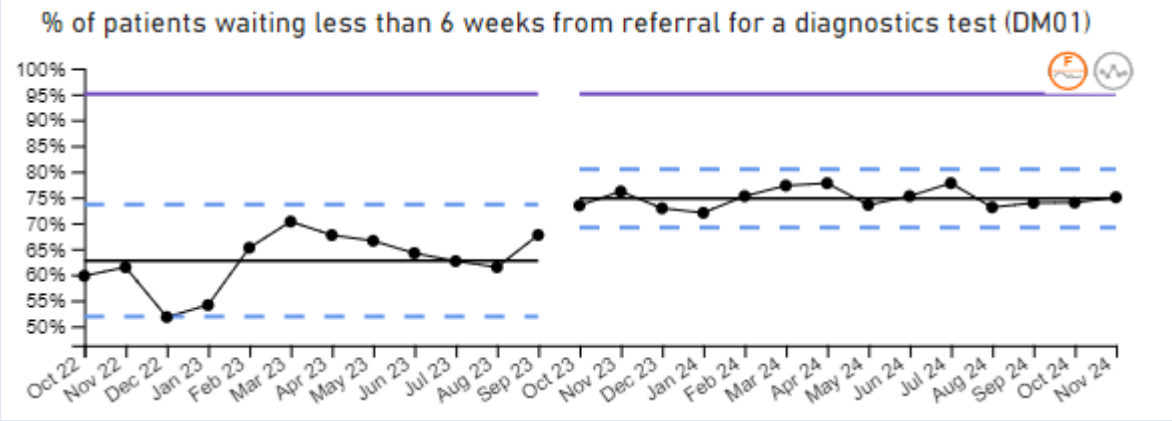


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	In November 2024, 75.0% of patients received their diagnostic test within 6 weeks of referral, against the national planning requirement of 95% by March 2025. A recently signed off change to the audiology calculation has been applied from September reporting. Re-basing took place September 2023 at which point there was additional MRI & CT activity carried out to reduce waits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Audiology and non obstetric ultrasound are the key drivers of the underperformance with the majority of patients waiting > 6 weeks in these two diagnostic tests. The Trust has outsourced a further 200 adult patients for Audiology hearing assessments and an Audiology recovery plan is in place. Additional capacity is being sourced for non obstetric ultrasound.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3434 Timely access to diagnostic services

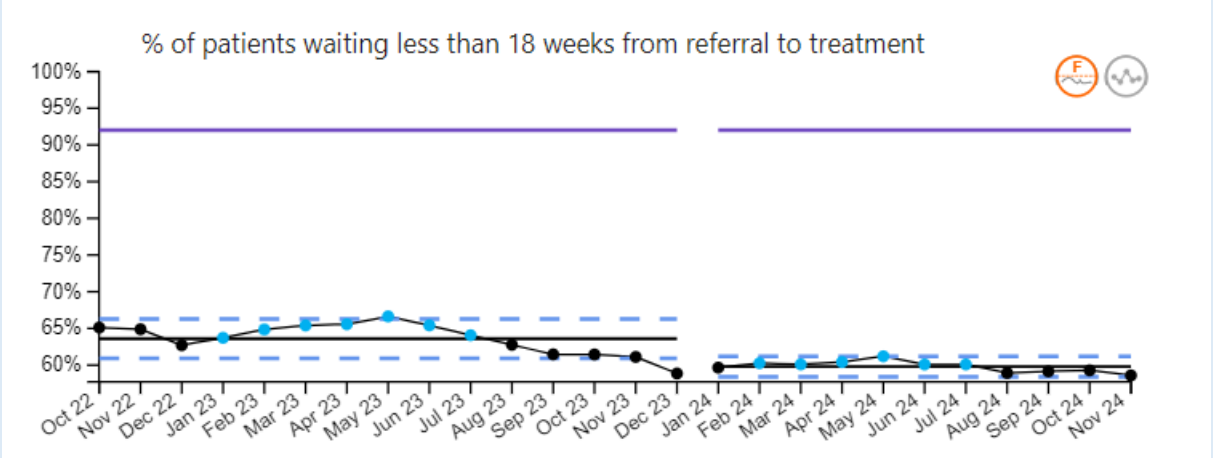


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	58.6% of the patients on the waiting list have been waiting for less than 18 weeks. 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.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ongoing work on increasing productivity within the outpatient and theatre improvement programmes will continue to ensure capacity to see waiting patients is used as effectively as possible. Senior operational oversight is in place with a focus on eliminating 65 / 78 week waits, except where patients choose to wait longer.
Action timescales and assurance group or committee	The standard is not forecast to deliver in 2024/25 and the national focus remains on virtually eliminating waits > 65 weeks. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care.

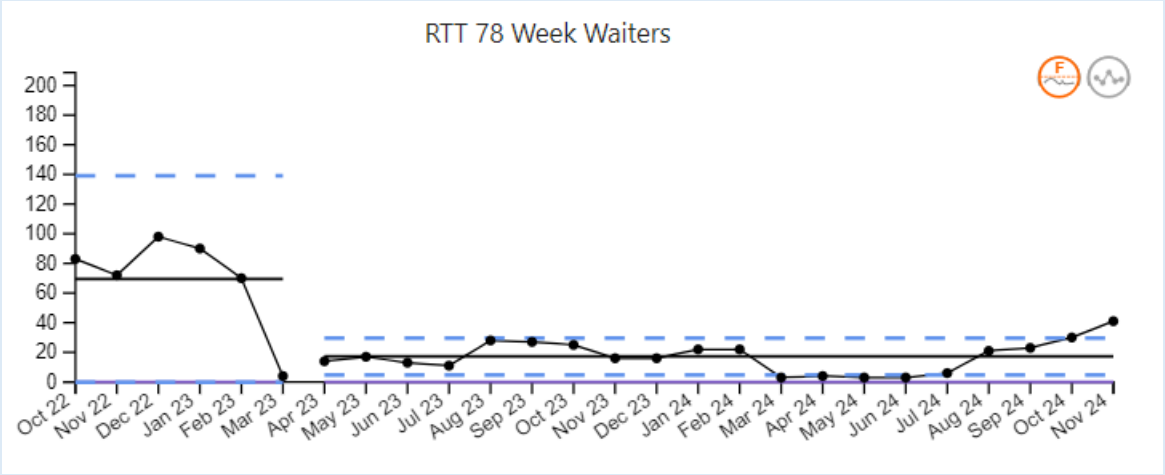


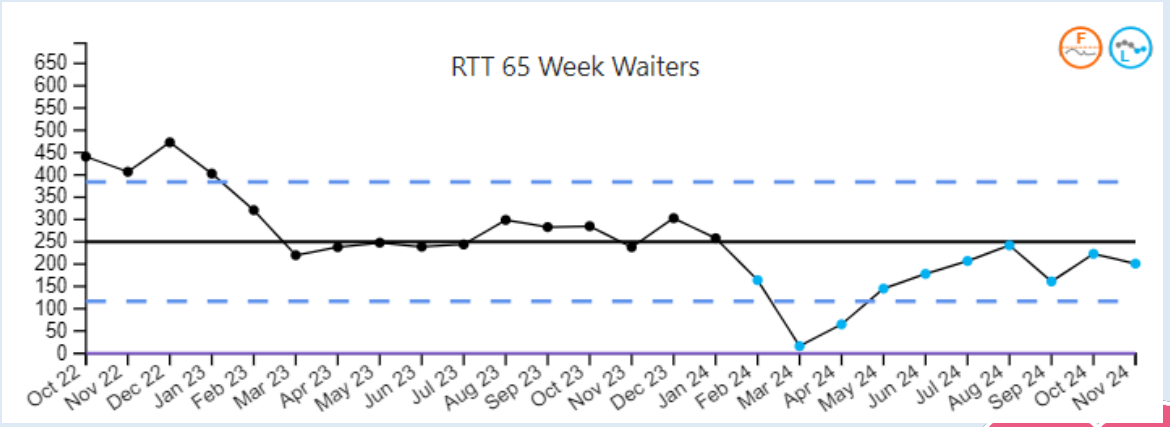
Source DBTH_IQPR_Dashboard_November_2024

Assurance report

RTT – 78+ / 65+ Week Waiters

Summary of challenges & risks	In November 2024, 41 patients were waiting > 78 weeks, against the trajectory of 0. In November 2024, there were 201 patients waiting > 65 weeks, against the trajectory of 0. <u>RTT 78 Weeks</u> 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 March 2023. <u>RTT 65 Weeks</u> Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER.** This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Senior operational oversight is in place with a focus on eliminating 65 / 78 week waits, except where patients choose to wait longer. The majority of patients waiting > 65 / 78 weeks are in ENT and T&O. **ENT** – maximising existing outpatient capacity, additional outpatient capacity, mutual aid request, Audiology recovery plan in place, Additional theatre time allocated to consultant with Septorhinoplasty waits **T&O** – maximising existing theatre capacity and additional theatre sessions
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



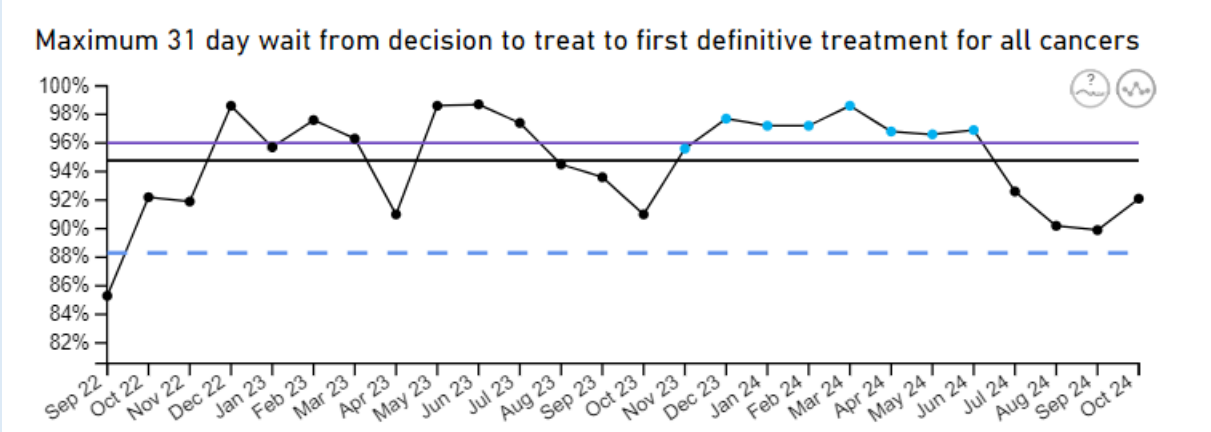


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	Performance in October 2024 was 92.1% against the national standard of 96%. 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 standard was achieved for all tumour sites except Head & Neck and Skin. One patient breached the standard in Head and Neck. 16 patients breached the standard in Skin. An increase in demand has been noted for suspected skin cancer referrals. External funding for additional minor operations capacity is in place to mitigate this.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	N/A

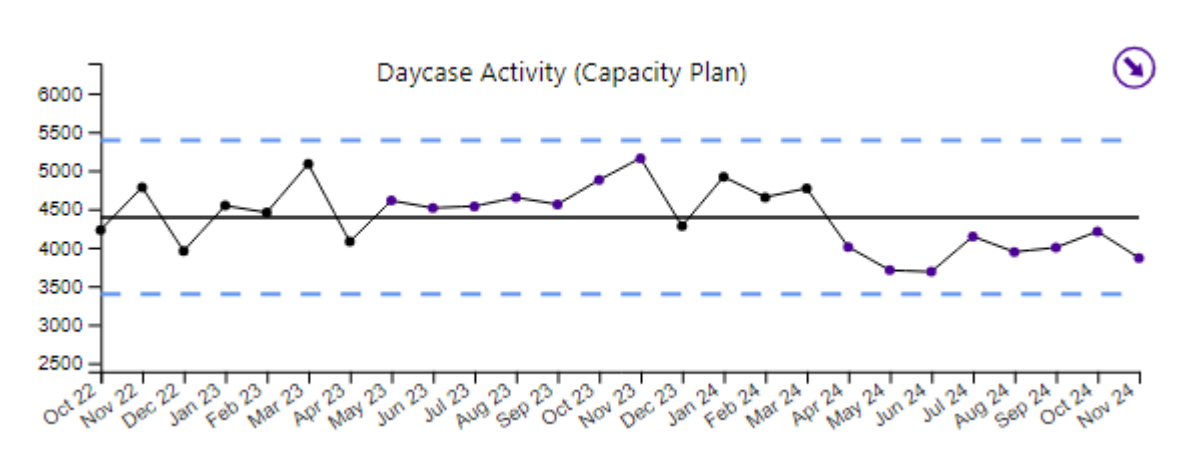


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Daycase Activity

Summary of challenges & risks	In November 2024, excluding MEOC, the Trust delivered 86.0% of the day case plan. YTD the Trust has delivered 89.1% of the day case plan. Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In November, Gastroenterology and General Surgery are the key drivers of the underperformance against day case plan. The Theatres improvement programme continues to focus on utilisation of all core capacity, reducing on the day cancellations and increasing utilisation to 85%.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

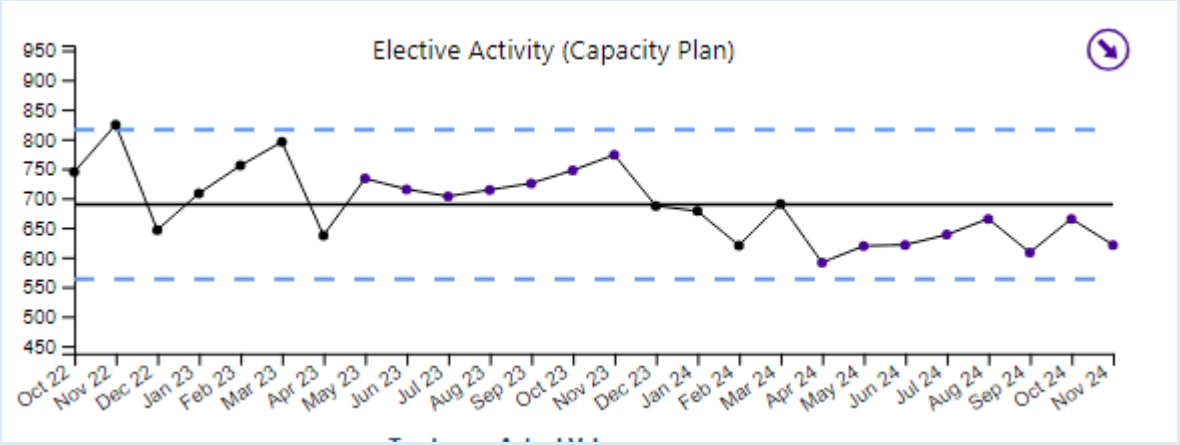


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Elective Activity

Summary of challenges & risks	In November 2024, excluding MEOC, the Trust delivered 95.0% of the elective plan. YTD the Trust has delivered 94.7% of the elective plan. Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In November, the Trust was 31 elective cases behind plan overall, with some specialties over performing. The key driver of the under performance is elective orthopaedics, which was 59 cases behind plan. The Theatres improvement programme continues to focus on utilisation of all core capacity, reducing on the day cancellations and increasing utilisation to 85%.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

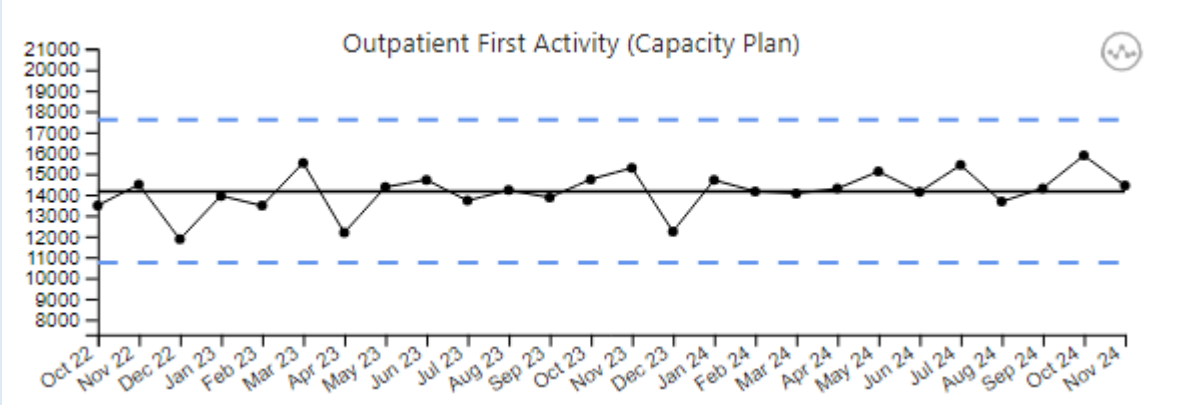


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Outpatient First Activity

Summary of challenges & risks	In November 2024, the Trust delivered 99.6% of plan for new outpatient appointments. Year to date the Trust has delivered 99.0% of the new outpatient plan. Common cause variation, **NO SIGNIFICANT CHANGE.** Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In November, the Trust was 60 appointments behind plan overall, with a number of specialties over performing. Ophthalmology remains one of the key challenges, with workforce gaps impacting on outpatient activity. Two Consultant vacancies have recently been recruited to. The outpatient improvement programme continues to focus on utilisation of all clinic sessions and reducing the DNA rates.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

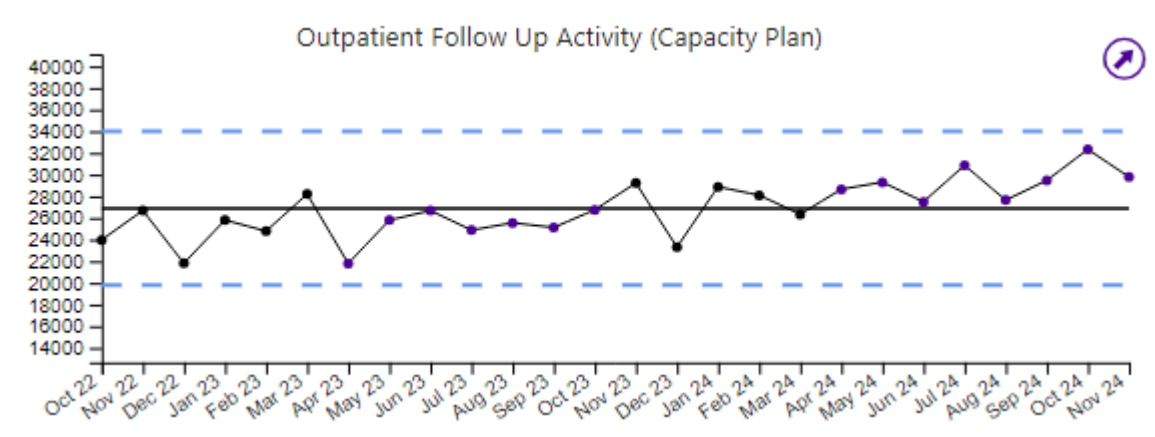


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Outpatient Follow Up Activity

Summary of challenges & risks	In November 2024, the Trust delivered 99.0% of plan for outpatient follow up appointments. Year to date the Trust has delivered 94.5% of the follow up outpatient plan Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	In November, the Trust was 429 appointments behind plan overall, with a number of specialties over performing. Ophthalmology remains one of the key challenges, with workforce gaps impacting on outpatient activity. Two Consultant vacancies have recently been recruited to. T&O is also behind plan, with clinical capacity being prioritised for day case, elective and outpatient first appointments. The outpatient improvement programme continues to focus on utilisation of all clinic sessions and reducing the DNA rates.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

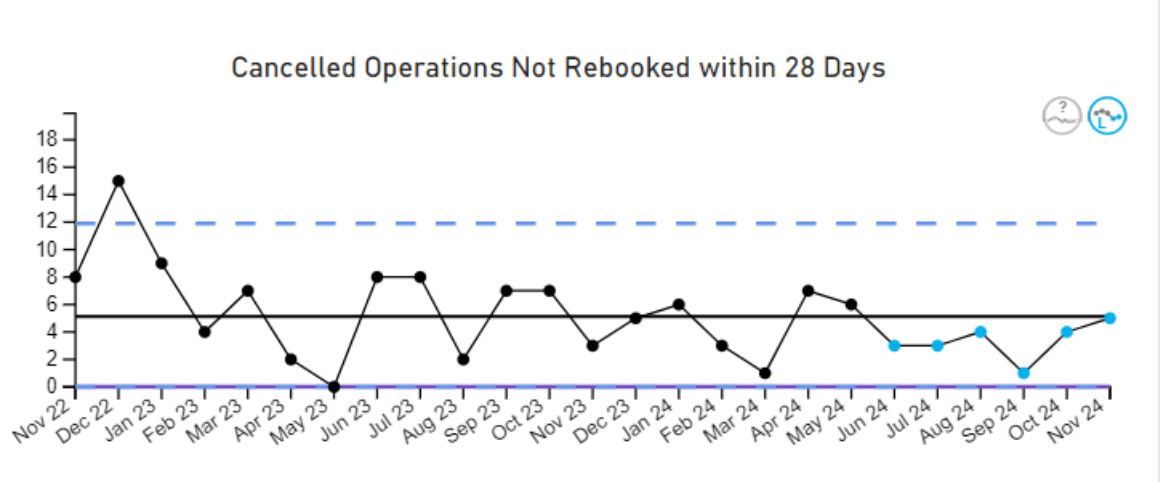


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Cancelled Operations Not Rebooked within 28 Days

Summary of challenges & risks	There were 5 breaches of the 28-day guarantee in November 2024 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	Continuation of revised oversight and escalation in place within the Division
Action timescales and assurance group or committee	The Trust trajectory remains zero breaches of the 28 day guarantee. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

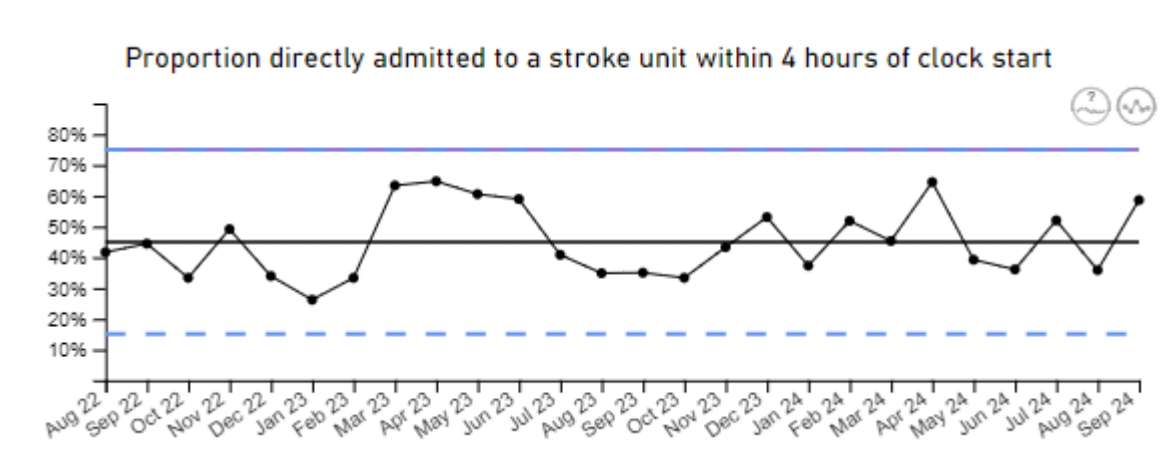


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	In September 2024, performance was 58.6% against the standard of 75%. 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	Collaborative working with Emergency Medicine to review the stroke triage process to minimise late diagnosis. Collaborative working with ambulance service providers ensure patients with suspected stroke are conveyed the appropriate site. Collaborative working with ambulance service providers to explore options for providing real time advice to ambulance service providers and direct admission to the stroke unit, where clinically appropriate. Capacity and demand analysis of Stroke pathway. Stroke consultant recruitment process underway.
Action timescales and assurance group or committee	Monthly reporting to the Divisional Performance Review meeting
Risk register	Risk 3495

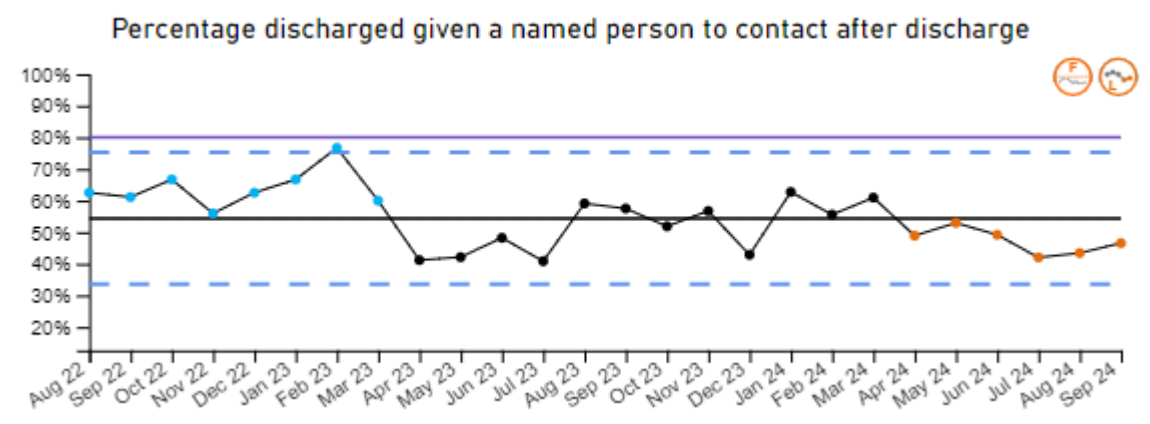


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	In September 2024, performance was 46.6% against the standard of 80%. Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	IT solution being developed to amend the clinical system to facilitate complete data entry, which will enable the information to be included on the discharge summary.
Action timescales and assurance group or committee	Monthly reporting to the Divisional Performance Review meeting
Risk register	Risk 3495



Source DBTH_IQPR_Dashboard_November_2024

Assurance report

YTD distance from financial plan I&E

Note: The Trust's agreed financial target for 2024/25 has been amended following the receipt of additional funding from the ICB. The annual plan is now a £2.4m deficit against the original £26.2m deficit.
The Trust's reported deficit in month 8 was £1.6m, £0.5m adverse to budget, £0.9m adverse to forecast and £1.4m adverse to month 7. The Trust's reported deficit YTD at month 8 was £2.3m, £1.2m adverse to budget and £2.0m adverse to forecast.
YTD variance to budget - £1.2m adverse
The Trust's reported deficit YTD at month 8 was £2.3m, £1.2m adverse to budget. The key drivers of this are below:

Income: £8.6m adverse to budget

- ERF income is £5.8m adverse to budget, mainly relating to T&O performance (£6.2m), which is offset with a favourable variance of £2.9m on independent sector expenditure
- MEOC income is £4.1m adverse to budget, with CDC being £0.6m adverse to budget. Both MEOC and CDC are in the process of scaling up activity and this is largely offset with reduced pay and non-pay expenditure
- Nottinghamshire ICB contract £0.5m adverse due to contract difference on convergence assumption
- South Yorkshire ICB contract £0.3m adverse due to phasing expected to recover by yearend
- Offset by favourable variances on Drugs & Devices income (£2.7m) and this is offset by increased expenditure in drugs and clinical supplies

Pay: £1.8m adverse to budget

- MEOC is £1.6m favourable to budget, offsetting the lower income
- CDC is £0.5m favourable to budget, offsetting the lower income
- CIP performance is £0.4m favourable to budget
- Offset be adverse variances mainly due to:
- Pay award funding adverse by £1.1m, discussions are ongoing at SWICB for further funding
- Continuing pressure on medics pay agency expenditure and additional sessions covering sickness and vacancies £3.2m

Non-pay: £8.7m favourable to budget

- MEOC is £2.0m favourable to budget, offsetting the lower income
- CDC is £1.3m favourable to budget, offsetting the lower income
- Independent sector expenditure is £2.9m favourable to budget
- £1.1m favourable variance on Utilities due to the renegotiation of the contract
- Clinical supplies favourable by £1.4m due to reduced activity
- £2.0m one-off benefits have been identified from accruals
- £1.1m review of accounting policies
- Offset by increased drug costs being £2.7m adverse to budget, offset by income
- Adverse CIP variance of £0.4m
- Financing Costs: £0.5m favourable to budget
- This relates to increased interest income due to higher than budgeted cash levels.

- MEOC and CDC - Overall impact on the position for CDC is £1.2m favourable. MEOC is £0.5m adverse due to the expected planned surplus not being achieved fully as activity is lower than planned.

YTD variance to forecast - £2.0m adverse
The Trust's reported deficit YTD at month 8 was £2.3m, which was £2.0m adverse to forecast. The key driver of this variance is lower income due to ERF performance.

Assurance report

YTD distance from financial plan I&E

Actions to address risks, issues and emerging concerns relating to performance and forecast	See actions on pay spend assurance and ERF position assurance. MEOC: MEOC Board focusing on improvements in filling the lists and improving productivity and case mix. Finance Challenge and Support Meetings are taking place with each Division led by the CFO with a number of actions taking place to reduce expenditure.
Action timescales and assurance group or committee	Ongoing
Risk register	16 - Failure to achieve compliance with Financial Performance and achieve Financial Plan.

1. Income and Expenditure vs. Budget

Performance Indicator	Annual budget	Monthly Performance				YTD Performance			
		Budget	Actual	Variance to budget		Budget	Actual	Variance to budget	
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	
Income	(620,716)	(55,051)	(52,553)	2,497	A	(420,634)	(412,010)	8,624	A
Pay	394,624	35,054	36,146	1,093	A	264,675	266,513	1,838	A
Non Pay	219,930	20,323	17,360	(2,963)	F	151,275	142,529	(8,746)	F
Financing Costs	8,590	716	615	(101)	F	5,727	5,246	(481)	F
(Profit)/Loss on Asset Disposals	0	0	0	0	F	0	0	0	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**2,428**	**1,042**	**1,568**	**526**	**A**	**1,043**	**2,278**	**1,235**	**A**

Income: Over-achieved F; Under-achieved A

Key

F = Favourable **A** = Adverse

Expenditure: Underspent F; Overspent A

Assurance report

ERF Position

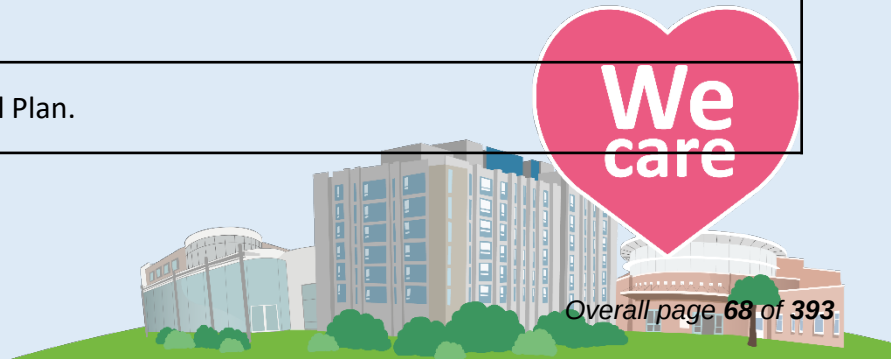
Summary of challenges & risks	ERF is £5.8m behind plan YTD at month 8. This is mainly driven by Orthopaedics which is £6.2m behind plan (£3.3m core activity and £2.9m Independent Sector)
Actions to address risks, issues and emerging concerns relating to performance and forecast	Recovery plan is pending for elective activity, particularly for Orthopaedics. This is with the Operational Teams and the Chief Operating Officer. Additional sessions are taking place to reduce backlog in ENT.
Action timescales and assurance group or committee	The Surgery Division is due to present the T&O recovery plan in early January 2025.
Risk register	16 - Failure to achieve compliance with Financial Performance and achieve Financial Plan.

ERF position by POD	M8 variance to ERF Target
Daycase	£2,027
Elective	£6,007
Outpatient First	-£211
Outpatient Procedures	-£802
A&G / costing adjustment	-£1,206
Total	**£5,815**

Assurance report

Pay spend against plan

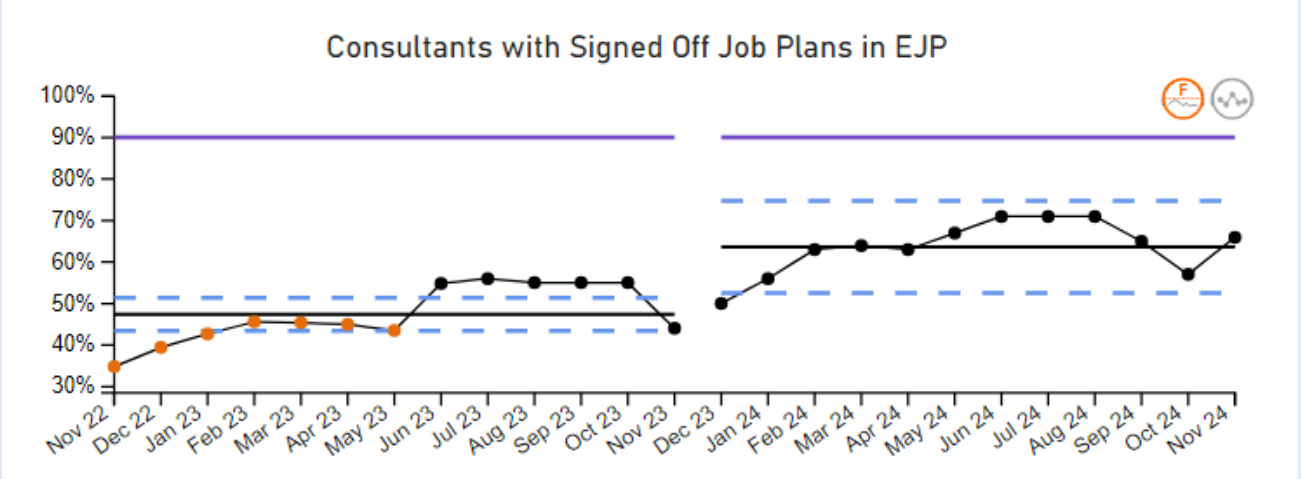
Summary of challenges & risks	The Trust's position on pay expenditure is £1.8m adverse to budget. This is driven by: • MEOC is £1.6m favourable to budget, offsetting the lower income • CDC is £0.5m favourable to budget, offsetting the lower income • CIP performance is £0.4m favourable to budget • Offset be adverse variances mainly due to: • Pay award funding adverse by £1.1m, discussions are ongoing at SWICB for further funding • Continuing pressure on medics pay agency expenditure and additional sessions covering sickness and vacancies £3.2m
Actions to address risks, issues and emerging concerns relating to performance and forecast	Medical and Dental staff: Medical Director review of rotas in the Division of Urgent and Emergency Care. Divisional Directors review of Medical and Dental spend at Finance Challenge and Support meetings. Medical Director input into agency spend CIP workstreams. Nursing and Midwifery staff: Patients have more complexity requiring enhanced care driving the bank spend. Divisional Nurse review of Nursing and Midwifery spend at Finance Challenge and Support meetings. Director of Nursing input into the agency spend CIP workstreams. Allied Health Professionals: workforce plan being led by the Director of Nursing, commenced in August.
Action timescales and assurance group or committee	Ongoing - being reviewed in CIP workstreams and Finance Challenge and Support meetings. Pay Award funding is being discussed at FCEDG meetings.
Risk register	16 - Failure to achieve compliance with Financial Performance and achieve Financial Plan.



Assurance report

Consultants with Signed Off Job Plans in EJP

Summary of challenges & risks	For November 2024 66% of Consultants had a signed off job plan Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAL BELOW** the target without process redesign. Re-basing has taken place November 2023 as job planning completion was linked to CEA programme
Actions to address risks, issues and emerging concerns relating to performance and forecast	Work continues to address data quality issues resulting from the transition to L2P job planning system. This can be seen in the data as the position is now steadily starting to recover. The National Medical Director for Secondary Care and Quality has set an ambitious target for all providers to job plan 95% of their senior medical workforce by the end of Q4 2024/25. The Executive Medical Director's office are working closely with Divisional clinical leads and L2P to drive achievement of this target.
Action timescales and assurance group or committee	95% of senior medical staff with a signed off job plan by the end of March 2025.
Risk register	Not on risk register as all senior medical staff are working to current job plans and process/plan in place to recover position.

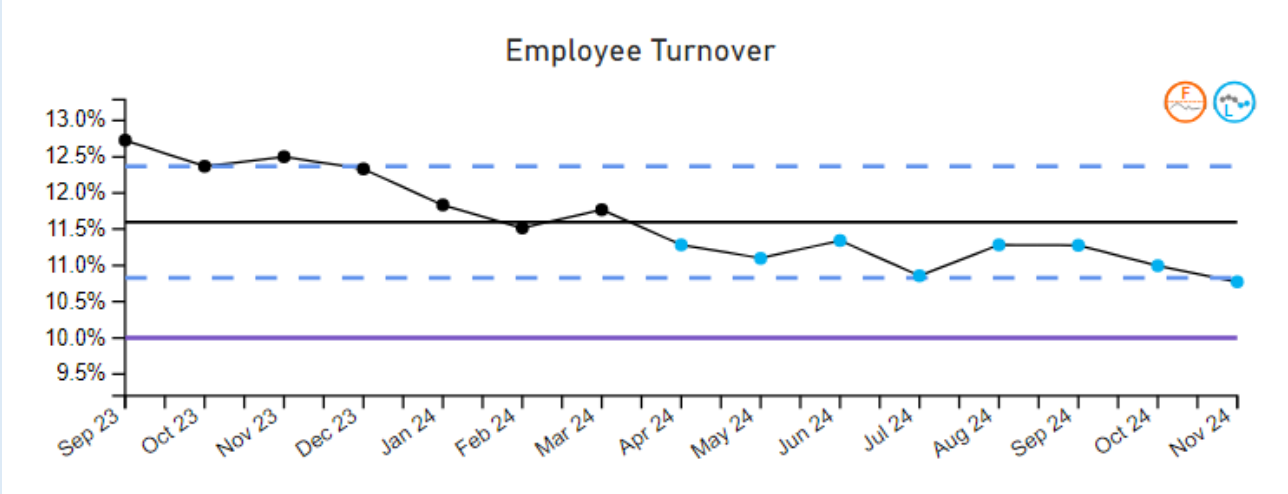


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Employee Turnover Rolling 12 months

Summary of challenges & risks	Employee turnover for November 2024 was 10.8% Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Work continues in relation to improving retention • Draft Leavers Policy in development • Quality improvement approach being undertaken in relation to learning from leavers to improve the response rates of exit interviews and feedback from those leaving the Trust to enable improved thematic analysis • Improved appraisal process complemented by Scope for Growth conversations and succession planning discussions – embedded in the appraisal process
Action timescales and assurance group or committee	Leavers policy due for approval in Feb 25 Monitor improvements in relation to learning from leavers Q4 Appraisal process to include connections with the Scope for Growth conversations and talent management through 2025 appraisal season window April – July
Risk register	N/A

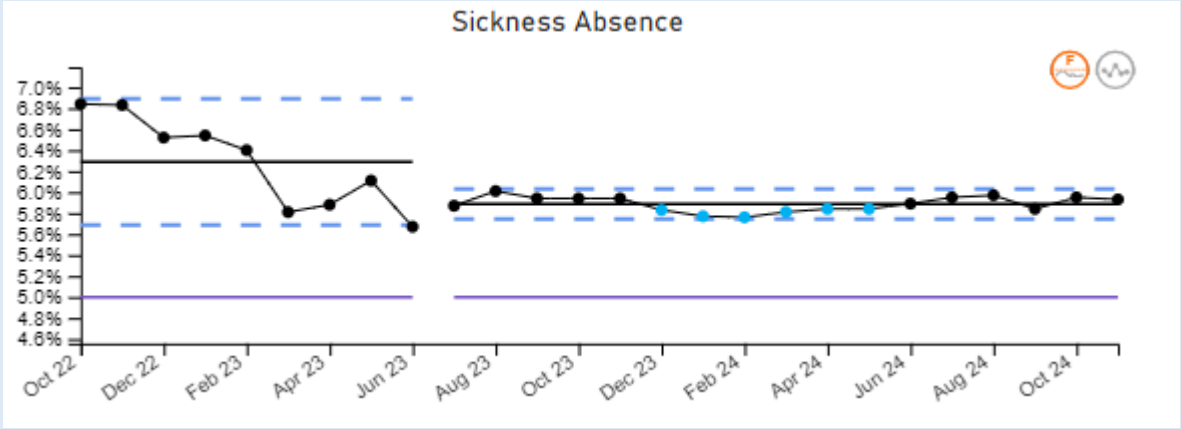


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Overall Sickness Absence

Summary of challenges & risks	For November 2024, the Trust sickness rate is 5.9% against a target for 5%. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. Re-basing has occurred June 2023 recognising the significant improvement following the review and implementation of the Sickness absence policy
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Undertaking post implementation review (PIR) of the revised sickness absence policy • Effective management of long term sickness absence cases including at the final stage of the process • Offer of additional support and training from the People Business Partner Teams • Focus and data analysis on specific staff groups, Health Care Assistants completed, Nursing review underway • Identification of patterns of absence and appropriate actions that can be taken in line with the policy • Improvement work underway supporting absence management for medical colleagues with feedback, input and support from Clinical Directors
Action timescales and assurance group or committee	Completion of the PIR in Q4 Nursing workforce review Q4 Medical workforce absence improvement work Q4 and into 2025/26
Risk register	N/A

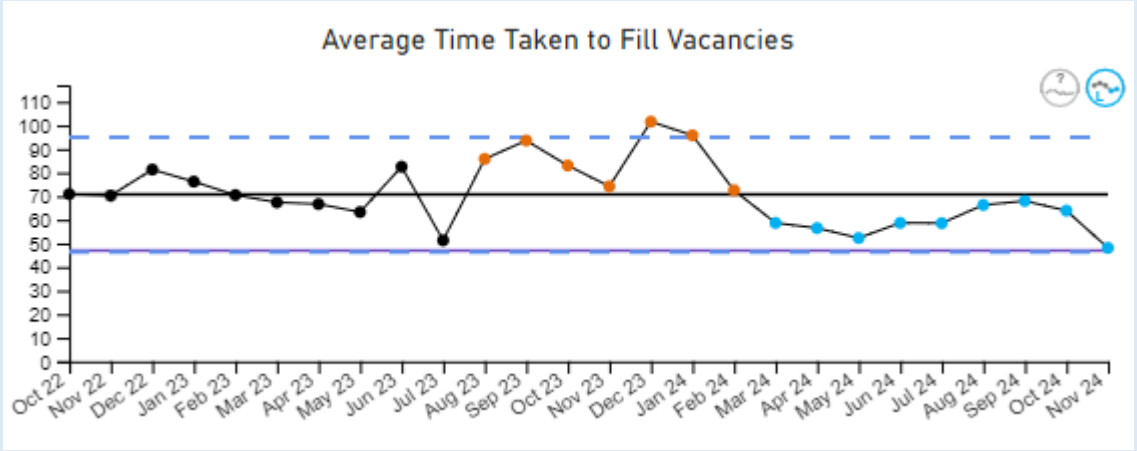


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Average Time Taken to Fill Vacancies

Summary of challenges & risks	The Trusts time to hire is 47 days for September 2024. Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Further support to managers in managing campaigns with the identified KPIs • Additional training and support offered by the recruitment team • Improvements being made to the internal transfer register with plans to pilot the process in the New Year for clinical admin and clerical roles – anticipated to have a positive impact on reduction of number of vacancies
Action timescales and assurance group or committee	Support actions and training offer are ongoing Internal transfer work to be completed by end March 25
Risk register	N/A

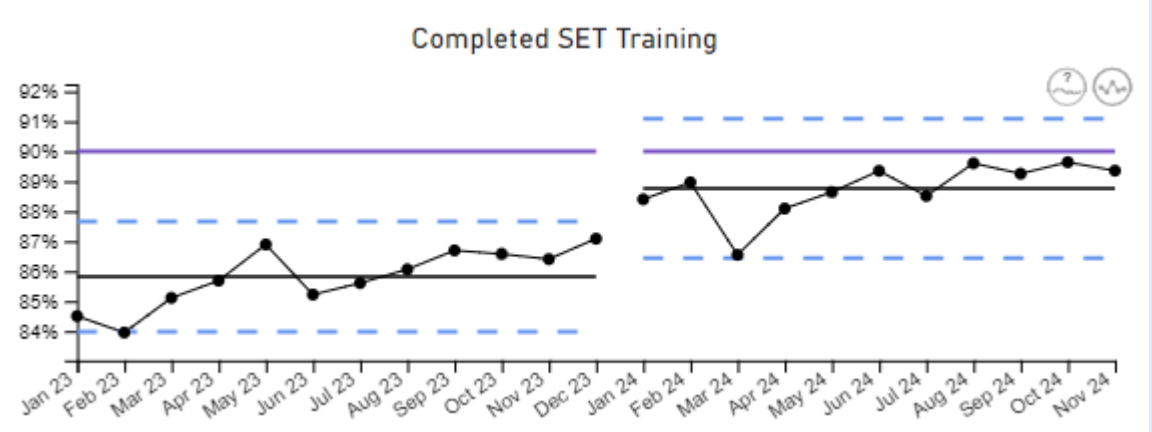


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

Completed SET Training

Summary of challenges & risks	In November 2024 the Trust had a SET completion rate of 88.9% against a target of 90% 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 occurred December 2023 as there was a statistically significant improvement in compliance, attributed to the linkage between the CEA and appraisals process.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Education Team has undertaken analysis of compliance and identified some key areas where focused support will improve the position to achieve the 90% target. Three subjects have been identified as focus areas, where small improvements will lead to overall compliance to 90%.
Action timescales and assurance group or committee	Identified actions to be completed by March 2025
Risk register	ID 3005

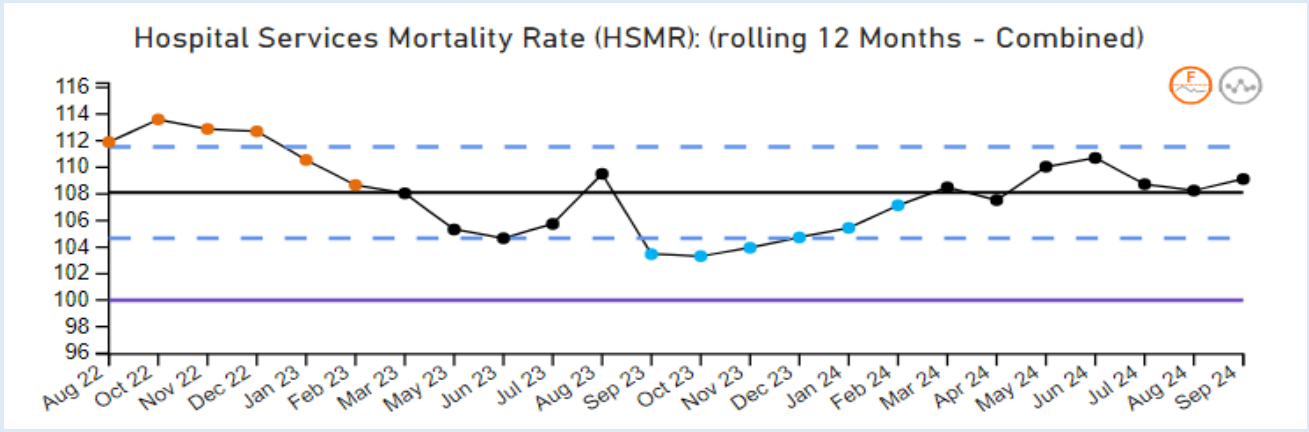


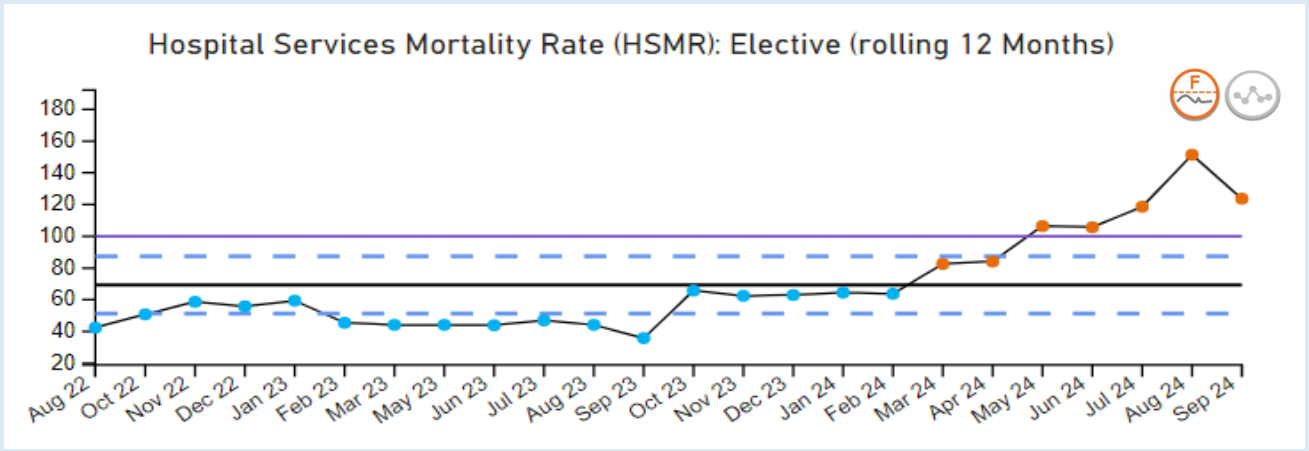
Source DBTH_IQPR_Dashboard_November_2024

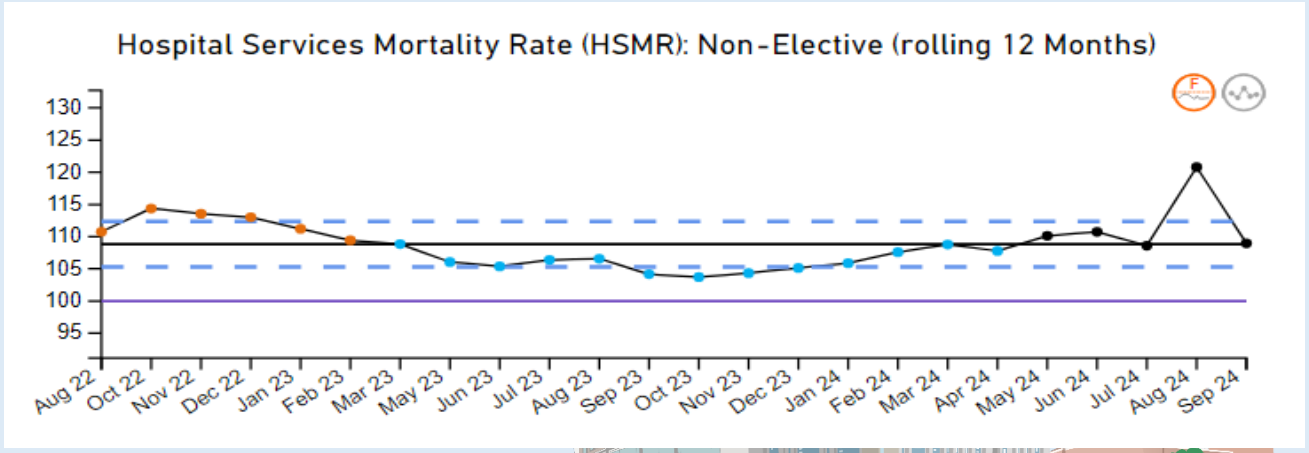
Assurance report

Hospital Services Mortality Rate (HSMR):

Summary of challenges & risks	The Trusts combined HSMR rolling 12-month rate is 109.1 against a target of 100 for September 2024. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. The Trusts elective HSMR rolling 12-month rate is 123.6 against a target of 100 for September 2024. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign. The Trusts non-elective HSMR rolling 12-month rate is 109.0 against a target of 100 for September 2024. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Action plan in place to address clinical coding and depth of coding, which affects the Trust's number of expected deaths (denominator). Structured Judgement Review (SJR) action plan in place. SJR process commenced with senior clinicians (medical and nursing) undertaking SJRs, SJR MDT established, focussing on areas where higher than expected number of deaths have occurred.
Action timescales and assurance group or committee	Due to the lag in reporting mortality data it will take time for performance to reflect the improvements made. Assurance route is through governance framework to Quality Committee.
Risk register	



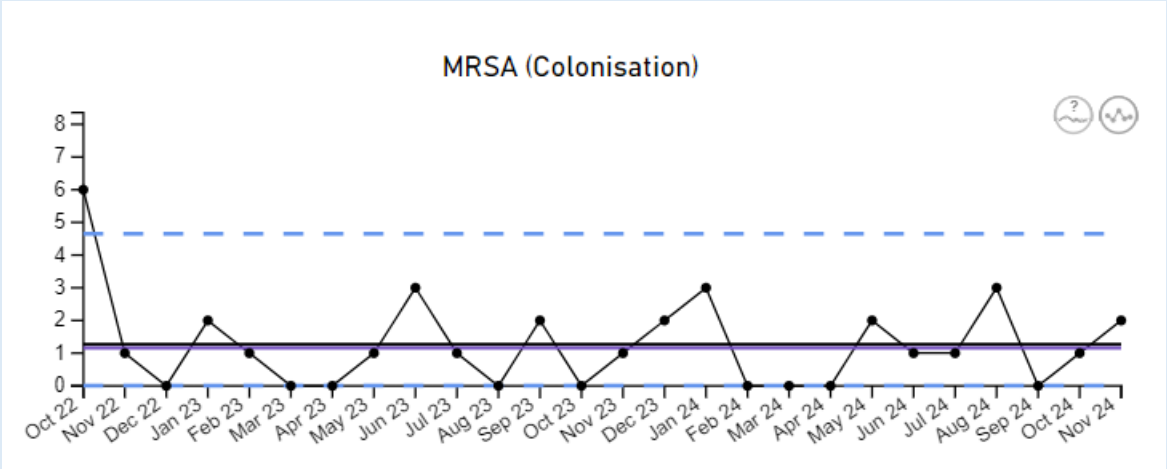




Assurance report

Hospital Acquired MRSA (Colonisation) Cases Reported in Month

Summary of challenges & risks	Hospital Acquired MRSA (Colonisation) Cases Reported in November 2024 was 2. Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	MRSA screening of all emergency admissions and selected elective admissions Weekly MRSA screening in high risk augmented areas, ITU DCC, SCBU and NNU. Weekly MRSA screening of all patients with PICC catheters and significant wounds Prontoderm foam use on all high-risk patients, Nursing home, previous MRSA, invasive devices spot check are done and audits via tenable. All MRSA patients are tagged via Camis and all MRSA patients are reviewed by IPC and medical staff informed. Alert reviews are carried out to monitor management of inpatients.
Action timescales and assurance group or committee	Ongoing actions reviewed as required. Monitored by Infection Prevention and Control Strategic Group and escalated to patient safety committee as required.
Risk register	N/A

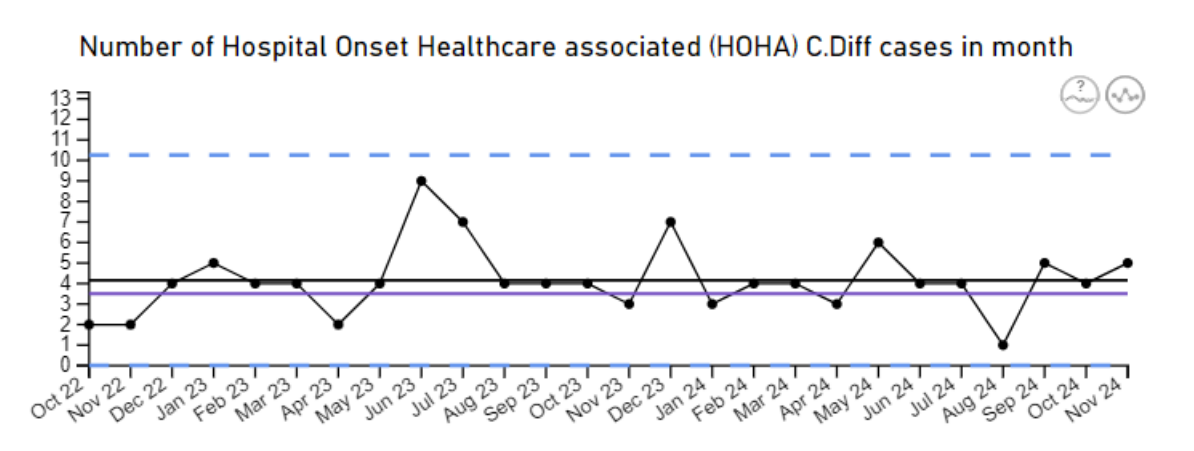


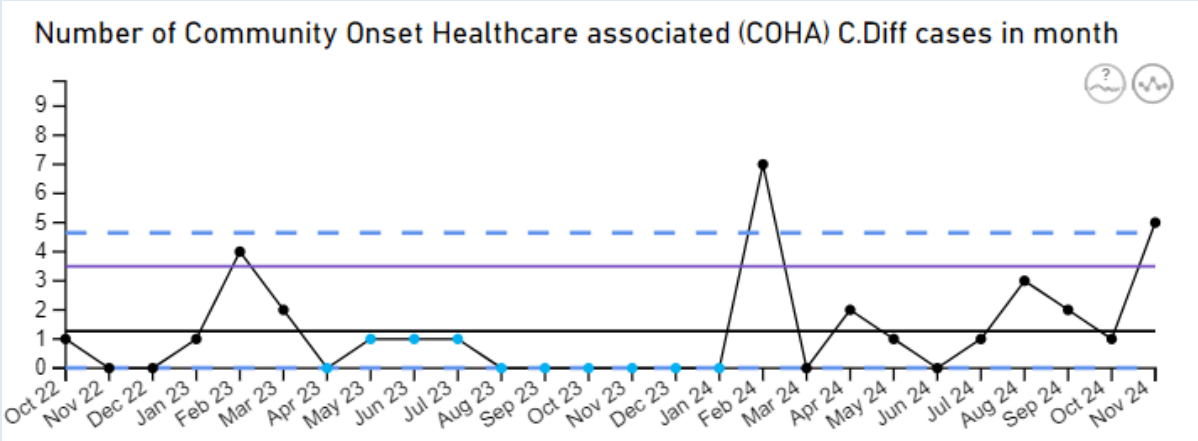
Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	The combined number of Hospital Onset Healthcare associated (HOHA) and Community Onset Healthcare associated (HOHA) C.Diff cases in month was 10 in November 2024 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	Ongoing QI project Key actions forming part of the Qi project include: • IPC team increased ward attendance • Digital documentation approaches. • Implementing a joint protocol with primary care prescribers and secondary care prescribers on the use of PPIs. Hot debriefs are undertaken for each case to identify learning and immediate actions required Anti microbial nurse specialist commenced in post December 2024
Action timescales and assurance group or committee	Ongoing programme with regular touch points. Monitored as part of infection control operational group and Infection control strategic group
Risk register	Logged as risk ID - 3517

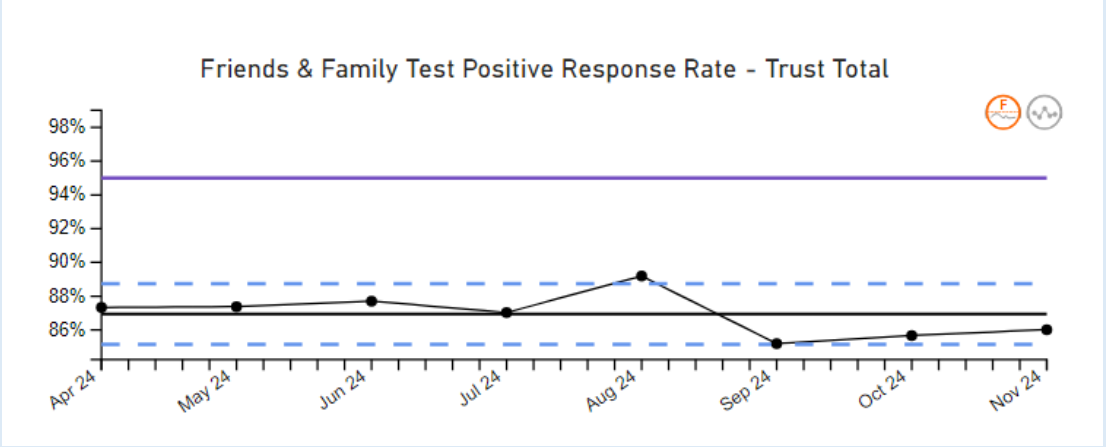




Assurance report

Friends & Family Response Rates

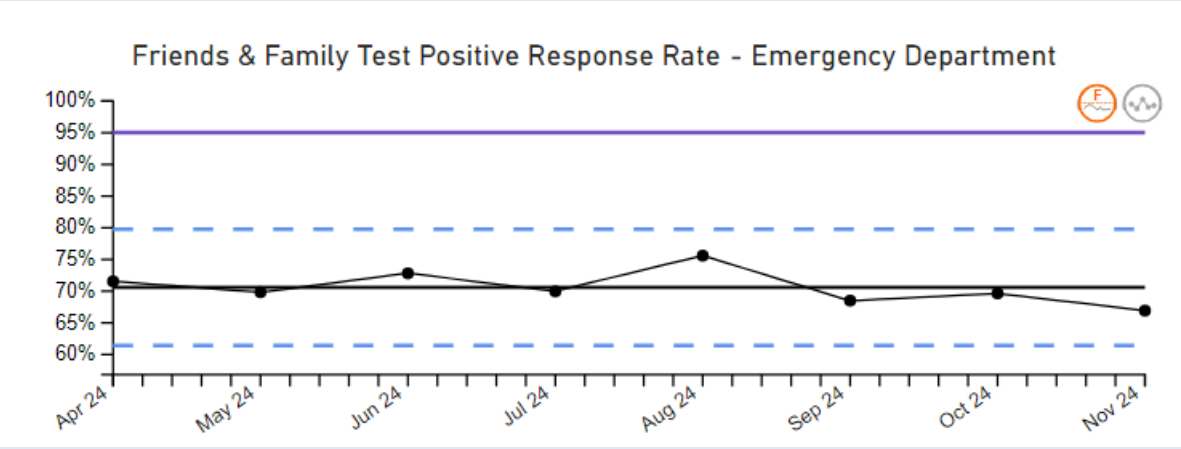
Summary of challenges & risks	Friends and family positive response rates fell below the standard of 95% in November 2024 for the Trust – 86.0% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Reviewing of themes / narrative from Iwantgreatcare as part of patient experience group Review of acting on concerns as part of ward sister / charge nurse roles.
Action timescales and assurance group or committee	Ongoing. Monitored via the patient experience group and escalated as required to the Caring Committee.
Risk register	N/A

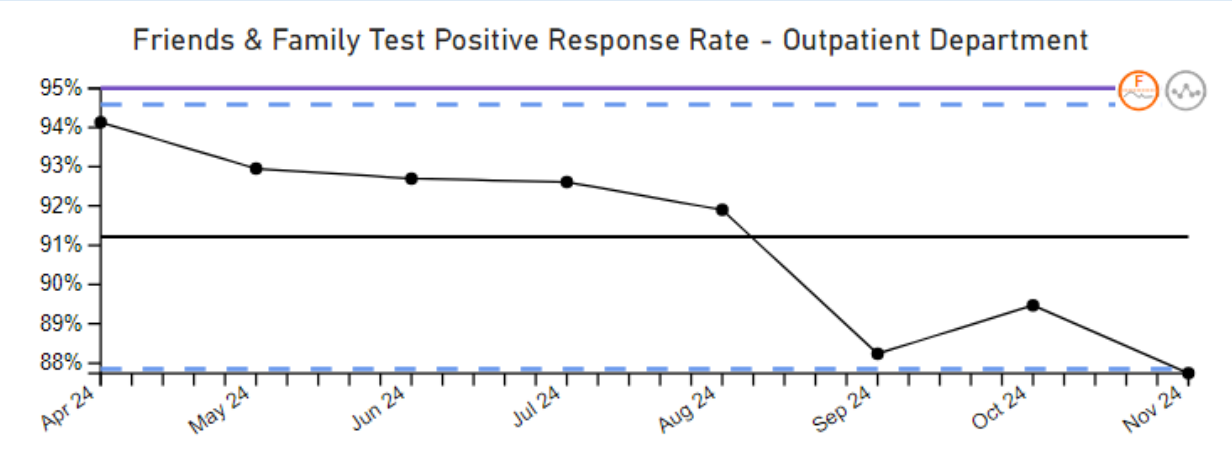


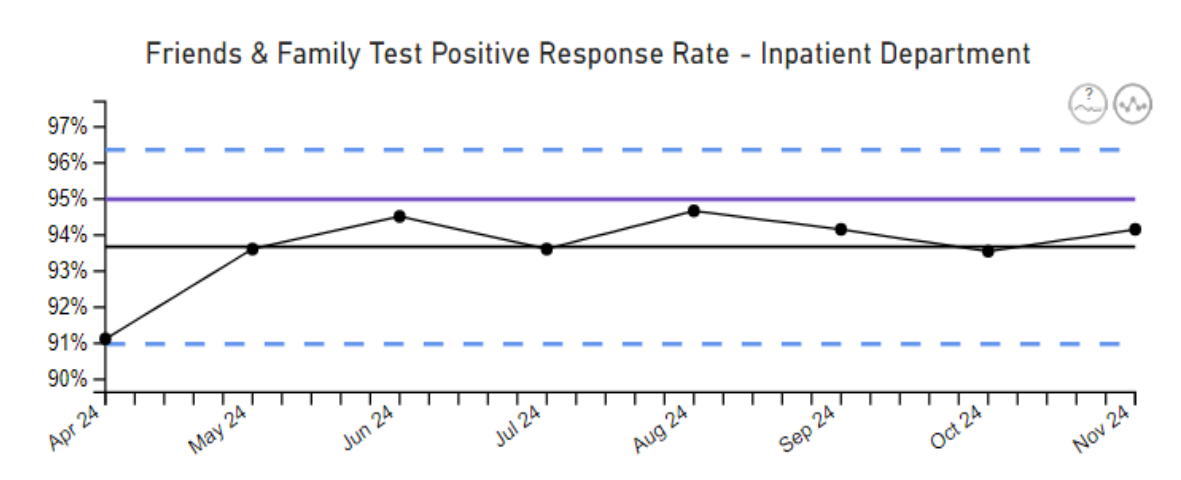
Source DBTH_IQPR_Dashboard_November_2024

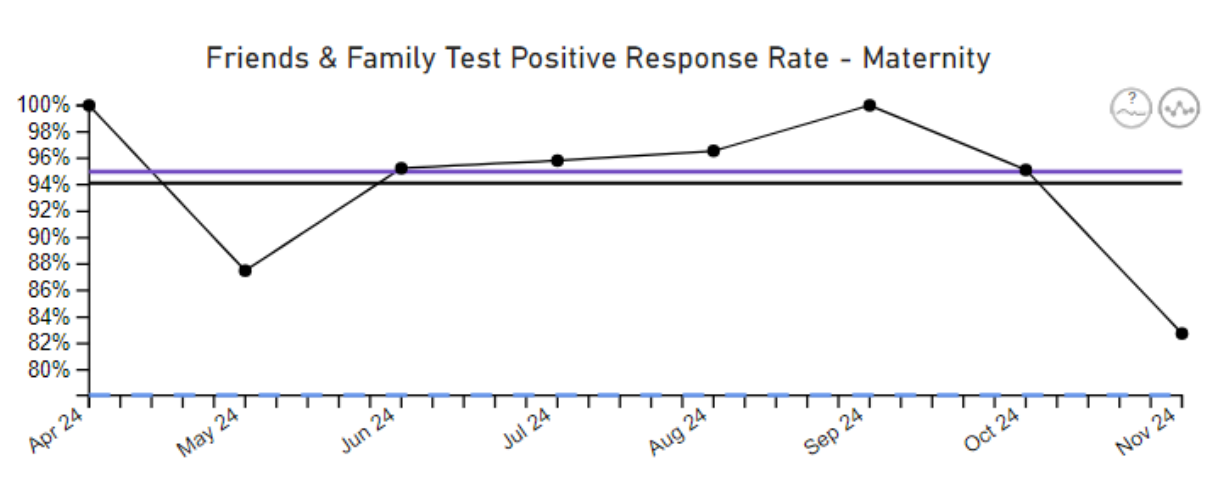
Assurance report

Friends & Family Response Rates





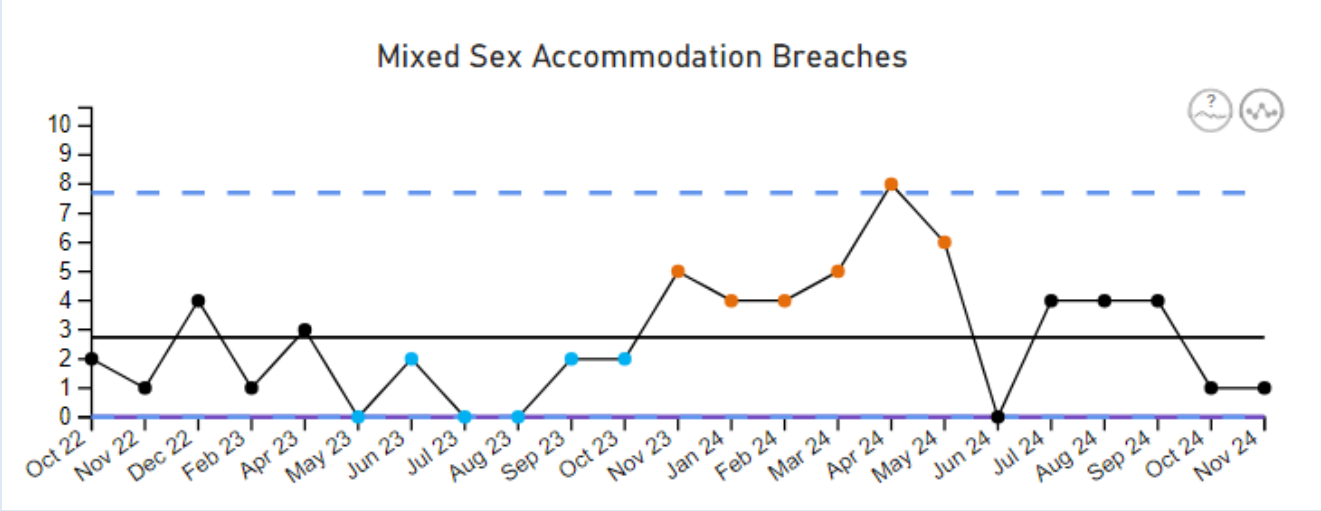




Assurance report

Mixed Sex Accommodation - nationally reported breaches in month

Summary of challenges & risks	There was 1 mixed sex accommodation breach in November 2024. 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	Patients for critical care step down are discussed in each of the three times daily operational flow meetings. Intensive Care (where possible) utilise side rooms to avoid breaching.
Action timescales and assurance group or committee	Ongoing
Risk register	

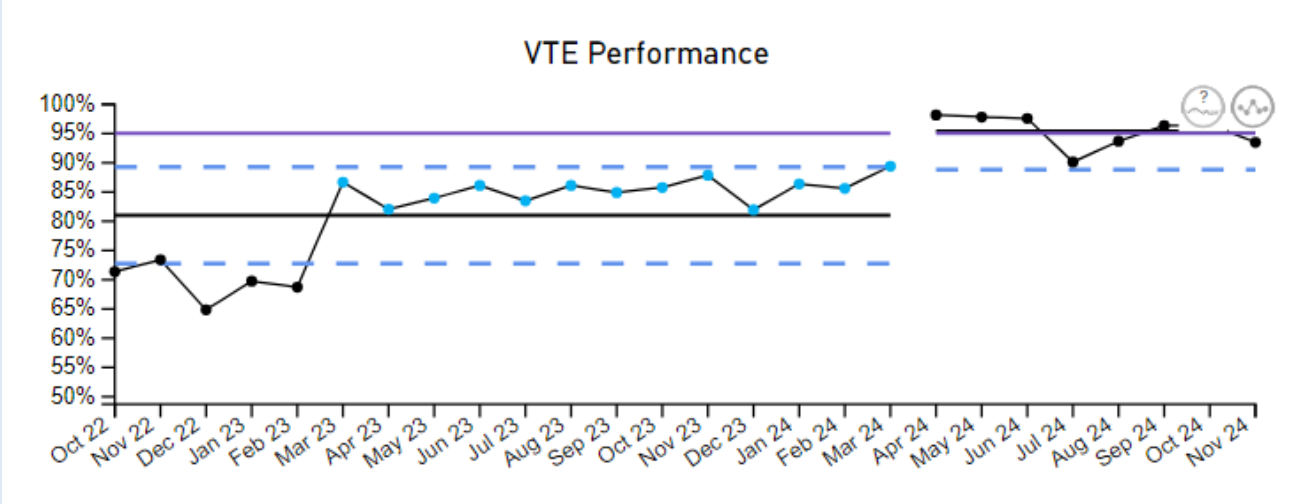


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

VTE - % of patients having a VTE Risk Assessment

Summary of challenges & risks	In November 2024, 93.5% of patients had a VTE Risk Assessment completed 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 March 2024 as VTE reporting moved to electronic reporting on Wellsky
Actions to address risks, issues and emerging concerns relating to performance and forecast	VTE addressing areas of non compliance. Improvement work underway with CSS and Surgery for areas not undertaking electronic risk assessments.
Action timescales and assurance group or committee	Assurance through divisional clinical audit lead, reviewed by VTE Group and monitored by Audit & Effectiveness Forum.
Risk register	

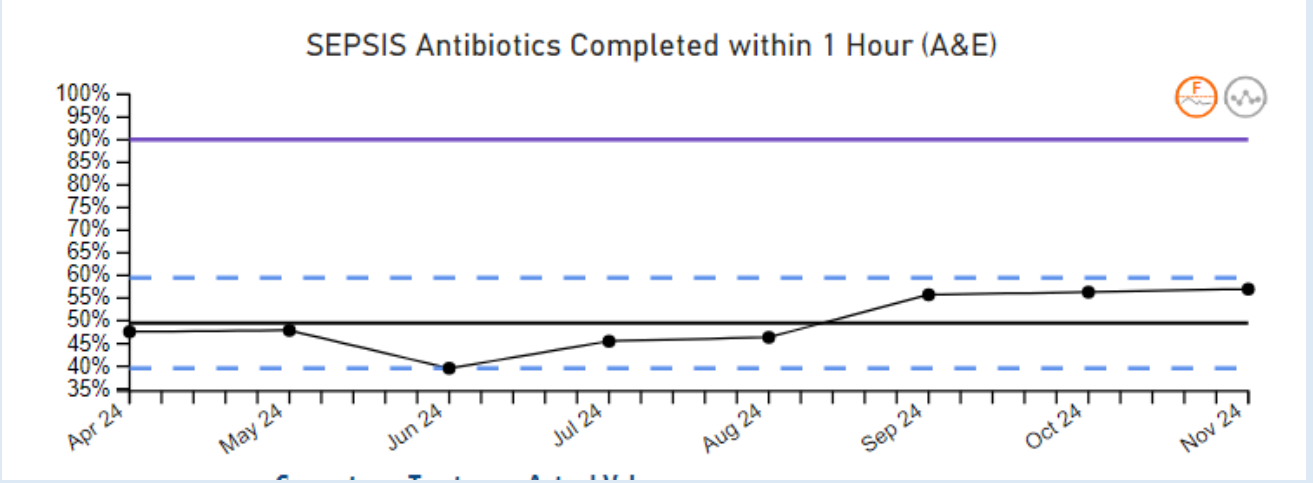


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	The proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 57.0% compared to a target of 90% 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	We have had education initiatives in the form of sepsis modules for all staff and the world sepsis day symposium on 13/09/24. We have reviewed sepsis deaths in the mortality group and feed back learning points to divisional leads for sepsis particularly relating to blood cultures and antibiotics. We now have a lead for sepsis in each division. They are overseeing the QI projects to improve our response to sepsis. We have ward based sepsis initiatives and education in small groups. We have renewed the sepsis guidelines to reflect NICE guidance. The move to EPR will improve our data collection on sepsis patients and also help compliance with our electronic sepsis and CAP bundles.
Action timescales and assurance group or committee	12 months. You can follow ED and inpatient compliance with the above metric on the sepsis dashboard in Derick.
Risk register	

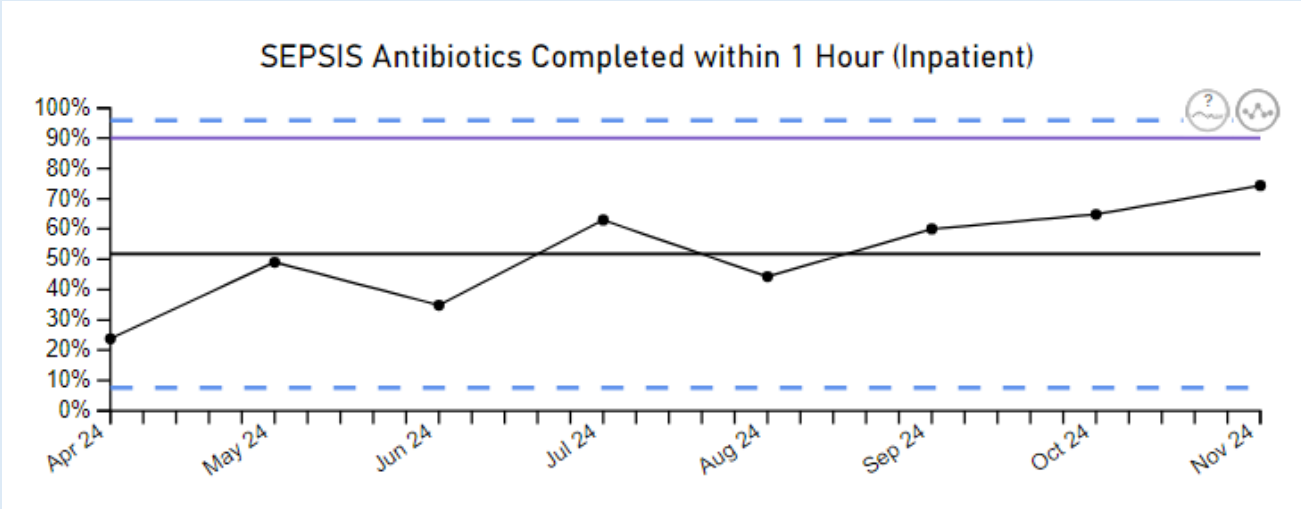


Source DBTH_IQPR_Dashboard_November_2024

Assurance report

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

Summary of challenges & risks	Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis was 74.3%. 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	ED have had several initiatives on blood cultures and antibiotics. We have had education initiatives in the form of sepsis modules for all staff and the world sepsis day symposium on 13/09/24. We have reviewed sepsis deaths in the mortality group and feed back learning points to divisional leads for sepsis particularly relating to blood cultures and antibiotics. We now have a lead for sepsis in each division. They are overseeing the QI projects to improve our response to sepsis. We have ward-based sepsis initiatives and education in small groups. We have renewed the sepsis guidelines to reflect NICE guidance. The move to EPR will improve our data collection on sepsis patients and also help compliance with out electronic sepsis and CAP bundles.
Action timescales and assurance group or committee	12 months. You can follow ED and inpatient compliance with the above metric on the sepsis dashboard in Derick.
Risk register	



Source DBTH_IQPR_Dashboard_November_2024

Metrics in development

- Medical Appraisals completed – *Back dated forms to be completed*
- Duty of Candour (failure to undertake in its entirety) *Awaiting changes to be made in Datix*
- Monthly SHMI measure – *Awaiting QEC sign off*
- Zero Tolerance Methicilin-resistant Staphylococcus aureus – *Unknown owner and data source*
- Minimise rates of gram-negative bloodstream infections – *Unknown owner and data source*
- Vacancies (specific staff groups) – *Awaiting grouping clarification*
- Severe harm falls per 1000 bed days – *To be added to report*
- No urgent operation to be cancelled for a second time – *Further investigation required.*
- Proportion of all outpatient attendances that are for first appointments or Fus attracting a procedure tariff – *Development resource required*
- Combining of COHA & HOHA – *In Test*
- Flu Vaccinations – *Development Resource Required*

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2501 - C2 FINANCIAL POSITION UPDATE

Discussion Item | Jon Sargeant, Chief Financial Officer | 10:30

10 minutes

REFERENCES

Only PDFs are attached

C2 - Financial Position Month 8.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	07 January 2025	**Agenda Reference:**	**C2**
Report Title:	**Financial Position Update**		
Sponsor:	Jon Sargeant / Sam Wilde – Chief Financial Officer		
Author:	Yasmin Ahmed – Deputy Director of Finance		
Appendices:	N/A		

Report Summary

The Trust's reported deficit in month 8 was £1.6m, £0.5m adverse to budget, £0.9m adverse to forecast and £1.4m adverse to month 7. The Trust's reported deficit YTD at month 8 was £2.3m, £1.2m adverse to budget and £2.0m adverse to forecast.

YTD variance to forecast - £2.0m adverse

The Trust's reported deficit YTD at month 8 was £2.3m, which was £2.0m adverse to forecast. The key driver of this variance is lower income due to ERF performance. Overall income is favourable to forecast mainly due to other operating income favourable variances.

At month 8, the adverse year to date variance to the forecast of £2m will require close monitoring for the remainder of the year but also the need to continue to develop plans and sustain them going forwards on a recurrent basis is imperative for future years.

Capital

YTD capital spend excluding donated assets/charitable funds is £12.0m, compared to a year to date budget of £12.3m therefore showing an underperformance of £0.3m.

Cash

Cash has decreased by £8.1m to £41.0m at the end of month 8.

CIPs (Cost Improvement Programme)

In month 8 the Trust has delivered £1.4m of savings versus the plan submitted to NHSE of £2.2m, an under-delivery of £0.8m. YTD, the Trust has delivered £8.9m of savings versus the plan submitted to NHSE of £10.7m, which is a net under-delivery of £1.9m.

Recommendation:	The Board is asked to note • The Trust's reported deficit in month 8 was £1.6m, which was £0.5m adverse to budget, £1.2m adverse to forecast and £1.2m adverse to month 7. • At month 8, the adverse variance to the forecast of £2m will require close monitoring for the remainder of the year but also the need to continue to develop plans and sustain them going forwards on a recurrent basis is imperative for future years. The Board will need to review its position at Month 9 to take assurance that the financial plan is deliverable.			
Action Required:	**Approval**	**Review and discussion**	Take assurance	**Information only**

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

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

Legal/ Regulation:	Identify if the purpose of the report is linked to a legal requirement (e.g. Health and Social Care Act / HSE) or regulatory requirements (e.g. CQC). **<u>If so, indicate impact</u>.**
Resources:	Please indicate any impact on resources.
Assurance Route	
Previously considered by:	N/A
Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

FINANCIAL PERFORMANCE

Month 8 – November 2024

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M08 November 2024

1. Income and Expenditure vs. Budget

Performance Indicator	Annual budget	Monthly Performance						YTD Performance					
		Budget	Actual	Variance to budget		Forecast	Variance to forecast	Budget	Actual	Variance to budget		Forecast	Variance to forecast
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000		£'000	£'000
Income	(620,716)	(55,051)	(52,553)	2,497	A	(50,918)	(1,636) F	(420,634)	(412,010)	8,624	A	(411,485)	(525) F
Pay	394,624	35,054	36,146	1,093	A	35,814	333 A	264,675	266,513	1,838	A	268,154	(1,641) F
Non Pay	219,930	20,323	17,360	(2,963)	F	15,044	2,316 A	151,275	142,529	(8,746)	F	137,962	4,567 A
Financing Costs	8,590	716	615	(101)	F	737	(122) F	5,727	5,246	(481)	F	5,644	(398) F
(Profit)/Loss on Asset Disposals	0	0	0	0	F	0	0 F	0	0	0	F	0	0 F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**2,428**	**1,042**	**1,568**	**526**	**A**	**677**	**891 A**	**1,043**	**2,278**	**1,235**	**A**	**275**	**2,003 A**

Key

F = Favourable **A** = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual Plan
	Plan	Actual		Plan	Actual		
	£'000	£'000		£'000	£'000		£'000
Drugs	64	35	A	242	39	A	500
Income (Other Operating Income)	51	331	F	788	688	A	992
Income (Patient Care Activities)	378	44	A	1,790	211	A	3,351
Non-Pay	526	226	A	2,123	1,730	A	5,288
Pay	21	43	F	167	289	F	250
Pay (Skill Mix)	564	565	F	2,880	3,388	F	5,350
Pay (WTE Reductions)	589	155	A	2,757	2,504	A	5,469
Total CIP	**2,193**	**1,398**	A	**10,747**	**8,850**	A	**21,200**

3. Statement of Financial Position

	Opening balance	Closing balance	Movement
	£'000	£'000	£'000
Non Current Assets	**296,949**	**296,229**	**-720**
Current Assets	85,253	84,293	**-960**
Current Liabilities	-92,373	-90,881	**1,492**
Non Current liabilities	-13,812	-14,022	**-210**
Total Assets Employed	**276,017**	**275,619**	**-398**
Total Tax Payers Equity	**-276,017**	**-275,619**	**398**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan
	Plan	Actual	Plan	Actual	
	£'000	£'000	£'000	£'000	£'000
Cash Balance		41,031		41,031	18,250
Capital Expenditure	2,586	1,422	12,266	11,967	38,531

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,861.32	6,340.09	314.37	68.25	6,722.71
Previous Month	6,845.54	6,183.08	273.94	97.36	6,554.38
Movement	15.78	157.01	40.43	-29.11	168.33

Month 8 Financial Position Highlights

The Trust's reported deficit in month 8 was £1.6m, £0.5m adverse to budget, £0.9m adverse to forecast and £1.4m adverse to month 7. The Trust's reported deficit YTD at month 8 was £2.3m, £1.2m adverse to budget and £2.0m adverse to forecast.

YTD variance to budget - £1.2m adverse

The Trust's reported deficit YTD at month 8 was £2.3m, £1.2m adverse to budget. The key drivers of this are below:

- **Income: £8.6m adverse to budget**
    - ERF income is £5.8m adverse to budget, mainly relating to T&O performance (£6.2m), which is offset with a favourable variance of £2.9m on independent sector expenditure
    - MEOC income is £4.1m adverse to budget, with CDC being £0.6m adverse to budget. Both MEOC and CDC are in the process of scaling up activity and this is largely offset with reduced pay and non-pay expenditure
    - Nottinghamshire ICB contract £0.5m adverse due to contract difference on convergence assumption
    - South Yorkshire ICB contract £0.3m adverse due to phasing expected to recover by yearend
    - Offset by favourable variances on Drugs & Devices income (£2.7m) and this is offset by increased expenditure in drugs and clinical supplies
- **Pay: £1.8m adverse to budget**
    - MEOC is £1.6m favourable to budget, offsetting the lower income
    - CDC is £0.5m favourable to budget, offsetting the lower income
    - CIP performance is £0.4m favourable to budget
    - Offset be adverse variances mainly due to:
    - Pay award funding adverse by £1.1m, discussions are ongoing at SWICB for further funding
    - Continuing pressure on medics pay agency expenditure and additional sessions covering sickness and vacancies £3.2m
- **Non-pay: £8.7m favourable to budget**
    - MEOC is £2.0m favourable to budget, offsetting the lower income
    - CDC is £1.3m favourable to budget, offsetting the lower income
    - Independent sector expenditure is £2.9m favourable to budget
    - £1.1m favourable variance on Utilities due to the renegotiation of the contract
    - Clinical supplies favourable by £1.4m due to reduced activity
    - £2.0m one-off benefits have been identified from accruals
    - £1.1m review of accounting policies

- Offset by increased drug costs being £2.7m adverse to budget, offset by income
- Adverse CIP variance of £0.4m

- **Financing Costs: £0.5m favourable to budget**
  - This relates to increased interest income due to higher than budgeted cash levels.
- **MEOC and CDC**
  - Overall impact on the position for CDC is £1.2m favourable. MEOC is £0.5m adverse due to the expected planned surplus not being achieved fully as activity is lower than planned.

YTD variance to forecast - £2.0m adverse

The Trust's reported deficit YTD at month 8 was £2.3m, which was £2.0m adverse to forecast. The key driver of this variance is lower income due to ERF performance. Overall income is favourable to forecast mainly due to other operating income favourable variances.

Month 8 vs Month 7 - £1.4m adverse

The Trust's reported deficit in month 8 was £1.6m, which was £1.4m adverse to month 7. The key driver of this are lower clinical income levels.

Year-end Forecast

Several scenarios have been developed and reviewed as reported at the September Board meeting, taking into account the current pressures and challenges that are facing the Trust, particularly entering the winter season. These range from delivering £4.7m better than plan to an adverse position of £7.5m against plan. The mid-range scenario is based on the current CIP forecast and we spend the contingency is £5m behind plan.

To achieve the planned deficit of £2.4m, the Trust are concentrating on the following actions:

- Stricter financial controls: Targeting a 5% reduction in non-pay expenses, aiming to save approximately £600,000 monthly, leading to a £3.6 million improvement by year-end.
- Staffing and vacancy management: Tighter control over temporary staffing and recruitment oversight, aiming to save £4.2 million.
- Review of accounting policies: Conducting a full review of our accounting practices and balance sheet to realise approximately £5 million, while weighing immediate benefits against long-term impacts.
- Maximising income and efficiency: Enhancing efficiency through initiatives like overbooking clinics and improving productivity in theatres and outpatients. Streamlining services and optimising procurement are also key to generating lasting improvements.

Consistent effort is essential if the Trust are to meet the planned deficit without compromising commitment to quality and safety. This message has been communicated to all Trust staff, as they play a vital and integral part in achieving our goal.

At month 8, the adverse variance to the forecast of £2m will require close monitoring for the remainder of the year but also the need to continue to develop plans and sustain them going forwards on a recurrent basis is imperative for future years.

Capital

YTD capital spend excluding donated assets/charitable funds is £12.0m, compared to a year to date budget of £12.3m therefore showing an underperformance of £0.3m. YTD capital spend for charitable funds is £2.6m which relates to the Da Vinci Robot and the Stroke Rehab Robot. Therefore, the YTD total capital spend is £14.6m. The planned programme requires cash support to under pin the programme. The cash support request of £7.0m has been submitted to the NHSE Capital and Cash team, this is still awaiting approval.

Cash

Cash has decreased by £8.1m to £41.0m at the end of month 8. This is as a result of the Trust receiving the funding for the Tax/NI/Pensions element of the backpay in month 7, which was paid in November (£3.7m), as well as the education expenditure without the quarterly income (£2m), with the rest being the underlying deficit.

CIPs (Cost Improvement Programme)

In month 8 the Trust has delivered £1.4m of savings versus the plan submitted to NHSE of £2.2m, an under-delivery of £0.8m. YTD, the Trust has delivered £8.9m of savings versus the plan submitted to NHSE of £10.7m, which is a net under-delivery of £1.9m.

The Trust plan is more heavily phased towards the latter part of 2024/25 so delivering the total plan remains a significant risk (Q1 plan c£600k per month versus Q4 plan of £2.7m per month).

Although a number of workstreams are delivering effectively, significant risks to delivery remain in other areas.

Recommendations

The Board is asked to note:

- The Trust's reported deficit in month 8 was £1.6m, which was £0.5m adverse to budget, £1.2m adverse to forecast and £1.2m adverse to month 7.
- At month 8, the adverse variance to the forecast of £2m will require close monitoring for the remainder of the year but also the need to continue to develop plans and sustain them going forwards on a recurrent basis is imperative for future years. The Board will need to review its position at Month 9 to take assurance that the financial plan is deliverable.

2501 - C3 AUDIOLOGY SERVICE UPDATE

Discussion Item | Zara Jones, Deputy Chief Executive | 10:40

10 minutes

REFERENCES

Only PDFs are attached

C3 - Audiology Services Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	07 January 2025	**Agenda Reference:**	**C3**
Report Title:	**Audiology Service Update**		
Sponsor:	Zara Jones, Deputy Chief Executive Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Zara Jones, Deputy Chief Executive		
Appendices:	N/A		

Report Summary

Purpose of the report & Executive Summary

The Board of Directors received a report in November 2024 setting out the position regarding our audiology service. This included specific challenges relating to the paediatric service, linked to a national NHS England established programme, alongside more local issues across the entire service associated with IT, physical estate, equipment and compliance with expected standards following some clinical observations.

These further concerns required the Trust to limit the service offer until improvements can be made.

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

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

This paper provides a brief update on the position regarding paediatric harm reviews which were underway at the time of the last Board of Directors meeting.

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

The Trust continues to make progress against the wider workstream 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.

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

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

Recommendation:	The Trust Board is asked to review and discuss the content of the report.			
Action Required:	~~Approval~~	**Review and discussion**	~~Take assurance~~	~~Information only~~

Healthier together – delivering exceptional care for all					
Relationship to strategic priorities:	**PATIENTS**		**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.		***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**			**NHS Nottingham & Nottinghamshire ICS**	
	Yes			**Yes**	
Implications					
Relationship to Board assurance framework:	**X**	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action		
	X	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way		
	X	BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards		
	X	BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues		
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term		
	X	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw		
		BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term		
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **NO**				
Legal/ Regulation:	Identify if the purpose of the report is linked to a legal requirement (e.g. Health and Social Care Act / HSE) or regulatory requirements (e.g. CQC). If so, indicate impact.				
Resources:	Resources associated with the quality improvements and recovery actions stated.				
Assurance Route					
Previously considered by:	Executive Team, Trust Leadership Team, Quality and Effectiveness Committee, Finance and Performance Committee				
Date:	Various dates 2024				

Any outcomes / next steps	• Deliver the improvement plan • Ongoing communications with patients and stakeholders • Prioritising urgent patients for mutual aid • Stand service back up when safe to do so
Previously circulated reports to supplement this paper:	Last Board of Directors report (November 2024).

Paediatric Quality Review Update January 2025

In the last update to the Board, it was described that as part of the independent review process a 5-year case review was undertaken by Subject Matter Experts (SME) external to the Trust who remotely reviewed a total of 368 case notes.

We received the final report on 25th July 2024. 137 children were recommended for recall and prioritised into categories of urgency. This number has reduced to 131 due to subsequent review of patient information which had not been reviewed previously for six children and one child had undergone an external review as part of a separate review of patient notes earlier in the year.

40 children in this cohort were identified as highest priority, known as priority 1 (P1) and duty of candour was completed. Consent to be seen for a follow-up appointment at Sheffield Children's Hospital was sought from each family. For three children, consent was not given by the families to have a follow up appointment.

37 children were therefore referred to Sheffield Children's Hospital and have now all been assessed. Clinical assessments have been sent back for SME review and allocation of harm levels where applicable.

To date 13 cases have been reviewed by the SMEs and harm allocated. The outcome is three moderate harms, two low harms and eight no harms.

Duty of candour 2 has commenced with all 13 cases and is being followed up in writing. Two of the children who are graded as moderate harm require speech therapy as a result of the delay to aid (treatment) and the referral pathway into speech and language therapy has been agreed to ensure they receive the ongoing support and treatment required. It is not clear at this stage whether the harm sustained is short or long term. For those children determined to have low levels of harm, the expectation is there will be no long-term impact.

All the themes identified have an improvement plan covered in the overarching audiology action plan for improvement. Cases were also presented to the Patient Safety Incident Investigation (PSII) panel on 24th December 2024 for completeness.

We are working with Sheffield Children's Hospital for support to see the further 14 paediatric patients graded as priority 2 (P2) and 76 graded as priority 3 (P3).

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

BREAK 10:50 - 11:00

?

2501 - C4 BOARD ASSURANCE FRAMEWORK

Discussion Item | Zara Jones, Deputy Chief Executive | 11:00

Executive Directors
20 minutes

REFERENCES

Only PDFs are attached

C4 - Board Assurance Framework.pdf

C4 - Appendix 1 Board Assurance Framework.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**E1**
Report Title:	**Board Assurance Framework (BAF) and Trust Risk Register**		
Sponsor:	Zara Jones, Deputy Chief Executive Officer		
Author:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance Tracy Evans-Phillips Trust Risk Manager		
Appendices:	Appendix 1 - BAF (risk 1-6) Appendix 2 – Risk register report		

Report Summary

Purpose of the report

This report presents the Board Assurance Framework (BAF) for 2024-25 up to and including reviews into December 2024. The Board Assurance Framework and Trust risk register are presented to the Board of Directors for further discussion and assurance.

Executive Summary

The Board Assurance Framework brings together the Trusts agreed strategic objectives and identifies and quantifies the risks to achieving those objectives. It is aligned to the Trust four priority areas – Patients, People, Partnerships and Pounds and the 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 and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the annual governance statement in the annual report.

Discussions with the Internal Auditors regarding the BAF have highlighted the dual role for Board in respect of Risk 6 (Partnerships), this is an area that will be discussed and further developed within the board development session in Feb 25.

Conclusion

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

The 'clean version' of the Board Assurance Framework is enclosed in appendix 1 for Board review, discussion

and assurance. This has had all the tracked changes that were shared within the committee updated. The BAF will continue to mature in line with the developing strategy and identified milestones. Risks impacting on any strategic risk are referenced within the individual BAF risk and continue to be managed through the monthly Risk Management Group.				
Recommendation:	The Board of Directors are asked to: **Receive** the report. **Acknowledge** the removal of Risk 7 (Qi) from the BAF **Discuss and Agree** Risk 6 (Partnerships) as the responsible group for this risk currently. Take **assurance** from the approach taken to further develop the 2025/26 BAF. **Note** that the BAF is a live document which will be reviewed and updated regularly throughout the year.			
Action Required:	**Decision**	**Review and discussion**	**Take assurance**	~~Information only~~
Healthier together – delivering exceptional care for all				
Relationship to strategic priorities:	**PATIENTS**	**PEOPLE**	**PARTNERSHIP**	**POUNDS**
	We deliver safe, exceptional, person-centred care.	***We are supportive, positive, and welcoming.***	***We work together to enhance our services with clear goals for our communities.***	***We are efficient and spend public money wisely.***
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications			
Relationship to Board assurance framework:	x	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	X	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
	x	BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
	X	BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
	x	BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES**		
Legal/ Regulation:	The Well led framework requires Boards to have an effective Board Assurance Framework and risk management process in place and regularly reviewed within its governance arrangements		

Resources:	
Assurance Route	
Previously considered by:	Delegated Committees of the Board Board development session 3 December 2024
Date:	Finance and Performance Committee, 29 October / 26 Nov 2024 People committee, 17 Dec 2024 Quality Committee 4 December 2024
Any outcomes/next steps	Board Development Session 4 Feb 2025
Previously circulated reports to supplement this paper:	N/A

Board Assurance Framework and Trust Risk Register Review

Board Assurance Framework (Appendix 1)

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

Following a detailed review on 3 December 2024 with the Board of Directors, discussion was had around the strategic risks currently identified and how these can be updated to reflect the progress made, and some of the changes that have been implemented, both internally and externally. This review will commence in January 2025 and the new BAF will be ready for the new financial year. In order that there are no assurance gaps, the BAF will continue to operate, using current and new formats together, until finalised.

BAF Summary:

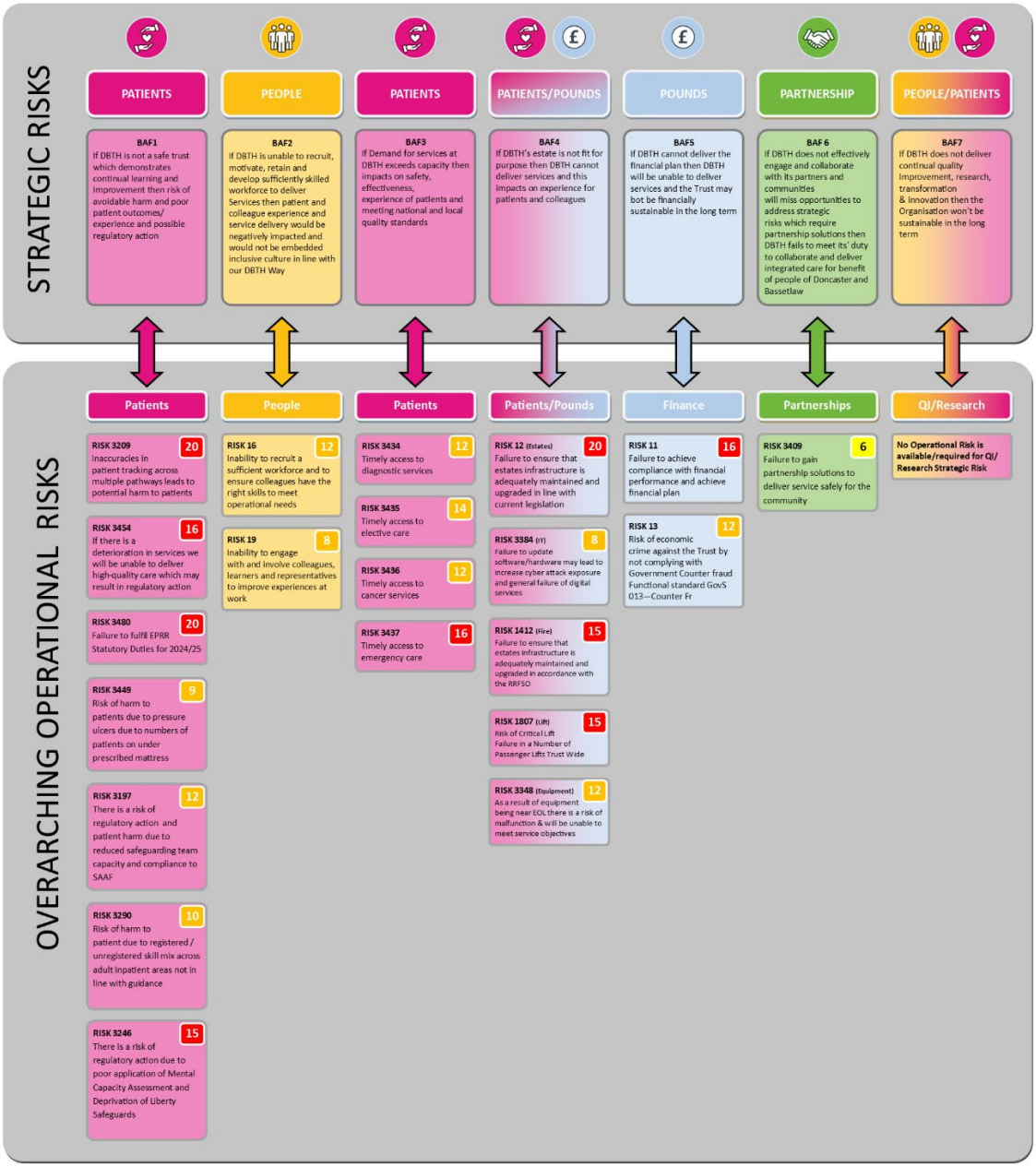
- Assurance levels on actions and controls have been agreed by respective lead committees – see highlight reports from each committee.
- Risk 6 (partnerships and collaboration) will be reviewed by the Board of Directors as owners of this strategic risk, as well as taking assurance on the whole BAF process. This position is to be reviewed within the board development session in Feb 25
- Risk 7 was proposed to be removed from the BAF going forward.

Trust Risk Register (Appendix 2)

Introduction

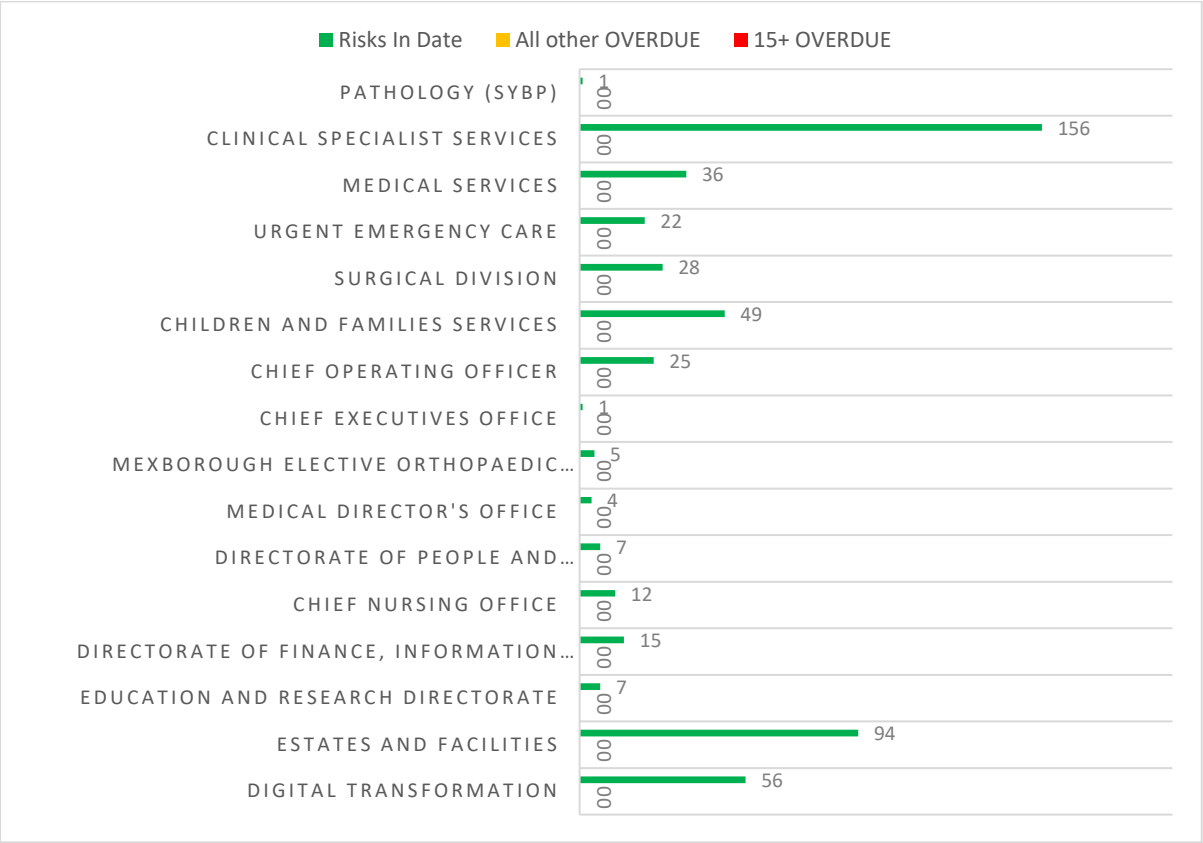
The following report provides an update to the Board of Directors following review of all risks on the Trust Risk Register. The risks contained within this report include Overarching Operational risks that directly relate to the Strategic Risks in the BAF, and any 15+ risks that are standalone. Each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

Strategic and Overarching Operational Risk Relationship



Risk Review Dates

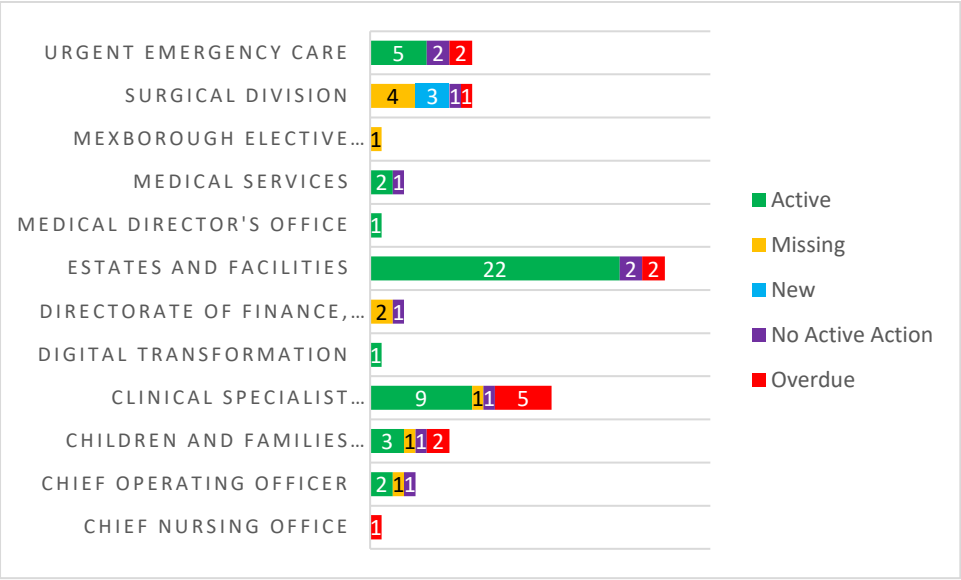
In terms of compliance with risk review dates, the chart below shows all risks in the Trust, including those with a risk score of over 15 (15+ risks) for each of the Divisions and Directorates. Since the review of the Trust Risk Report (data 12 December 24) at Risk Management Group, further improvement has been made to the review dates. The 23 overdue risks are reviewed and compliant. The chart below provides an overview of compliance with review dates per Division and Directorate as of the 18 December 24. The Board will note that all 15+ risks are within their review date and all risks reported on Datix are within their review date.



The above chart shows the 504 Trust Risks, which include 76 extreme risks [Data 18 December 24]

Risk Action Plans

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



The above chart shows the action summary of 81 extreme risks as of 14 December 24 [note that 5 risks were downgraded between 14 and 18 December 24]

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

Changes to Trust Risk Register

Following an intensive review of risks, 20 risks were downgraded and no longer appear on the Trust Risk Register, one has been downgraded but remains an overarching operational risk, and seven risks have been closed. Details below:

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

- **RISK 3146 Exercise stress tests equipment.**
  A business case has been submitted for review at the Medical Equipment Group for new equipment to support with this risk.
- **RISK 3224 Out of Support Server Hardware**
  A quantity of new (replacement) server hardware has been included in capital planning for March 2025 implementation; which reduces the impact of this risk.
- **RISK 3258 Lack of paediatric ophthalmology capacity - risk to 52/78-week breech positions**
  Ongoing recruitment for paediatric ophthalmology service is in progress. There are additional ophthalmology sessions implemented to reduce any breaches, therefore likelihood of breaching the timeframe is minimal.
- **RISK 3280 + 3282 Information Technology system requirements**
  Capital funding is in the plan for 2025/26; the equipment will be replaced before the manufacturer end of life date.
- **RISK 3285 Server - Capacity and forward planning**
  Server hardware and licensing has been included in capital planning for March 2025 implementation, which will increase capacity of the server and reduce the risk.
- **RISK 3287 Windows 10 is end-of-life on October 2025 (upgrade needed to Windows 11)**
  Budget and work are in plan for 2024/25 (work completed and in progress) and 2025/26 (through end October 2025) to implement the associated hardware and software upgrades.
- **RISK 3375 Location of Information Technology systems on site**
  Estates have confirmed that the preventative work to ensure safe functioning of Information Technology Systems has happened.
- **RISK 3404 Increase in equipment to support safe care in Emergency Department.**
  The Additional equipment required to support higher volume of patients coming into the department has been planned.
- **RISK 3267 Radiographer capacity in theatres**
  Standard operating procedures reduce instances where a radiographer may be required to attend two patients in theatre at the same time, and there is a facility to estimate demand ahead of time.
- **RISK 3405 Acute capacity to review patients and provide Same Day Emergency Care cover.**
  Increase Acute Medical consultants during winter pressures.
- **RISK 3426 General Surgery Weekend Ward Rounds**
  Consultants are on a rota to see patients at weekends and bank holidays, therefore risk downgraded.
- **RISK 3458 Diagnostic topography in Ophthalmology Not on the Network**
  The system for diagnostic topography in Ophthalmology is now connected via a wired port with full network access.
- **RISK 3461 InTouch Self Check-In Kiosks**
  Confirmed contract for InTouch kiosks, procured on an annual rolling basis, including a warranty package for the kiosks.
- **RISK 3471 Inadequate cover for Endoscopic Retrograde Cholangiopancreatography** (ERCP)
  ERCP – for upper gastrointestinal endoscopy and xrays now have all lists fully covered.

- **RISK 3474 Cloud technology Enterprise Licence Agreement**
  A business case written and approved for supporting a hardware refresh, implementation expected by end March 2025.
- **RISK 3546 Administration of Radioactive Substances Advisory Committee (ARSAC) license holders projected retirement**
  Remote supervisions have been implemented for the Nuclear Medicine Service, this is running well and patients are not affected.
- **RISK 3548 Unsealed service access**
  Estates have confirmed that all service access (holes in the walls where wires and services access a room) have been sealed.
- **RISK 3556 Acute trauma operative backlog**
  Additional sessions have been run to respond to an increase in trauma patients presenting to the Trust.
- **RISK 3575 Accessing files linked to the Radiology Information System (RIS)**
  All historical x-ray images and reports are available for patients.

Risks reduced but remain on the Trust Risk Register

- **RISK 3197 Compliance with the Safeguarding Accountability and Assurance Framework.**
  The Trust has all statutory roles in place with Domestic Abuse posts being finalised, when this can be downgraded.

Risks closed.

- **RISK 3147 ageing Echo machines currently in use leading to service reduction or interruption**
  New echo machines purchased and now in place.
- **RISK 3420 Paediatric Audiology Risk**
  This incorporates various risks within paediatric audiology. This risk has been superseded with four specific risks RISK 3533, 3542, 3250 and 3237 monitored through the Risk management group, internal and external oversight groups and reporting centrally.
- **RISK 3451 Shortage of oncologists**
  Risk closed due to oncology recruitment and no waiting times.
- **RISK 3470 Lack of ultrasound machine for prostate biopsies**
  Ultrasound machines purchased and available for use.
- **RISK 3473 Lack of Equipment to manage Retinopathy Of Prematurity screening.**
  Duplicate risk covered by RISK 3219 and therefore closed.
- **RISK 3505 Virtual Fracture Clinic (VFC) Capacity and Inappropriate Referrals**
  Additional sessions implemented where possible. Capacity reviewed for 25/26.
- **RISK 3537 Missed Child Protection Information Sharing alerts for unscheduled child attendance in Emergency Department**
  Risk closed as this is overseen from a Trust perspective under RISK 3521.

New Risks

Three new risks have been added to Datix with a 15+ rating. One of these risks has not been presented at Risk Management Group and is currently going through the divisional governance process before it is moderated in this forum.

- **RISK 3580 Loss of escalation beds in paediatrics**
  New swipe doors fitted to re-open escalation cubicles.
- **RISK 3553 Obstetric Ultrasound machine**
  Trialling new ultrasound machines. Business case for purchase of new machines
- **RISK 3587 lack of trauma day case bed capacity leading to increased waiting times**
  Movement of cases between Doncaster and Bassetlaw to increase capacity.

Appendix 2 Trust Risk Register

BAF	Risk ID	Risk Owner	Title	Review date	Rating (current)	Time at current risk rating (months	Rating (Target)	Number of Dependent Extreme Risks	Risk score requires review	Actions requires review
BAF 1	3197	Brown, Simon	There is a risk of regulatory action and patient harm due to reduced safeguarding team capacity and compliance to SAAF	03/03/2025	12	1	6	0	No	No
BAF 1	3209	Smith, Denise	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	09/09/2024	20	22	6	1	Yes	Yes
BAF 1	3246	Brown, Simon	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	06/01/2025	15	21	9	1	No	No
BAF 1	3290	Jessop, Karen	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	02/06/2025	10	19	6	1	No	No
BAF 1	3449	Brown, Simon	Risk of harm to patients due to pressure ulcers due to numbers of patients on under prescribed mattress	24/03/2025	9	1	6	1	No	No
BAF 1	3454	Mallaband, Nicholas	If there is a deterioration in services we will be unable to deliver high-quality care which may result in regulatory action	14/10/2024	16	8	8	8	No	Yes
BAF 1	3480	Reay, Jeannette	Failure to Fulfil EPRR Statutory Duties	12/08/2024	20	1	12	0	No	Yes
BAF 2	16	Lintin, Zoe	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	20/12/2024	12	5	9	38	No	Yes
BAF 2	19	Lintin, Zoe	Inability to engage with and involve colleagues, learners, and representatives to improve experiences at work	03/09/2014	8	1	8	0	No	Yes
BAF 3	3434	VASEY, BEN	Timely access to diagnostic services - Demand, Capacity & Flow	07/10/2024	12	9	12	12	No	Yes
BAF 3	3435	VASEY, BEN	Timely access to elective care - Demand, Capacity & Flow	07/10/2024	12	9	12	0	No	Yes
BAF 3	3436	Barnett, Lesley	Timely access to cancer services - Demand, Capacity & Flow	27/11/2024	12	5	12	1	No	Yes
BAF 3	3437	Stubbs, Suzanne	Timely access to emergency care - Demand, Capacity & Flow	05/08/2024	16	9	12	9	No	Yes
BAF 4	12	Timms, Howard	Failure to ensure that estates infra-structure is adequately maintained and upgraded in line with current legislation	30/05/2025	20	*102	10	19	Yes	No
BAF 4	1412	Timms, Howard	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	30/06/2025	15	44	10	7	Yes	No
BAF 4	1807	Hutchinson, James	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	01/02/2025	15	12	8	4	Yes	Yes
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	06/10/2023	12	14	10	13	No	Yes
BAF 4	3384	HOWARD, DAN	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	07/06/2024	8	1	8	17	No	Yes
BAF 5	11	Sargeant, Jonathan	Failure to achieve compliance with financial performance and achieve financial plan	19/07/2024	16	*73	8	1	Yes	Yes
BAF 5	13	Sargeant, Jonathan	Risk of economic crime against the Trust by not complying with Government Counter Fraud Functional Std GovS 013	08/04/2025	12	13	8	0	No	Yes
BAF 6	3409	JONES, ZARA	Failure to gain partnership solutions to deliver services safely for the community	07/02/2025	6	11	6	5	No	No

**** N.B it was noted that recurrent risks (such as financial plan compliance) would be 12 months risks only, as relate to a single operational year and so following review at the end of 24/25, these would be articulated and added as new risks, with the old ones closed down.***

Full details of the risk and any dependent risk is on Datix.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision is:

Healthier together – delivering exceptional care for all.

Our four strategic priorities are:

BOARD ASSURANCE FRAMEWORK

December 2024

BOARD ASSURANCE FRAMEWORK SUMMARY

Dec-24

Strategic Priorites	BAF Ref	BAF Executive Owner	Strategic Risk IF	Strategic Risk THEN	Oversight Committee	Target for March 25	Apr-24	May-24	Jun-24	Jul-24	Aug-23	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Current LxC	Current	Target Score
PATIENTS	BAF 1	Chief Nurse	If DBTH is not a safe trust which demonstrates continual learning and improvement	Then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action	Quality	12	16	16	16	16	16	16	16	16	16				4 (L) x 4 (C)	16	12
PEOPLE	BAF 2	Chief People Officer	If DBTH is unable to recruit, motivate, retain and develop sufficiently skilled workforce to deliver services	Then patient and colleague experience and service delivery would be negatively impacted and would not be embedded inclusive culture in line with our DBTH Way	People	12	12	12	12	12	12	12	12	12	12				4 (L) x 3 (C)	12	12
PATIENTS	BAF 3	Chief Operating Officer	If Demand for services at DBTH exceeds capacity	Then this could impacts on safety, effectiveness, experience of patients and meeting national and local quality standards	Finance and Performance	9	12	12	12	12	12	12	16	16	16				4 (L) x 4(C)	16	9
PATIENTS/ POUNDS	BAF 4	Chief Financial Officer	If DBTH's estate is not fit for purpose	Then DBTH cannot deliver services and this impacts on experience for patients and colleagues	Finance and Performance	20	20	20	20	20	20	20	20	20	20				5 (L) x 4 (C)	20	20
POUNDS	BAF 5	Chief Financial Officer	If DBTH cannot deliver the financial plan	Then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term	Finance and Performance	12	16	16	16	16	16	16	16	16	16				4 (L) x 4 (C)	16	12
PARTNERSHIP	BAF 6	Dep CEO	If DBTH does not effectively engage and collaborate with its partners and communities will miss opportunities to address strategic risks which require partnership solutions	Then DBTH fails to meet its' duty to collaborate and deliver integrated care for benefit of people of Doncaster and Bassetlaw	Confidential Board	6	6	6	6	6	6	6	6	6	6				2 (L) x 3 (C)	6	6

Board Assurance Framework 2024/25

Links to Strategic Ambitions

Patients

Strategic Objective

We deliver safe, exceptional, person-centred care

BAF 1 Executive Owner

Karen Jessop

Chief Nurse

Strategic Risk

BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action	16

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

1.1	Inability to maintain patient safety and quality of care and failure to learn from patient safety events, leading to increased incidence of avoidable harm, poor outcomes and poor patient experience
1.2	Poor compliance with Clinical Infection prevention and control guidance, leading to outbreaks of infection with resultant patient harm and/or closure of available hospital estate.
1.3	Failure to manage and improve compliance with regulatory and legislative standards relevant to specific strategic ambition (e.g CQC/MHA/MCA….)

Lead Committee

Quality Committee (QC)

Date last reviewed

04-Dec-24

Links to operational risks

3209; 3454; 3480; 3449; 3197; 3290; 3246

Risk Assessment

	Consequence	Likelihood	Risk Score
Initial Risk assessment (July -23)	4	3	**12**
Current Risk assessment	4	4	**16**
Target Risk (Plan for Dec 24)	4	4	**16**
Target Risk (Plan for Mar 25)	3	4	**12**

Risk Appetite

Quality - (Cautious) - Our Preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes and appropriate controls are in place **Regulatory / Compliance (MINIMAL)** We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

Risk Ref	Key controls currently in place to manage the risk (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)	Sources of assurances 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**)	Current Assurance Level Assigned
1.1	# Nursing Midwifery and Allied Health Professional Quality Strategy (2023-2027) # Clinical leadership structures (divisions) quality, governance arrangements, including divisional governance meetings, Patients safety committee, Effectiveness committee and Caring committee # Clinical policies and clinical guidelines # Clinical Audit # LFPSE panels, Trust Executive Patient Safety Oversight Group # Biannual workforce reviews in line with national developing workforce safeguards for nursing and midwifery #Just Culture programme allied with Chief People Officer team #Freedom to speak up #Professional Nurse advocates #Chief Nurse Oversight Framework, Performance review framework aligned with this # Learning from deaths review process #Mortality Governance processes # Trust complaints process #Engagement with seldom heard groups led by Head of Patient engagement & experience # Maternity, Quality and safety committee # Maternity Exec and NED safety champions #NED/ED engagement visits #Patient safety partners in place #Trust wide patient safety improvement plans #Patient safety incident response plan #Family Liaison officer in place (1 remaining to recruit) #Clinical Audit oversight strengthened and monitored utilising Monday.com	Year 1 progress report on NMAHPs Strategy to QC (Aug 24) (2) Patient experience Annual reports to Trust Board (sept 24) (2) Biannual establishment review reporting for Nursing and Midwifery to People Committee (oct 24) (2) CQC Action plan update to QC (Oct 24) (2) Internal Audit Complaints Handling Policy (3) (Oct 24) Humber LMNS review of still birth report (3) LMNS CNST Check and Challenge Meeting year 6 (3) Mortality report to QC (Aug 24) (2) Never Event Exception report to QC (Oct 24) (2) Hospital Acquired Pressure Ulcer Cat 4 report to QC (Aug 24) (2) Audit and Effectiveness update report to QC (Oct 24) (2) Audit and Effectiveness Annual report to QC (Aug 24) (2) PSIRF Progress and Outcomes report to QC (Oct 24) (2) Mortality report inc. Mortality Data Quality Assurance report to QC (oct 24) (2)	Full Assurance Significant Assurance - with minor improvement opportunities Full Assurance Full Assurance Moderate Assurance Full Assurance Significant Assurance - with minor improvement opportunities Full Assurance Full Assurance Full Assurance Full Assurance Full Assurance Full Assurance
1.2	# Infection prevention and control programme, policies, guidance and staff training #National performance metrics and monitoring #environmental cleaning audits #system in place for national comms dissemination #Fully established infection prevention and control team #Flu vaccination programme (local) National Covid vaccination programme #Infection prevention and control governance structure #Infection prevention and control Board assurance Framework compliance #Infection control outbreak processes established	IPC annual report (sept 24) (2) Integrated Quality and Performance report (Nov 24) (2) IPC report to Patient safety committee (Oct 24) (2)	* * Significant Assurance with minor improvement opportunities
1.3	#Safeguarding team and structures reviewed and increased, including recruitment #Chief Nurse Oversight Framework of MCA assessors # CQC quarterly engagement meetings #CQC Action plan and monitoring #Clinical Negligence Scheme for Trusts monitoring and oversight (maternity and neonates) #Risk Management Board	CQC Action plan update to QC (Oct 24) (2) Internal audit Report - Divisional Risk Management (3) Maternity and Neonatal report to Trust Board of Directors at **every meeting** (2) Safeguarding Annual report to Trust Board (sept 24) (2) Safeguarding Accountability and Assurance Framework, gap analysis submission (3) (July 24)	Full Assurance Moderate Assurance * * *

	Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance)	Actions to address identified Assurance Gaps
1.1	Unknown impact of winter and the need to increase capacity to maintain patient safety	Winter plan approved by Trust board and to be implemented (COO) Staffing plan in place to bring a team together to support a winter ward, supported by a QPIA (CN) accomodations made within the estate to support a defined winter area on both sites (COO/CN) Divisional leadership structure to support winter model.

Significant Gaps in current controls and plans to improve (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)

Ref	GAP	Lead	Time scale	Progress
1.1	Internal Audit Complaints Handling Policy implement recommendations	CN	Feb-25	Implementation of recommendations commenced
1.1	Nursing skill mix of RN/Non RN is not in line with national guidance	CN	Mar-25	Business case under development including priority areas/recommendations based on Quality risks
1.1	Data to support Quality monitoring - Dashboard under development	CN & CFO	Mar-25	Development recommenced with phased approach, regular updates received, updates in test currently
1.1	Data to support monitoring of Quality and workforce for AHPs	CN & CFO	Feb-25	Preliminary report in progress, finalising data, content and format for PC reporting
1.1	Clinical coding is poor which impacts on reporting and both Patient and financial outcomes	EMD	Q4 - 24/25	Internal audit commissioned re: clinical coding awaiting final report to agree actions Maxwell Stanley coding validation work ongoing. In line with national guidance any chronic longstanding condition documented as a pre-existing condition can be brought into subsequent episodes. This will improve depth of coding for 1st / 2nd episodes of care. Commenced August 2024. Local Policy in place for recording obesity, so coding BMI from 1 September. Using clerking notes from ED for admissions to improve depth of coding. Clinical coding training package - shared at MAC and plan to attend clinical governance meetings in the new year (2025).
1.1	Insufficient structured judgement reviews (SJRs) completed to contribute to Learning From Deaths	EMD	Mar-25	Interim Learning from Deaths Manager has trained a group of medical and non-medical staff in SJRs. Training to be extended to newly recruited consultants and protected time offered for SJRs to increase number of reviews taking place. Divisions to review job plans to ensure SJRs timetabled
1.1	Lack of learning from Mortality reviews	EMD	Nov-25	Mortality Governace Group - ToRs updated, membership reviewed and work plan for committee in place. Will have oversight of mortality data assurance improvement plan.
1.1	No substantive Learning from Deaths manager in post	EMD	Apr-25	Mitigated with 1 day a week support from NHSP, plan in place for recruitment
1.1	Trust wide safety improvement plans under development and not embedded	CN	Mar-25	Under development (2 of 5 finalised), implementation of each plan, monitoring via Patient safety committee (Apr 25)
1.1	Lack of visibility re: Resuscitation activity and Respect compliance	EMD	Mar-25	Work underway with MD office and Education team to establish baseline position to inform next actions

1.2	Inability to provide deep cleaning due to limitations of estate (lack of spare ward space) Noncompliance with national cleaning standards due to finance constraints	CN /CFO	Apr-25	Bay by bay cleaning in place as mitigation Progression of compliance with national cleaning standards following review
1.2	No formally established Trust wide fit testing programme	COO	Apr-25	Fit testing Plan being developed by COO team aligned with EPRR standards (Apr 25)
1.2	No Antimicrobial resistance (AMR) Specialist Nurse in post	CN	Jan-25	Recruitment in place, start date agreed.
1.2	Lack of medical attendance at AMR steering group	EMD	Jan-25	Improving position and will be monitored via effectiveness committee
1.3	Gaps remain in safeguarding team following support of the business case	CN	Mar-25	Implementing a phased approach to recruitment to manage balance of safeguarding gaps, training requirements and financial risks
1.3	Datix risks not reviewed and no actions attached reported through to Risk Management Board and individuals accountable within the meeting forum. Escalations through to Trust Leadership team	MD	Feb-25	Actions articulated and designated to divisional leads in Nov Risk Management board to be reviewed at each meeting commenced Nov 24 Summary report to Trust leadership team and accountable directors commenced Dec 24

Board Assurance Framework 2024/25

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

BAF 2 Executive Owner	Strategic Risk		Current Risk Score
Zoe Lintin Chief People Officer	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way	12

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

Availability of overall workforce in context of national shortages in some areas and the nationally identified need to increase training numbers
National context of unsettled employee relations
Introduction of NHS Long Term Workforce Plan (LTWP), which is aligned with our People Strategy. Further details to be confirmed nationally on the LTWP including funding, with a review due in 2025
National context including 24/25 operational and financial planning guidance, which has a focus on restricted workforce growth in the short term. In this context, and despite significant assurance on the implementation of the DBTH People Strategy and positive movement on key People indicators.

Overseeing Committee

People Committee

Links to operational risks

16; 19

Date of last Committee review

People Committee - 17 December 2024

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

Risk Appetite

People- (OPEN)-We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.

	Key controls currently in place to manage the risk (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)	Sources of assurances 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)	Current Assurance Level Assigned
1	People Strategy 2023-27 launched May 2023, with detailed delivery plans and regular assurance reporting to People Committee	Chief People Officer Senior Leadership Team (1)	Significant Assurance - with minor improvement opportunities
		Reports to every People Committee meeting providing progress updates (2)	Significant Assurance - with minor improvement opportunities
		Annual staff survey results and learner surveys (3)	Significant Assurance - with minor improvement opportunities
		Internal audit on health & wellbeing undertaken Q4 - Significant Assurance (3)	Significant
		Recognition and award nominations at national level (3)	Significant Assurance - with minor improvement opportunities
2	Development of strategic Trust-wide workforce plan, including implementation of strategic workforce planning tool and embedding of deep dive/focus workshop approach	Workforce & Education Committee (1)	Significant Assurance - with minor improvement opportunities
		Reports to every People Committee meeting (2)	Significant Assurance - with minor improvement opportunities
		Internal audit report - Recruitment (22/23) (3)	Moderate assurance
		Internal audit report - Return to work interviews (22/23) (3)	Moderate assurance
		Internal audit report - Bank & agency controls (2024/25) (3)	Limited Assurance
3	Launch and ongoing embedding of the DBTH Way to set out expectations on behaviours and embed an open and inclusive organisational culture	Reports to Trust Leadership Team (1)	Significant Assurance - with minor improvement opportunities
		Reports to People Committee providing progress updates (2)	Significant Assurance - with minor improvement opportunities
		Annual staff survey results and learner surveys - further significant improvements seen in 2023 staff survey results (3)	Significant Assurance - with minor improvement opportunities
4	Equality, diversity and inclusion action plan including NHS England high impact actions	EDI Committee (1)	Significant Assurance - with minor improvement opportunities
		Reports to People Committee providing progress updates (2)	Significant Assurance - with minor improvement opportunities
		Annual staff survey results and learner surveys (3)	Significant Assurance - with minor improvement opportunities
		NHS England Dashboard, Workforce Race Equality Standard/Workforce Disability Equality Standard (3)	Significant Assurance - with minor improvement opportunities
5	Provision of quality education, learning and development	Workforce & Education Committee (1)	Significant Assurance - with minor improvement opportunities
		Reports to Trust Leadership Team (1)	Significant Assurance - with minor improvement opportunities
		Reports to every People Committee meeting providing progress updates (2)	Significant Assurance - with minor improvement opportunities
		Education quality visits and outcome reports - positive feedback in NHSE report Q4 23/24, positive feedback from University of Sheffield visit Q2 24/25 (3)	Significant
		Learner satisfaction surveys (3)	Significant

Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance)	Areas where further assurance against controls is required
Estates/environment impacts on colleague morale and training capacity	Strategic issue, local mitigation
Succession and talent management approaches to be embedded	Succession planning approach developed and rolled out Q4 23/24, Talent management tools developed in Q3, piloted in Q4 and launched late March 2024 to align with 2024 appraisal season. Appraisal season 90% compliance target exceeded in 2024 (93.52%). Succession planning and Scope for Growth to be recommunicated in Q3/4
Retention data requires review through exit interview themes	New format for capturing exit interview data launched 2023/24 to increase amount of data received. Renewed focus in Q4 2023/24 to increase amount of data being collated centrally, reported at WEC in October 2024. Further work needed to increase data recording, Qii approach underway and actions identified
Sickness absence remains higher than target, despite year on year trend of reducing rate (discussed at Board 05.11.24)	Actions in place through Workforce workstream, reporting into Efficiency & Effectiveness Committee

Significant Gaps in current controls and plans to improve (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)

Ref	Action	Lead	Target Date	Progress
1	Delivery of year 1 of People Strategy in line with agreed delivery plan	Zoe Lintin	31/03/2025 for year 2	Delivery plans updated regularly and assurance report presented at every People Committee. Plans on track, actions completed. Significant assurance reported at 22 October 2024 meeting

3	Continue to Embed the DBTH Way throughout the Trust	Zoe Lintin	Mar-26	Further update planned at 17 December 2024 meeting describing actions on progress
2	Effective use of strategic workforce planning tool and embedding of deep dive/focus workshops	Zoe Lintin/Anthony Jones	Mar-25	Workforce Supply & Demand papers at every PC meeting, committee assured. Work ongoing to determine best use of the tool in changing national context in relation to workforce growth, working with KPMG to strategically reframe the use of the tool.
4	Refresh of EDI plan to include NHSE High Impact Actions and delivery of 2024/25 actions in the plan	Zoe Lintin/Gavin Portier	Mar-25	EDI action plan refreshed to reflect NHS High Impact Actions with new actions added. Further update planned at 17 December 2024 meeting
1, 5	Delivery of education priorities within People Strategy and Research & Innovation Strategy including new Education Quality Framework	Zoe Lintin/Sam Debbage	31/03/2025 for year 2	Plans on track. Positive feedback received from NHS England education quality visit and report. Positive feedback from University of Sheffield quality visit. Early implementor of national Safe Learning Environment Charter, launched Q3 24/25
2	Internal Audit recommendations Bank and Agency	Zoe Lintin/Anthony Jones	Mar-25	Report received October 2024, triangulating actions with F&P Committee
2	Internal audit report - Return to work interviews (22/23)	Zoe Lintin/Anthony Jones	Mar-25	Further work identified on sickness rates (see above comment in gaps)

Board Assurance Framework 2024/25

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

BAF 3 Executive Owner	Strategic Risk		Current Risk Score
Denise Smith Chief Operating Officer	BAF3	If Demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards	16

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

Increased waiting list size and increased waiting times for elective care following the pandemic
Sustained high demand for urgent and emergency care
Lack of capacity (physical capacity and workforce capacity)to meet the demand and clear the elective backlog
Underutilisation of clinical capacity
High bed occupancy and discharge delays have a detrimental impact on patient flow out of the ED

Overseeing Committee

Finance & Performance Committee

Links to operational risks

3434; 3435; 3436; 3437;

Date of last Committee review

Oct-24

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	16
Current Risk Assessment	4	4	16
Target Risk **(Plan for Dec-24)**	3	4	12
Target Risk **(Plan for Mar-25**)	3	3	9

Risk Appetite

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

Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1. Urgent and Emergency Care Improvement Programme which includes maximising same day emergency care and reducing length of stay in order to reduce inpatient bed demand and bed occupancy	Monthly SRO oversight through the Programme Board (1)	Partial Assurance - with improvements required
	Monthly highlight reports to Doncaster UEC Board (2)	Partial Assurance - with improvements required
	Monthly report to Transformation Board (2)	Partial Assurance - with improvements required
	Monthly report to F&P (2)	Partial Assurance - with improvements required
	National data submissions confirm Trust position / performance (2)	Partial Assurance - with improvements required
	Monthly ICB / Regional report detailing performance / benchmarking (2)	Partial Assurance - with improvements required
	GIRFT reports (3)	Partial Assurance - with improvements required
	Model health reports (3)	Partial Assurance - with improvements required
	Trust participation in national benchmarking programme (3)	Partial Assurance - with improvements required
2. Diagnostic Improvement Programme to ensure demand is in line with clinical guidelines / best practice and to maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1)	Significant Assurance - with minor improvements required
	Monthly Diagnostic & Elective Oversight Group for Acute Fed performance (2)	Significant Assurance - with minor improvements required
	Monthly Programme Board report to Transformation Board (2)	Significant Assurance - with minor improvements required
	Monthly Access Standards report to F&P (2)	Significant Assurance - with minor improvements required
	National data submissions confirm Trust position / performance (2)	Significant Assurance - with minor improvements required
	GIRFT reports (3)	Significant Assurance - with minor improvements required
	JAG accreditation for Endoscopy (3)	Significant Assurance - with minor improvements required
	Model Health reports (3)	Significant Assurance - with minor improvements required

3. Outpatient Improvement Programme to manage demand for new / follow up appointments, maximise technology enabled care and maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1) Monthly Access Standards report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3) Internal audit report (waiting list management) (3)	Significant Assurance - with minor improvements required
	Monthly Diagnostic & Elective Oversight Group for Acute Fed performance (2)	
	Monthly report to Transformation Board (2)	
4. Theatres Improvement Programme to maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance(2) Monthly report to Transformation Board (2) Monthly Access Standards report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3) Internal audit report (waiting list management) (3)	Significant Assurance - with minor improvements required
5. Operational Governance arrangements to maintain oversight of activity delivery vs plan, delivery of the access standards / improvement trajectories, delivery of the operational planning guidance improvements	Monthly Divisional Performance Review Meetings (1) Weekly COO oversight of 65 / 78 week forecast (1) Weekly theatre booking / scheduling meetings (1) Divisional PTL meetings and Grip & Control meetings (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance(2) Monthly Access Standards report to F&P (2) Monthly Elective Activity Report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3)	Significant Assurance - with minor improvements required
6. Elective Care Improvement Programme to ensure the fundamentals of good elective care management and governance are in place across the Trust	DQ Steering Group (1)	Partial Assurance - with improvements required

Significant gaps in current controls	Areas where further assurance against controls is required
Elective Care Improvement Programme on hold currently as senior leadership capacity is directed to elective recovery plans and theatre / outpatient utilisation	
	Standardised Corporate PTLs for RTT and Cancer, in line with best practice
	Senior operational oversight of BAU patient flow metrics

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
2	Corporate PTL meeting refresh for RTT and Cancer	COO	Q2	Complete for RTT.
4	Weekly oversight of activity vs plan (forward look)	COO	Aug-24	Theatre and Outpatient planning / scheduling / utilisation meetings in place
5	Weekly Patient Flow meeting to provide oversight of BAU actions	COO	Dec-24	Delayed - implementation deferred to Q3

Board Assurance Framework 2024/25

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

BAF 4 Executive Owner	Strategic Risk		Current Risk Score
Jon Sargeant Chief Financial Officer	**BAF4**	**If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues**	**20**

Key issues

Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation(i) Breaches of regulatory compliance and enforcement including:

Risk of Failure of Critical Ventilation Plant Throughout the Trust due to Condition and Operating Standard Non-Conformance. A significant number of the critical air handling systems providing supply and exhaust ventilation to operating theatres and other critical areas Trust wide are not fit for purpose and do not comply with the standards of: HTM 03-01, Health Building Note 26 and NHS Model Engineering Specification CO4. In many cases the 6/7 facet information and annual verification reports identify the plant as being
- Aged
- Life expired
- Unsuitable
- Inappropriate

Fire - Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO. Increased Risk to Life and Property in the Event of Fire Due to Current Inadequacy of Fire Compartmentation ire compartmentation has been identified as being inadequate in each of the Trust's properties. Fire compartmentation is required to minimise the spread of fire and smoke, and to facilitate progressive horizontal evacuation (PHE) strategies. As a result there is currently an increased risk to life and property in the event of fire. Update: Suspected Fire Incident occurred 22nd October in South Block, full evacuation required due to strong smell of smoke, smoke and presence of soot/ash covering S12. SYFR investigated, felt to be ventilation system pulling in smoke/odour from external bonfires in neighbouring gardens.

Electrical - Risk of electrical failure due to age and condition of HV/LV infrastructure AE Audit reports completed across Trust properties for HV/LV electrical systems have identified a number of non-compliances with the requirements of HTM 06-01, HTM06-02 & HTM 06-03.

Water Systems/Legionella - Local Water Storage Tanks Local cold water storage tanks located Trust-wide have been identified as requiring remedial work and/or replacement due to their age and condition. The tank condition has been verified by both 6 facet surveys and water quality risk assessments. Failure to maintain clean, safe and appropriate water storage systems poses an increased risk of unsafe water systems, leading to a risk to all users

Lifts - Risk of critical lift failure leading to (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area

Overseeing Committee

Finance & Performance Committee

Links to operational risks

12;3384; 1412; 1807; 3348

Date of last Committee review

26-Nov-24

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	**16**
Current Risk Assessment	4	5	**20**
Target Risk	4	5	**20**

Risk Appetite

Finance/VFM- (OPEN) We strive to deliver our services within the budgets set out in our financial plans and are prepared to accept some financial risk as long as appropriate controls are in place.
We have a holistic understanding of VFM with price not the overriding factor.

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Granger Review 2021 & action plan contains a number of actions that are either completed or on track. Top up insurance now in place.	Reports to Audit and Risk Committee (via H&S Report) (2) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
2	Full Asset capture 2022/23 - informing business case to increase Planned Preventative Maintenance schedule to reflect infrastructure risks in line with industry standard SFG 20. Review included all sites. Funding identified for the staffing in the final quarter of 2024/25.	Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Partial Assurance - with improvements required
3	Report provided to BoD June regarding way forward for DRI site to invest in the current site, and progress the support for the new build bid. Both pieces of work aim to eradicate risk of poor infrastructure of the DRI site. Request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb. Announcement expected Nov 22nd as part of the Autumn Statement, bids for EWB, Theatres, DCC and W&C have been developed in readiness. DCC case signed off by DHSC with NHSE sign off imminent (August 2024) works started in discussion with DHSC team. East Ward Block SOC work starting for completion in July 2025 Doncaster CEO priorities project to look to move some services to other sites to alllow closure of poorest estate at DRI	Board Report (2) Board report (2) F&P Paper (2)	Partial Assurance - with improvements required Partial Assurance - with improvements required Partial Assurance - with improvements required Partial Assurance - with improvements required
4	Annual Capital Programme developed using Risk Based methodology - focus on DRI backlog/Critical infrastructure risk reduction. £74m invested in DRI site in last 5 years	Annual Programme to Board of Directors for approval (2) Annual Programme to ICB for information (3) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
5	Key Financial Control Processes in place: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. Reintroduction of financial escalation process with Divisions from June.	POSM & Transformation meetings (1) 360 assurance performance mgt audit Q4 2022/23 (3)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
6	Comprehensive EFM Risk Register in place, containing actions to mitigate and eradicate risk	Internal Audit 21/22 (3) Reports to Audit and Risk Committee (via H&S Report) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities

Significant gaps in current controls	Areas where further assurance against controls is required
Insufficient investment to eradicate backlog/infrastructure risk at the DRI site	Further assurance Enhanced planned preventative maintenance
lack of an effective NHS capital regime	
A requirement for additional revenue to support Top Up Insurance of £500k pa and increased estates resource value of circa £900k (£600k pay, £300k revenue)	

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
3	~~Develop options for investment of the current DRI site, as per request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb~~	~~JS~~	~~Dec-23~~	~~Paper to Board in June, Paper F&P 26th July 2023. updated paper to F&P and BoD in Sept re Autumn statement funding announcement Bid pack completed as required in November, shared with DHSC and NHSE, awaiting further instruction regarding next steps~~
	Work on the Doncaster CEO Priorities to include moving services to other locations in Doncaster, plus review of step up/step down facilities and provision of new car parking and accomodation	JS	ongoing	Project commissioned by place CEO's with budget identified. Project team being assembled and governance structure being setup.
3	SOC for East Ward Block	JS	Jul-25	Paper to FP, project team being pulled together.

3	Staffing to be recruited in for final quarter of 24/25 for PPm in response to the granger report.	JS	Nov/Dec 2024	Funding in budget for 2024/25
2	Site Development plan for DRI and BDGH being prodcued	JS	Jan-25	inititated

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
12	4	3	20	Risk of Fire to the Estate

Risk Number	Risk Description	Risk Rating
12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation.	20
1214	Increased Risk to Life and Property in the Event of Fire Due to Current Inadequacy of Fire Compartmentation	20
1277	Increased Risk of Fire and Smoke Spread in IBH Plant Room due to Inadequate Fire Compartmentation	20
1246	Risk of Failure of Critical Ventilation Plant Throughout the Trust due to Condition and Operating Standard Non-Conformance	20
1807	1807 Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	20
1782	LV Electrical Distribution DRI- life expired increasing risk of electrical faults	15
1274	DRI East Ward Block tanks and associated roof top services- life expired increased risk of bacteria growth and failure	15
1781	DRI Outpatients Water System Non-Conformities increasing risk of biological growth and infection	15
2682	DRI South East Block lifts operating beyond their expected lifecycles- Risk of Failure. Rating	15
1412	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	15
2863	High Voltage switchgear and transformers in Substation 4 at DRI does not meet current standards for safety.	15
1083	Risk of electrical failure due to age and condition of HV/LV infrastructure	15
1208	Risk of Failure of a standby generator under power loss conditions would lead to a total loss of power	15
1095	Risk of Failure of Critical High and Significant Infrastructure (Backlog Maintenace) at DRI.	15
1225	Risk of fire alarm automatic fire detection capabilities may not be adequate in some areas	15
2941	Risk of Further Fire Enforcement from SYFRS within the DRI EWB if Current agreed Actions are not Progressed	15
1224	Risk of increasing the difficulty of safe evacuation in the event of fire due to not having provision of fire rated lifts	15
1216	Risk of potential fire spread as a result of aged and none compliant fire doors.	15
1209	Risk of reduced lighting following power failure events increased by inadequate emergency lighting	15
2335	Risk of Regulatory Non-Compliance, Critical Plant Failure & Delivery of SSOW Due to Insufficient Estates Workforce Resource	16
1077	Risk of smoke and fire spread through insufficient information regarding the location of fire and smoke dampers	15
1264	Ventilation- annual inspection and verification (Critical Systems)	15
1082	Water quality risk assessments in Trust properties have identified non-compliances with HTM04 & associated Legislation	15

Board Assurance Framework 2024/25

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

BAF 5 Executive Owner	Strategic Risk		Current Risk Score
Jon Sargeant Chief Financial Officer	BAF5	**If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term**	**16**

Key issues

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

2) The Trust has a c£50m underlying deficit, placing pressure on its long term financial sustainability. A key issue is delivering recurrent cash releasing CIPS in order to support reducing this deficit position.

3) Cash - the Trust has had to request central revenue cash support of £26.8m to meet its obligations and c£7m capital. This comes at a cost to the Trust of 3.5% worsening the Trust's financial position but also reduces the ability to invest in services.

4) Productivity - reductions in productivity were seen during COVID, where activity being delivered is below pre-pandemic levels, whilst resource has increased. The challenge in 24/25 has been to deliver above pre-pandemic levels of activity within resources allocated whilst providing safe and sustainable services. The challenge as we enter 24/25 is to deliver the activity lost from industrial action and improve productivity further within the resources the trust has. If activity is not delivered in line with plan the Trust's income position will be at risk. Currently the Trust is not delivering these productivity gains, through either the BAU operational processes or the The Theatres and Outpatient efficiency workstreams.

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

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

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

Oct-24

Links to operational risks

11; 13;

Risk Assessment	Consequence	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	**16**
Current Risk Assessment	4	4	**16**
Target Risk	4	3	**12**

Risk Appetite

Finance/VFM- (OPEN) We strive to deliver our services within the budgets set out in our financial plans and are prepared to accept some financial risk as long as appropriate controls are in place.
We have a holistic understanding of VFM with price not the overriding factor.

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Key Financial Control Processes: Vacancy Control Panel, Corporate Investment Group (CIG), Grip and Control Nursing and Medics, Capital Monitoring Committee, Cash Committee. Escalation through financial meetings with Divisions and to POSM. SFI's/SOs.	Internal Audit - HFMA Review	Significant Assurance - with minor improvement opportunities
		Internal Audit - Temporary Staffing	Partial Assurance - with improvements
		External Audit - 24/25	Significant Assurance - with minor improvement opportunities
		DoF Senior Leadership Team @ POSM	Significant Assurance - with minor
		SFI's/SO's updated and being reviewed by ARC in September (due to YE accounts) Board in Nov	FULL Assurance
		Deloittes review of financial controls July 2024	Significant Assurance - with minor improvement opportunities
		Reports to Audit and Risk Committee	Significant Assurance - with minor improvement opportunities
		Reports to Finance and Performance Committee	Significant Assurance - with minor improvement opportunities
2	Commissioning of drivers of underlying financial deficit.	Refreshed report received Aug 2024.	Assured
			Significant Assurance - with minor improvement opportunities
3	Budget Setting and Business Planning	Board and F&P sign off of plan (April 2024)	Significant Assurance - with minor improvement opportunities
		Internal Audit - Business Planning	Significant Assurance - with minor improvement opportunities
4	Internal and external audit programme including counter fraud	Internal Audit - HFMA 22/23 Review	Partial Assurance - with improvements required
		Internal Audit - Temporary Staffing	Significant Assurance - with minor
		Counter Fraud reports to ARC	Significant Assurance - with minor
		External Audit - 22/23	Significant Assurance - with minor improvement opportunities
5	24/25 financial forecast prepared for F&P	Report to FP July 2025 And Board seminar	Partial Assurance - with improvements required
6	Working with the ICB and Doncaster PLACE through CEO's and DoFs regarding financial delivery and saving opportunities	Reports to Finance and Performance Committee	Significant Assurance - with minor improvement opportunities
7	Development and Delivery of CIP plan	Implementation of the Efficiency and Effectiveness Committee reporting into FP and CEO chaired	

Significant gaps in current controls	Areas where further assurance against controls is required
Medical Agency Spend	Medical grip and control meetings

Estates critical infrastructure risk at DRI key financial issue, risk level 20, frequent incidents occurring.	Develop options for investment of the current DRI site, as per request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb
Temporary staffing controls	Enhanced grip and control meetings plus executive attendance at meetings
Elective underperformance against ERF targets	COO to produce a recovery plan with monitoring through execs and FP

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
3	Development and delivery of CIP plan	CFO	Mar-25	Delivery of CIP plan in year has seen good progress but further work required on delivery of recurrent savings. Focus now on developing CIP plan for 24/25.
4	Delivery of reduced temporary staffing spend including grip and control in medic areas.	CPO	Mar-25	Nursing temporary staffing spend has reduced in 22/23 due to reduction in agency and bank rates, usage and improved controls. Further assurance now required in medic spend including robust implementation of medic grip and control meetings.
5	Daily cash flow forecast and submission of national request for central cash support	CPO	Ongoing	Daily cash flow in place, with more robust controls in place regarding payment sign off (e.g. sign off by Deputy Dof and Head of Procurement). National request for cash support completed for revenue and capital. Awaiting confirmation from central team on cash for revenue and capital.

Board Assurance Framework 2024/25

Links to Strategic Ambitions	Strategic Objective
Partnerships	We work together to enhance our services with clear goals for our communities

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

Key issues

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

Overseeing Committee

Confidential Board

Links to operational risks

3409

Date of last Committee review

October 2024

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

Risk Appetite

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

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
6.1	Prioritisation of DBTH participation in ICS activities and ensuring proportionate balance of time and input in relevant work.	Chair and CEO input and attendance at key South Yorkshire and Nottinghamshire forums to influence and advise on strategic direction and priorities. (1)	Significant Assurance - with minor improvement opportunities
		CEO Partner member SYICB Board and reporting outcomes from this. (2)	Significant Assurance - with minor improvement opportunities
		DCEO leadership in Nottinghamshire and Bassetlaw Place, regular dialogue with ICB, Place and Provider Collaborative leadership to ensure DBTH inclusion in opportunities for service development and reported externally. (2)	Significant Assurance - with minor improvement opportunities
6.2	Acute Federation (AF) / Acute Trusts engagement to support development of partnership approaches to sustain and protect key services and pathways	AF Clinical sustainability review work involvement (2) DBTH Audiology Service mutual aid agreements with partners (3) Review of collaborative opportunities with other SY DGH (2)	Partial Assurance - with improvements required
6.3	Health Inequalities strategy at Trust and Place level focused in business planning and performance processes.	Internal Audit of HI strategy (3)	Under review
		Reporting through to F&P Committee (2)	
6.4	DBTH's strategic intentions for partnership working is stated within the partnerhip plan.	Internal Audit of Partnership plans (3)	Under review
		Reporting through to Board(2)	**Significant Assurance - with minor improvement opportunities**
6.5	Partnership governance arrangements are in place	Internal audit review of partnership governance. (3)	Under review
		Partnership Activity is evidenced through the Trust Board Agenda and reporting (2)	Under review
		Trust Leadership Team and Divisional level horizon scanning.(2)	Under review

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

Key actions to close gaps

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

2501 - C5 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Day, Non-executive Director | 11:20

5 minutes

REFERENCES

Only PDFs are attached

C5 - Chair's Assurance Log - Finance and Performance Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Finance and Performance Committee Meeting	**Board Date: January 2025**
Prepared By:	Mark Day, Committee Chair & Non-executive Director	
Approved By:		
Presented By:	Mark Day, Committee Chair & Non-executive Director	
Purpose	The paper summaries the **key highlights** from the Finance and Performance Committee meeting held on 26 November 2024	

Matters of Concern/Escalation Items (with Partial or No Assurance)	**Major Actions Commissioned / Work Underway**
2024/25 Financial Performance and Forecast Outturn - adverse forecast and slippage on CIP represents a significant risk to the financial position with the Committee noting that recovery plans are not delivering the required operational or financial benefits. CEO led meetings to provide challenge to divisional recovery plans had not taken place and now need to be put in place urgently. **Escalate to Board.** **Access Standards** – Trusted entered into 'Tier2' for elective surgery, with mandated performance management meetings. Noted that the Urgent and Emergency Care plan is not delivering the required benefits, and that ambulance conveyance rates and handovers remains areas of concern. Audiology continues to be the most significant are under performance. **Elective Activity Report** – the Committee noted some improvement in performance, but the overall position remains a concern. Divisions are encouraged to further consider the approach to manging outpatient bookings. **Access Elective Recovery Plan** – current forecasts indicate performance significantly behind plan. Directorate recovery plans being reviewed but initial indications show a residual shortfall, and plans are not risk adjusted for winter pressures. **CT Demand Management** – the Committee welcomed signs of improvement resulting from revised management arrangements. Remains partial assurance given the overall challenge and the need for further and consistent action.	**GIRFT Report -** Committee welcomed improved visibility brought by new reporting arrangements and noted that the Trust has been invited to join the 'Further Faster Programme' and Ophthalmology leads have been asked to join a national focus group which would bring additional support to the speciality.
Significant or Full Assurances to Provide	**Decisions Made**

Estates Performance KPI Report – Full Assurance	**Committee Workplan** – Approved.

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

2501 - C6 CHAIR'S ASSURANCE LOG - QUALITY & EFFECTIVENESS COMMITTEE

Discussion Item | Jo Gander, Non-executive Director | 11:25

5 minutes

REFERENCES

Only PDFs are attached

C6 - Chair's Assurance Log - Quality Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality Committee Meeting - Chair's Highlight Report to Trust Board

Subject:	**Quality Committee Meeting**	**Board Date: January 2025**
Prepared By:	Emyr Wyn Jones, Committee Deputy Chair & Non-executive Director	
Approved By:	Quality Committee Members	
Presented By:	Emyr Wyn Jones, Committee Deputy Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on 4 December 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
• Paediatric Audiology – Service is undergoing a complex and necessary recovery and improvement process with significant work ongoing and good progress being made. However, only limited service is currently available. Concern expressed about the knock-on effect on adult audiology because of the paediatric audiology problem. Also, concerns that ENT consultants/clinical staff had not been adequately briefed on what is happening with audiology in general and that communications with key staff need to be timely and updated. Regular updates on progress with Audiology will be provided to the Public Board of Directors. **Partial Assurance** • Patient Tracking Inaccuracies – report received on good progress being made to resolve remaining issues with oversight from NHS England – **Moderate Assurance** • Concerns regarding Trust mortality data showing higher than comparator Trusts – though reducing. Significant work being undertaken to investigate and analyse mortality data and to improve the process of Structured Judgement Reviews (SJRs). **Moderate Assurance**	• Paediatric Audiology incident resolution • Ongoing work on Learning from Deaths
Significant or Full Assurance	**Decisions Made**
• Maternity and Neonatal Update (incorporating CQC Maternity Report, Sands Review of Bereavement Services, MBRACE Maternity Report and Picker Maternity Survey) **Full Assurance** • Radiation Safety - IRMER Standards Compliance Report **Full Assurance** • PSIRF Progress and Outcomes report **Full Assurance** • Psychiatry Liaison Report **Full Assurance** • Internal Audit Complaints Update Report **Full Assurance** • Mortality Surveillance System and process compliance **Full Assurance** • Clinical Audit Progress against annual plan and outcomes including NICE Compliance and National Clinical Audit Alerts **Full Assurance**	• Quality Committee Workplan agreed • Support for the proposal that mortality data should be reported in the Integrated Performance Report and for a move away from use of Hospital Standardised Mortality Rate (HSMR) to Summary Hospital-level Mortality Indicator (SHMI) • Agreed that Quality Committee needs to ensure that the agenda fully reflects the Board Assurance Framework (BAF) and that, in order to increase QEC's focus on BAF, future Cover Sheets for Committee papers need to highlight BAF implications of the paper.

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

2501 - C7 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

Discussion Item | Mark Bailey, Non-executive Director | 11:30

5 minutes

REFERENCES

Only PDFs are attached

C7 - Chair's Assurance Log - People Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board		
Subject:	**People Committee Meeting**	**Board Date: January 2025**
Prepared By:	Mark Bailey, Committee Chair & Non-Executive Director	
Approved By:	People Committee Members	
Presented By:	Mark Bailey, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 17th December 2024	

Matters of Concern **(Moderate, Partial or No Assurance)**	**Work Underway / Major actions commissions**
Just Culture: Partial Assurance Year on year analysis of employee relations casework shows an increase in activity with sickness absence being notably higher. Resolution times have lengthened with performance management and bullying & harassment category cases showing significant deterioration. Remedial actions are being identified however the ability to materially reduce the number of cases and with it shorten timescales is likely to be diminished in what is likely to be a difficult year for employee relations and economic conditions nationally.	**NHS England - Sexual Safety Charter** Policies, behavioural standards and training development to underpin commitment to zero-tolerance approach to unwanted, inappropriate and / or harmful sexual behaviours to our workforce. **Bi-annual nursing workforce establishment review** Safer Nursing Care Tool (SNCT) analysis confirms establishment levels are being met for nursing but the mix of registered to unregistered nurses falls below new national recommendations. Trust Executive review in February 2025 to consider options to progressively achieve the recommended skill mix. **Education** 'Optimise, rationalise, reform' NHSE programme for Statutory / Mandatory training. Apprenticeship plans assessment due to proposed national changes. Alignment with National T&C updates. **People Systems** Implementation programme for digitisation of rostering and job planning processes used for Consultant, SAS and Resident doctors.

Significant or Full Assurances	Decisions Made
People Strategy: **Full Assurance** Comprehensive high-level summary of implementation of year 2 actions in the strategy and forward view of the delivery plans. Linkage to operational performance and staff survey measures with in-year targets. **Engagement & Leadership**: **Significant Assurance** Trust level and local engagement on 2023 staff survey with clear actions. 2024 survey launched in September with adjustments reflecting experience to improve reach into all areas. National sexual safety at work charter and anti-racist organisation commitments. **Education:** **Significant Assurance** Statutory compliance - six month stable, maintaining 89% compliance v. 90% target. Positive Medical student / GMC survey results for 2024 with specific improvement areas identified. Apprenticeship completions strong. **Violence & Prevention Standards:** **Significant Assurance** Trust wide programme for recording and prevention / reduction of incidents including security interventions, de-escalation and distraction training in clinical areas with risk assessments for patients presenting as high risk of violent and aggressive behaviour. **Safe Staffing**: **Significant Assurance** Comprehensive report giving evidence of processes and outcomes / actions taken to monitor and ensure safe staffing against national care quality standards. Acknowledgement of much stronger positions on achieving establishment staffing levels with continued progress on agency usage. **Workforce Supply & Demand:** **Significant Assurance** Structured approach to workforce planning component of the 2025/26 business planning. Process and data improvements identified in 2024/25 to be incorporated. **Equality, Diversity & Inclusion (EDI)**: **Significant Assurance** DBTH EDI improvement plan aligned to NHS goals for diversity and inclusivity. Progress on 6 high impact action areas with plans to incorporate neurodiversity adjustments into recruitment, training and workplace. Reciprocal Mentoring and Board Development Delegate programmes becoming embedded. **Audit & Assurance Committee:** Reports and action plans noted for: **Bank & Agency Control:** Limited assurance audit opinion **Pay Expenditure:** Significant assurance audit opinion	**Board Assurance Framework (including Trust Risk Register)** Updated and endorsed for submission to the Board. **People Committee – Workplan for 2025** Updated and confirmed against the refreshed Terms of Reference approved by the Board in November 2024.

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

2501 - C8 CHAIR'S ASSURANCE LOG - CHARITABLE FUNDS COMMITTEE

Discussion Item | Hazel Brand, Non-executive Director | 11:35

5 minutes

REFERENCES

Only PDFs are attached

C8 - Chair's Assurance Log - Charitable Funds Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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

Subject:	**Charitable Funds Committee Meeting**	**Board Date: January 2025**
Prepared By:	Hazel Brand, Committee Chair & Non-executive Director	
Approved By:	Committee Members	
Presented By:	Hazel Brand, Committee Chair & Non-executive Director	
Purpose	The paper summarises the key highlights from the Charitable Funds Committee meeting held on Thursday 5 December 2024	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissioned**
The Head of Charity (HoC) has tendered his notice to leave. This, with a further recruitment process, could lead to a disruption of previously agreed fund-raising plans/targets. **Partial assurance** For the first 7 months of 2024/25, the Charity had a deficit of £80k: income from all sources was £412k, total expenditure was £592k, and gains on investments was £100k. Total overall funds are £3.1m. Growing the charitable income is a key plank of the HoC's action plan. **Moderate assurance** Colleagues taking a place in an activity facilitated by the Charity, e.g. the London Marathon, must carry out the event to raise funds for the Charity and have appropriate branding. **Moderate assurance**	A pilot public lottery had been set up, beginning on 9 December. A draft Vision & Mission was considered; Zara Jones to present to a Board development session. Policies on Use of the Estate; Privacy; Fundraising; Gift Acceptance, Refusal & Return; Complaints; and Treating People Fairly to be drafted. A risk register to be developed. Take legal advice on taking over another charity, e.g. Cancer Detection Trust.
Significant or Full Assurances	**Decisions Made**
An investment update was given by LGT Wealth Management. **Significant assurance**	Trustees agreed that paper B2 (Approval of Expenditure) was not appropriate for trustees and the decision should be made by Doncaster & Bassetlaw Healthcare Services Ltd. Approved the draft Annual Report & Accounts 2023/24. At the March 2025 meeting, review Doncaster & Bassetlaw Healthcare Services Ltd management of the Charity and its operation.

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
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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.

2501 - C9 STANDING FINANCIAL INSTRUCTIONS, STANDING ORDERS AND SCHEME OF DELEGATION

Decision Item | Jon Sargeant, Chief Financial Officer | 11:40

10 Minutes

REFERENCES

Only PDFs are attached

- C9 - Standing Financial Instructions, Standing Orders and Reservation & Delegation of Powers.pdf
- C9 - Appendix A Standard Financial Instructions.pdf
- C9 - Appendix B BOD Standing Orders.pdf
- C9 - Appendix C Reservation and Delegation of Powers.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**C9**
Report Title:	**Standing Financial Instructions, Standing Orders and Reservation and Delegations of Powers to the Board**		
Sponsor:	Jon Sargeant – Chief Financial Officer		
Author:	Rebecca Allen - Associate Director Strategy, Partnerships and Governance		
Appendices:	Appendix A, B and C – Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation of Powers		

Report Summary

Purpose of the report & Executive Summary

As part of annual governance arrangements, the above documents have been reviewed and updated where appropriate. They went to the Audit and Risk Committee in September 2024, where they were agreed in principle with a few additional updates, before being recommended to the Board of Directors to approve.

The summary of changes are shown on each of the appendices and in summary these are:

- minor updates to job titles, presentation and typographical errors,
- Changes to reflect that petty cash facilities are no longer available across the Trust and as such, any staff expense reclaims need to go through the payroll expenses system.
- updates gender neutral language
- updates to show changes to reporting lines for losses and compensations that are shared at Audit and Risk Committee.
- Updates to reflect procurement legislative changes following the UK exit from the European Union and changes.
- Use of the UK 'Find a Tender Service' for procurement activities
- Reflections of changes to committee name – Quality Committee.

There is also a section outlining the role of the Grip and Control meetings, in assisting Divisions perform their delegated responsibilities.

These documents may be reviewed sooner than annually, if required, in line with changes to governance structures and processes at organisational and system level. A full review of these documents is likely with the new Chief Financial Officer, and to clarify the responsibilities and timetable of review for these governance documents for 2025/26.

Recommendation:	The Board of Directors are asked to **approve** the updated documents, previously recommended by the Audit and Risk Committee			
Action Required:	**Approval**	~~Review and discussion~~	~~Take assurance~~	~~Information only~~

Healthier together – delivering exceptional care for all

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

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

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

Assurance Route	
Previously considered by:	Audit and Risk Committee
Date:	September 2024
Any outcomes/next steps	If the Board of Directors approve these documents, they will be uploaded onto the DBTH website, in line with our Scheme of Publication.
Previously circulated reports to supplement this paper:	N/A

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions
September 2024

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	Matthew Bancroft – Head of Financial Control Jon Sargeant – Chief Financial Officer
Date written/revised:	September 2024
Approved by:	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2025
Target audience:	Trust-wide

Standing Financial Instructions

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 12	September 2024	• Minor typographical/layout changes • Updated guidance with regards to petty cash not being used within the Trust • Updated Procurement guidelines and threshold values • Updated 'Find a tender' service	Matthew Bancroft Richard Somerset Rebecca Allen
Version 11	July 2023	• Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Alex Crickmar Fiona Dunn Richard Somerset
Version 10	July 2022	• Removed references to NHS Improvement • Updated job titles • Introduction of IFRS 16 within capital section • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
Version 9	July 2021	• "Chairman" replaced by "Chair" • Updated reference to NHS Improvement/NHS England. • Clarified Procurement process for £25k-£50k	Matthew Bancroft
Version 8	July 2020	• Updated job titles throughout • Updated the NHS Logistics provider details • Updated references to NHSI/NHSE throughout. • Updated references to procurement legislation and the impact of leaving the EU • Updated references to "Estate code" • Updated references to "NHSLA"	Matthew Bancroft
Version 7	March 2019	• Updated names of structures/meetings • Updated sections relating to PBL, Data Protection, Health & Safety and budget virements.	Jon Sargeant
Version 6	30 January 2018	• Updated sections on Audit, Budgets, funded/ budgeted establishment, Banking, Payment of Directors and Employees, Non Pay Expenditure, Funds Held on Trust • Procurement and Tendering Appendix added	Winston Weir

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FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1. INTRODUCTION

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2. These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer subject to review by the Finance and Performance Committee.

1.1.3. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer **must be sought before acting**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4. **Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.**

1.2. Terminology

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

“the Board”	means the board of directors as constituted in accordance with the Trust Constitution;
"Budget"	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
"Budget Holder"	means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;
“Chair”	means the Chair of the Trust appointed in accordance with the Trust Constitution;
“Chief Executive”	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Constitution"	means the Trust Constitution and all annexes to it;

"Director"	means a director on the Board of Directors;
"Chief Finance Officer"	means the Chief Finance Officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Legal Adviser"	means the properly qualified person appointed by the Trust to provide legal advice;
"NHS England"	means the body corporate known as NHS England;
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Officer"	means an employee of the Trust;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

1.2.2. Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3. Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document.

1.3.3. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as Accountable Officer to NHS England, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6. It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7. <u>The Chief Finance Officer is responsible for:</u>

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

And, without prejudice to any other functions of directors and employees to the Trust, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to the Trust and its directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8. All directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with Standing Orders and the Audit Code for Foundation Trusts, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook.

The Board has established the Audit and Risk Committee to perform the role of the Audit Committee along with additional responsibilities in relation to risk management and assurance. The sub-committee will provide an independent and objective view of internal controls and risk management by:

(a) overseeing Internal and External Audit services;

(b) reviewing all internal audit reports;

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) ensuring that there are adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work;

(f) assessing and providing assurance to the Board on the validity of the control environment within the Trust

(g) reviewing schedules of losses and compensations and making recommendations to the Board;

(a) reviewing controls assurance systems, including disseminating relevant information to governors; and

(b) reviewing risk management arrangements.

The Board shall satisfy itself that at least one member of the committee has recent and relevant financial experience.

2.1.2 Where the committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chair of the committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England. (To the Chief Finance Officer in the first instance.)

2.1.3 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided and the committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 Fraud and Corruption

2.2.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with directions on fraud and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS).

2.2.3 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

2.2.4 The Local Counter Fraud Specialist will provide a written report to the Audit and Risk Committee, at least annually, on counter fraud work within the Trust and national context.

2.3 Security Management

2.3.1 The Chief Executive will monitor and ensure compliance with directions on NHS security management.

2.3.2 The Board shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS).

2.3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated by the Chief Executive to the Director responsible for Security Management (SMD) and the appointed Local Security Management Specialist (LSMS).

2.3.4 The LSMS shall work with the staff in NHS Counter Fraud Authority.

2.3.5 The LSMS will provide a written report, at least annually, to the Audit and Risk Committee on security management work within the Trust.

2.4 Chief Finance Officer

2.4.1 The Chief Finance Officer is responsible for;

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the mandatory audit standards;

(c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board. The report must cover:

(i) a clear statement on the effectiveness of internal control,
(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

2.4.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.5 Role of Internal Audit

2.5.1 Internal audit will provide an independent and objective opinion on risk management, control and governance arrangements by measuring and evaluating their effectiveness. The Head of Internal Audit will provide an annual opinion on the whole system of internal control.

2.5.2 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the integrity, reliability and suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.5.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

2.5.4 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all committee members, the Chair and Chief Executive of the Trust.

2.5.5 The Head of Internal Audit shall be accountable to the Audit and Risk Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit and Risk Sub-Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the best practice guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.6 External Audit

2.6.1 The external auditor is appointed by the Council of Governors and paid for by the Trust, in accordance with paragraph 35 of the Constitution. The auditor must be a member of one or more of the bodies referred to in paragraph 11, Annex 6 of the Constitution.

2.6.2 The Council of Governors must ensure that the auditor meets the criteria included by the Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General at the date of appointment and on an ongoing basis throughout the term of their appointment.

3. PRUDENTIAL BORROWING REQUIREMENT CONTROL

No longer required

4. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 In addition the Chief Finance Officer will annually compile, and submit to the Board, such financial plans as required by NHS England.

4.1.3 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the annual business plan;
- accord with workload and staffing plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks; and
- comply with NHS England requirements and other regulations

4.1.4 The Chief Finance Officer shall monitor financial performance against budget and business plan monthly and report to the Board and Financial Oversight Committee appropriately.

4.1.5 All budget holders must provide information in a timely manner as required by the Chief Finance Officer to enable budgets to be compiled.

4.1.6 All Budget Holders will sign up to their allocated Budgets at the commencement of each financial year.

4.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer. In defining what is either non-recurring or recurring the Chief Finance Officer will have the final decision.

4.3 Budgetary Control and Reporting

4.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

- income and expenditure to date showing trends, forecast year-end position, and variances against budget;
- balance sheet;
- cashflow;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- movements in reserves;
- details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and staffing budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers or virements.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not

incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

4.3.3 Detailed rules relating to budgetary virement are set out in Appendix 3.

4.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12.)

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS England and other parties as required.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by NHS England, the Trust's accounting policies, Government Accounting Manual and international financial reporting standards (IFRS);

(b) prepare and submit annual financial reports in accordance with current guidelines; and

(c) submit financial returns for each financial year in accordance with the guidance and timetable prescribed by NHS England.

5.2 The Trust's audited annual accounts and auditor's report and Quality Accounts must be presented to the Board of Directors for approval or to Audit and Risk Committee by delegation from the Board and to a general meeting of the Council of Governors.

5.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at the Annual Members' Meeting. The document will comply with NHS England's Annual Reporting Manual (ARM).

6. BANK AND GOVERNMENT BANKING SERVICE ACCOUNTS

6.1 General

6.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by NHS England.

6.1.2 The Board shall approve the banking arrangements.

6.2 Bank and Government Banking Service Accounts

6.2.1 The Chief Finance Officer is responsible for:

(a) Setting arrangements in place that NHS Shared Business Service compiles with its contract with the organisation for bank and banking services

(b) Commercial bank accounts and accounts operated through the Government Banking Service (GBS);

(c) establishing separate bank accounts for the Trust's non-exchequer funds;

(d) ensuring payments made from commercial banks or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

(e) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Procedures

6.3.1 The Chief Finance Officer will prepare detailed instructions (agreed with NHS Shared Business Services) on the operation of commercial bank and GBS accounts which must include:

(a) the conditions under which each commercial bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.3.3 Payments over £10,000 shall be supported by more than one authorised signature on the cheque or authority to pay as appropriate.

6.3.4 The Chief Finance Officer shall nominate members of his staff who are authorised to act as signatories in respect of commercial bank and GBS accounts.

6.4 Tendering and Review

6.4.1 The Chief Finance Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.2 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.3 The Chief Finance Officer shall be responsible for implementing any such guidance issued by NHS England in relation to the costing and pricing of services, and in particular services provided to NHS Commissioning bodies.

7.3 Debt Recovery

7.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of

officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss. Where receipt of such indemnities is problematic or unclear no such items shall be held in Trust safes.

7.4.5 A cheque and payable order register shall be kept in which all cheque and payable order stocks ordered, received and issued shall be recorded and signed for by nominated officers.

8. CONTRACTING FOR PROVISION OF SERVICES

8.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

8.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.

8.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income (linked to contract activity) with a detailed assessment of the impact of the variable elements of income and an assessment of any significant risks faced.

8.4 This also includes both partnership and provision of facilities arrangements to private healthcare providers in their provision of health care and diagnostic services to patients.

9. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders, the Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

(i) Identify and appoint candidates to fill Executive Director positions when they arise.

(ii) Identify and nominate a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

(iii) Decide any matter relating to the disciplining or the continuation in office of any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.

(iv) Monitor and evaluate the performance of individual Executive Directors on an annual basis.

(v) Decide and review the terms and conditions of office of Executive Directors and senior managers on locally-determined pay in accordance with relevant Trust policies, including:

a. Salary, including any performance-related pay or bonus;
b. Provisions for other benefits, including pensions and cars; and
c. Other allowances.

(vi) Decide all contractual arrangements for Executive Directors, including, but not limited to, termination payments.

9.1.3 The Committee shall report to the Board regarding its recommendations.

9.1.4 The Trust will remunerate the Chair and Non-executive Directors in accordance with instructions issued by the Council of Governors.

9.2 Funded/Budgeted Establishment

9.2.1 The staffing plans incorporated within the annual budget will form the funded / budgeted establishment. The funded/ budgeted establishment will list out the grade, amount, whole time equivalent for the relevant department(s) and must be set out and agreed each financial year.

9.2.2 The funded/budgeted establishment of any department may not be varied without the approval of the Chief Executive and Director of People & OD.

9.2.3 The funded/budgeted establishment of any clinical department will take account of the required safe levels of clinical staff as necessary for the running of those services.

9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration;

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Processing of Payroll

9.4.1 The Chief People Officer is responsible for:

(a) ensuring that arrangements in place so that the Trust receives an effective and efficient payroll service

(b) specifying timetables for submission of properly authorised time records and other notifications;

(c) the final determination of pay;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

9.4.2 The Chief People Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for pension, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payments to employees;

(i) procedures for the recall of bank credits

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately.

9.4.4 Where the Chief People Officer has contracted with another body to administer the Trust's payroll service responsibility for compliance with the above requirements remain with the Chief People Officer.

9.4.5 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to a manager for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9.6 Directors and Staff Expenses

9.6.1 Claims for expenses should be submitted in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

9.6.2 All claims should be submitted for authorisation, along with any accompanying receipts, as soon as possible after the end of the month concerned. However, all claims must be submitted within three months of the month in which the claim arose. Any claim periods in excess of this deadline will not usually be paid.

9.6.3 Once authorised, claims will be paid in accordance with current guidelines and regulations.

9.6.4 Claimants must not make duplicate claims for expenses from any other body in addition to that from the Trust.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought. Wherever appropriate, the supply of goods and services shall be covered by a contract following a competitive exercise.

10.2.2 The Trust's Head of Procurement shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

10.2.3 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds (whole life costs) should be incorporated in standing orders and regularly reviewed (see Appendix 4);

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and

services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

(f) be responsible for ensuring that all payments made by the Trust fall within its powers.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director must provide, in the form of a written report, a case setting

out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered, even where electronically generated;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with public procurement regulations);

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and NHS England/NHS Improvement;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered in advance on an official order as outlined in the Procurement Policy. All invoices received where an order is not already in place will be returned;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. All such instances shall be reported to the Chief Finance Officer and followed up with an official purchase order;

(h) No orders shall be issued retrospectively of the items being received or the service being delivered;

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are not permitted and any such expenditure should be performed on an exception basis, and reclaimed through the payroll expenses system.

10.2.7 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Legally Binding Agreements (e.g. leases)

10.3.1 Any leases or rental agreements must be vetted by the Chief Finance Officer prior to final agreement, to enable insurance issues and technical accounting treatment to be determined. In addition, all leases entered into on behalf of the Trust should represent value for money.

10.3.2 All lease agreements must be signed on behalf of the Trust by the Chief Finance Officer (or his deputy) in addition to being accompanied by the usual order and duly authorised in accordance with these SFIs.

10.4 Grants to Local Authorities and Voluntary Bodies

10.4.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 or section 64 of the Health Service and Public Health Act 1968 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

10.4.2 The financial limits for officers' approval of grants are set out in the Scheme of Delegation.

11. EXTERNAL BORROWING AND INVESTMENTS

11.1 External Borrowing

11.1.1 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHS England for NHS Foundation Trusts. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning Public Dividend Capital debt and all loans and overdrafts.

11.1.2 Any application for PDC, a loan or overdraft will only be made by the Chief Finance Officer or by an employee so delegated by him. Also, such applications must however first be authorised by the Board.

11.1.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for PDC, loans and overdrafts.

11.1.4 All borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

11.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan. Where there is a need to vary from this principle due to unforeseen in year events a revised business plan will be prepared and provided to the Board to support its deliberations when considering the need to borrow.

11.2 Investments

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board and within such government guidance as may be in place from time to time. The need to prudently manage public funds from unnecessary risk will be a key factor in any decision making regarding what bodies to deposit such funds with.

11.2.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

(d) shall ensure that processes and procedures are in place to monitor, record and report spend against each element of the Capital programme.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "The efficient management of healthcare estates and facilities" (previously "Estatecode") and other official guidance that may become available from time to time.

The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "The efficient management of healthcare estates and facilities" guidance and the Trust's Standing Orders.

12.1.5 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.1.6 Due to the introduction of IFRS 16, for the avoidance of doubt, leases of over 12 months in length should follow the process for capital projects.

12.2 Private Finance

12.2.1 Where appropriate the possibility of attracting private finance will be investigated for capital expenditure proposals.

12.2.2 The Chief Executive will consider such proposals along with all other bids received, in line with the Trust's priorities.

12.2.3 Where the proposal is approved the private sector will be invited to submit their bids based upon clear, high level, service based objectives.

12.2.4 Once the private sector bids have been received the Chief Finance Officer will provide or commission any specialist assistance to allow the bids to be appraised on a like for like basis.

12.2.5 The Chief Executive shall be responsible for deciding upon the preferred shape of the proposed contract and inviting the bidders to tender.

12.2.6 The Chief Finance Officer shall ensure that all privately financed proposals represent value for money and genuinely transfer risk to the private sector.

12.2.7 Proposals which include the lease of equipment and/or buildings will be tested for Value for Money and the Transfer of Risk by the Capital Accountant.

12.2.8 To allow this appraisal of the lease to take place the following financial details shall be obtained:

(a) Capital value of asset(s) supplied;
(b) Minimum lease period;
(c) Minimum lease payment;
(d) Frequency of lease payment, including details as to whether required in arrears or advance;
(e) Premium for payment by non-direct debit method if applicable;
(f) Interest rate implicit in the lease (if available).

12.2.9 Figures shall be requested for a number of different lease periods, to identify the option,

which gives the best returns for the Trust, and be exclusive of VAT.

12.2.10 For comparative purposes the capital value of the asset supplied will be the value at the start of the contract plus the discounted value of any enhancements during the minimum lease term less the discounted value of any disposal proceeds at the end of the lease term.

12.2.11 The fundamental requirements of a PFI proposal with regards risk are that it is allocated to the party which is best able to manage it and that it is genuinely transferred to the private sector.

12.2.12 By achieving optimum risk transfer between the parties to the PFI proposal there is a greater likelihood that value for money will also be achieved.

12.2.13 The risks associated with a project typically fall under the following headings:

(a) Design and Construction Risks;

(b) Commissioning and Operating Risks;

(c) Demand, Volume or Usage Risks;

(d) Technology and Obsolescence Risks;

(e) Regulation and Other Risks;

(f) Project Financing Risks.

12.2.14 The Value for Money attributable to a project is tested by comparing the net present value (or cost) of the estimated annual cash flows over an appraisal period equivalent to the PFI contract term.

12.2.15 In addition the PFI proposal shall be assessed for its affordability. This will show whether the proposal is affordable to the Trust and that the impact on prices can be afforded by the Trust's main commissioner.

12.2.16 The Chief Finance Officer will be notified in advance of all lease and PFI agreements before any commitment is made.

12.2.17 The Chief Executive will ensure that all proposed agreements are scrutinised by either in-house experts or the Trust's Solicitors to ensure that the agreements are comprehensive and are not disadvantageous to the Trust.

12.2.18 The Board must specifically agree all PFI proposals before any contracts are signed.

12.2.19 When comparing the financials of the various options VAT shall be included within the calculation in so far as it is irrecoverable. The Chief Finance Officer shall engage professional VAT advisers to facilitate this where it is felt necessary.

12.3 Asset Registers

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year. Where systems are in place to monitor these on an ongoing basis a rolling programme of checks and/or sampling will be acceptable.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be based on good accounting practice.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with good accounting practice and NHS England guidelines. A periodic revaluation of land and buildings will be undertaken, by an independent professional valuer, as required by accounting guidelines.

12.3.7 The value of each asset shall be depreciated using methods and rates as specified in accounting standards.

12.3.8 The Chief Finance Officer or his nominated representatives shall calculate capital charges.

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and similar items of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. Where stock control systems allow this may be undertaken on a rolling or sample basis as is felt best to ensure the accurate control and recording of stock.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also Chapter 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Supply Chain Coordination Limited (SCCL) central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the recharge.

13.9 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification.

13.10 The issue of stores shall be supported by an authorised requisition note and a receipt for the stores issued shall be returned to the Procurement Department, Issuing Department, or Chief Finance Officer.

13.11 Where a 'topping up' system is used a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variances.

13.12 All transfers and returns shall be recorded on forms provided for the purpose and approved by the Chief Finance Officer.

13.13 Breakages and other losses of goods in stores shall be recorded as they occur and a summary shall be presented to the Chief Finance Officer at regular intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, e.g. shrinkage in the case of certain food stuffs and natural deterioration of certain goods.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

The Trust may not dispose of any protected property without the approval of NHS England.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

14.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

14.2 Losses and Special Payments

14.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS, who will then inform NHS Counter Fraud Authority in accordance with Secretary of State for Health's Directions.

The Chief Finance Officer must ensure that NHS Counter Fraud Authority and the External Auditor are notified of all frauds.

14.2.3 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Finance Officer must immediately notify:

(a) the Board, and

(b) the External Auditor.

14.2.4 The Board shall approve the writing-off of losses. The level of delegation to Senior Officers of the Trust are set out in the Reservation of Powers to the Board and Delegation of Powers section 5, paragraph 11.

14.2.5 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

14.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 All losses and special payments must be reported to the Audit and Risk Committee at every meeting although the identities of individuals should not be reported unless requested.

15. INFORMATION TECHNOLOGY

15.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

15.2 The Chief Finance Officer shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 In the case of computer systems which are proposed General Applications, all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

15.6 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

15.7 The Chief People Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that is made publicly available.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the verbal advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where it is a requirement for the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) or other statue, the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the duel accountabilities to the Charity Commission for charitable funds held on trust and to NHS England for all funds held on trust.

17.1.2 The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.1.3 As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust. Any further guidance is set out in the Charitable Funds Policy (approved by Board of Directors on an annual basis).

17.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.5 The Chief Finance Officer shall maintain such accounts and records, including an investment register, as may be necessary to record and protect all transactions and funds of the Trust as trustees of funds held on trust.

17.2 Existing Trusts

17.2.1 The Chief Finance Officer shall make arrangements for the administration of all existing funds held on trust and shall produce instructions covering every aspect of the financial management of the funds.

17.2.2 The Chief Finance Officer shall periodically review the funds in existence and shall make

recommendations to the Board regarding the potential for rationalisation, within statutory guidelines.

17.3 New Trusts

17.3.1 The Chief Finance Officer shall arrange for the creation of a new trust where funds and/or other assets are received and cannot be adequately managed as part of an existing trust.

17.3.2 When making such as assessment as outlined in 17.3.1 above the needs for simplicity of administration and therefore downward pressure on costs shall also be considered.

17.4 Sources of New Funds

17.4.1 In respect of donations, the Chief Finance Officer shall:

(a) provide guidelines to officers of this Body as to how to proceed when offered funds. These to include:

(i) the identification of the donor's intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted and accepted.

17.4.2 The Chief Finance Officer shall deal with all Legacies and Bequests.

17.4.3 In respect of Fundraising, the Chief Finance Officer shall:

(a) deal with all arrangements for fund-raising by and/or on behalf of this Body and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge. The Chief Finance Officer shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) for alerting the Board to any irregularities regarding the use of this Body's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

17.4.4 In respect of Trading Income, the Chief Finance Officer shall:

(a) be primarily responsible with other designated officers, for any trading undertaken by this Body as corporate trustee; and

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

17.4.5 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 Investment Management

17.5.1 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) the formulation of investment policy within the powers of this Body under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Chief Finance Officer shall agree the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to approve;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

17.6 Disposition Management

17.6.1 The exercise of this Body's dispositive discretion shall be managed by the Chief Finance Officer in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Body; and

(f) the definitions of "charitable purposes" as agreed by the Charity Commission.

17.7 Banking Services

17.7.1 The Chief Finance Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Body as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

17.8 Asset Management

17.8.1 Assets in the ownership of or used by this Body as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Body. The Chief Finance Officer shall ensure:

(a) that appropriate records of all assets owned by this Body as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust are accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for;

(e) all share and stock certificates and property deeds shall be deposited either with the Trust's bankers or, where this is not practicable, held securely at trust premises.

17.9 Reporting

17.9.1 The Chief Finance Officer shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

17.9.2 The Chief Finance Officer shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Board.

17.10 Accounting and Audit

17.10.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

17.10.3 The Board shall be advised by the Chief Finance Officer on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

17.11 Administration Costs

17.11.1 The Chief Finance Officer shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

17.12 Taxation and Excise Duty

17.12.1 The Chief Finance Officer shall ensure that this Body's liability to taxation, duties and other such charges is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17.13 Authorisation Levels of Expenditure from Trust Funds

17.13.1 The Board has established levels of authorisation necessary for expenditure from the funds held on trust, these are set out in the Reservation of Powers to the Board and Delegation of Powers section 5, paragraph 8.

These will be reviewed on a regular basis to ensure that they remain at an appropriate financial level.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained following good practice under the direction contained in Department of Health guidelines.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 Programme of Risk Management

19.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

19.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to complete the annual governance statement within the Annual Report and Accounts.

19.1.3 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

19.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution (previously NHS Litigation Authority) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3 Insurance Arrangements with Commercial Insurers

19.3.1 The Board shall decide if the Trust will insure with commercial insurers to supplement or replace the cover available through the risk pooling schemes. If the Board decides to use commercial insurers this decision shall be reviewed annually.

19.4 Arrangements to be followed by The Board in Agreeing Insurance Cover

19.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

19.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision.

19.4.3 The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19.4.4 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Board Company Secretary shall ensure that all staff are made aware of the Trust Policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the department of health standards of business conduct for NHS staff set out in "Code of Conduct for Directors and employees".

APPENDIX 1 - INVESTMENTS

INVESTMENTS

1. The Chief Finance Officer shall ensure that all funds are invested in the name of the Trust. No officer other than the Chief Finance Officer shall open accounts to invest funds on behalf of the Trust.

2. The Chief Finance Officer shall advise bankers and other approved deposit facilities in writing of the conditions under which each account shall be operated.

3. Transfers of funds from bank and GBS accounts to investment accounts must be authorised by two signatories.

APPENDIX 2 – SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

1. All cash, cheques postal orders and other forms of payments received by an officer other than a cashier shall be entered immediately on an approved form. All cheques and postal orders shall be crossed immediately "Not negotiable -A/c Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust". The remittances shall be passed to the cashier from whom a signature shall be obtained.

2. The opening of coin operated machines and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Chief Finance Officer and the coin box keys shall be held by a nominated officer.

3. Where amounts of cash have to be transported, special arrangements shall be made by the Chief Finance Officer with a specialist security firm. Under no circumstances shall cash in excess of (£500) be transported by only one officer and the route travelled and times of collection shall be varied as far as practicable.

4. During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in his place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

5. All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

6. Staff shall be informed on appointment, by the appropriate departmental or senior officers, of their responsibilities and duties for the collection, handling or disbursement or cash, cheques, etc, in line with appropriate financial procedures. This must be in writing, acknowledged, and acknowledgement retained.

7. Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned shall be reported immediately to the Chief Finance Officer

APPENDIX 3 – BUDGETARY VIREMENT

BUDGETARY VIREMENT

1. Virement is the term used to define the movement of funds from one budget heading to another.

2. Virement within Individual Budgets:

2.1 Where a budget holder is expected to be under spent at the year-end, the budget holder may be allowed to offset this under spending against overspendings elsewhere in his/her budget, subject to the criteria itemised below.

2.2 Budget holders are not allowed to use non-recurrent savings for recurrent commitments, for example, savings on equipment purchased cannot be used to appoint new permanent staff.

2.3 Subject to the overall financial position of the individual Division and the Trust, virement will be allowed using the following criteria:

(a) Efficiency/CIP targets are being achieved;
(b) The predicted year end expenditure will be within budget;
(c) The predicted year end income will at least achieve the target;
(d) The proposed expenditure is within overall policy, i.e. virement cannot be used to initiate a development of a new / existing service, which is not policy;
(e) All other targets are being achieved;
(f) Approval has been obtained from the Chief Finance Officer.

2.4 Virement between Divisions:

Expected underspendings can be transferred to another Division subject to the agreement of both budget holders and the same constraints as above.

2.5 Virement between Revenue and Capital:

This can only be done in exceptional circumstances when approved in advance by the Chief Finance Officer.

2.6 Budgetary and Virement Limits of the Chief Executive:

Budgetary or virement limits of the Chief Executive delegated by the Board are outlined in the Scheme of Delegation

APPENDIX 4 - PROCUREMENT AND TENDERING

1 INTRODUCTION

1.1 The Trust's Standing Financial Instructions (SFI's) set out procedures to be adopted in obtaining goods and services.

1.2 This supplementary procedure note deals with the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and detailed procedures in relation to procurement and tendering.

1.3 The Chief Finance Officer (or Deputy in his absence) must personally authorise any contract which commits the Trust to expenditure from £5,000 up to £250,000 as determined by the scheme of delegation. The Chief Executive (or Chief Finance Officer in his absence) must authorise all expenditure from £250,000 to £1,000,000. Any contract over £1,000,000 requires Board approval before Chief Executive authorization.

1.4 Any commitment on behalf of the Trust in respect of all capital projects and financial commitments, including leases, costing between £0.5m and £1.5m, in their entirety if included in the Trust's Annual Plan or Capital Plan must be approved by the Trust's Corporate Investment Group (CIG). Any proposals above £0.5m and below £1.5m which have not already been approved in the Trust's Annual Plan or Capital Plan must be submitted to CIG for review and recommendation to the Board. These costs are whole life costs. All expenditure in excess of £1.5m requires approval of the Board.

1.5 In addition to the Trust delegated tendering limits, attention must be paid to the UK procurement regulations and any subsequent procurement legislation that become statutes following the UKs exit from the European Union in all cases advice should be sought from the Head of Procurement Head of Procurement to ensure compliance with appropriate thresholds.

2 COMPETITIVE TENDERING (Over £35,000)

2.1 The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most competitive price. The standard method of procurement will be by competitive tender for goods or services expected to cost in excess of £35,000; this may be waived under the following circumstances:

- Where the requirements are ordered under existing contracts or where in the opinion of the Finance Director:

- there is only one supplier and no reasonably satisfactory alternative product/service;

- competition would be impractical, impossible or not beneficial;

- the requirement is to be ordered under existing contracts;

- the work for practical reasons must be of the same manufacture, for instance repairs/spare parts for existing equipment;

- where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

2.2 In any of these circumstances the detail should be documented and the authorisation counter-signed by the Head of Procurement in confirmation of such circumstances.

3 COMPETITIVE AND NON-COMPETITIVE QUOTATIONS (£35,000 and under)

3.1 Three competitive quotations must be obtained for all contracts and services where the value is not expected to exceed £35,000 but is above £10,000. For quotations over £35,000, these must be undertaken by the Procurement Department.

3.2 Non-competitive quotations in writing may be obtained for the following purposes:

(a) where the supply of goods (or related goods) is of a special character and does not exceed £10,000;

or where in the opinion of the Finance Director:

(b) there being only one supplier and no reasonably satisfactory alternative product/service;

(c) competition would be impractical, impossible or not beneficial;

(d) the requirement is to be ordered under existing contracts;

(e) the work for practical reasons must be of the same manufacture, for instance, repairs/spare parts for existing equipment;

(f) where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the Head of Procurement in confirmation of such circumstances.

3.3 Officers should involve the Head of Procurement in choice of supplier, price negotiation and in the procurement process for all goods and services.

3.4 Where the supplier being used is nationally or regionally approved, and/or they are providing a continuous supply in operational terms, it may be appropriate to use annual orders duly authorised as appropriate. Annual orders must include a clear schedule of the items being ordered, their agreed individual prices, an estimate of the volumes required of each item for the period of the order and hence an agreed total cost which must not be exceeded. The advice of the Head of Procurement should be sought when establishing such annual orders to ensure that the correct format is applied and that value for money is obtained.

3.5 No single supplier or single annual order should be used for a period in excess of 12 months. The advice of Head of Procurement should be sought. Where this advice is not sought or not acted upon the requisitioner must advise the Chief Executive in writing seeking waiver of this rule.

4 TENDERING PROCEDURES

4.1 The basic procedures to be followed in relation to competitive tenders are set out below.

4.2 In all cases the tender that provides the best value for money must be accepted using a defined combination of cost and quality. Any proposal to waive this rule would need the approval of:

- goods/services in excess of £10,000 and up to UK Threshold (Find a Tender Service) of £111,750 — Chief Finance Officer

Anything over UK Threshold (Find a Tender Service) needs initial advice from the Head of Procurement before commencement.

4.3 Officers with any doubts concerning the appropriateness of competitive tendering in particular circumstances must seek formal clarification from the Chief Finance Officer. The Trust will not be responsible for officers committing costs other than in accordance with the above procedures.

4.4 Tenders shall be advertised, issued and submitted on the Trust's e-tendering system.

4.5 Every tender for building and engineering works, except any tender for maintenance work only, where "The efficient management of healthcare estates and facilities" guidance should be followed, shall embody or be in the terms of the current Edition of the Standard Form of Building Contract Local Authorities Edition with (or, where appropriate, without) quantities or the Agreement for Minor Building Works issued by the Joint Contract Tribunal as appropriate or (when the contents of the works is primarily engineering) the General Conditions of Contracts recommended by the Institute of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil

engineering work) the General Conditions of Contract recommended by the Institution of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These base documents should be modified and amplified to accord with current Departmental guidance forms of contract may be used after prior consultation with the Department.

4.6 Tenders submitted via e-tendering will be electronically date and time stamped.

4.7 Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

4.8 Alterations to tenders submitted via e-tendering will be electronically marked.

4.9 Tenders received after the due time and date may be considered only if the Chief Executive decides that there are exceptional circumstances, e.g. where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenderers concerned. The Chief Executive shall decide whether such tenders are admissible and where re-tendering is desirable.

4.10 Technically late tenders (i.e. those uploaded in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

4.11 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

4.12 Necessary discussion with a tenderer of the contents of his tender, in order to elucidate technical, etc, points before the award of a contract, need not disqualify the tender.

4.13 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tenders will remain electronically unopened.

4.14 Where only one tender/quotation is sought and/or received, the Trust shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

4.15 Every contract for building and engineering works, except measured term contracts where Estmancode guidance should be followed, should be embodied in a formal contract document which should conform to these Standing Financial Instructions. These formal contract documents should reflect any change in the terms and conditions of contract agreed following receipt of tenders.

4.16 No goods, services or works other than works and services, executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, which may be in hard copy or electronic media. Contractors shall be notified that they should not accept orders unless in an official format. Verbal orders shall be issued only in specific

instances, the first being by an officer designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". The second being by the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Chief Finance Officer.

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Financial instructions –June 2022 - CORP/FIN 1 (B) v.10	CE/Finance	Matthew Bancroft	Existing Policy	September 2024

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework within which the Trust can properly conduct its financial affairs and transactions.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: September 2025

Checked by: Matthew Bancroft Date: August 2024

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Orders
Board of Directors
September 2024

NHS Foundation Trusts must agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers. These documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Provisions within the Standing Orders which are not subject to suspension under SO 5.40 are indicated in italics.

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, <u>it is only valid for 24 hours.</u>**

Name and title of author/reviewer:	Matthew Bancroft – Head of Financial Control Jon Sargeant – Chief Financial Officer
Date written/revised:	September 2024
Approved by (Committee/Group)	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2025
Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 14	September 2024	• Updated job titles and Committees • Corrected minor typographical errors. • Updated Procurement references to EU tender regulations • Addition of 'find a tender service' and threshold values	Matthew Bancroft Rebecca Allen Richard Somerset
Version 13	July 2023	• Updated Board composition • Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB • Updated use of common seal to be clear when this is applied.	Alex Crickmar Fiona Dunn Richard Somerset
Version 12	July 2022	• Removed references to NHS Improvement • Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
Version 11	July 2021	• Removal of appendix 1 – Temporary COVID19 Business continuity Terms of Reference for Trust Board and Committee meetings. • Addition of People Committee • Change of Director of Nursing to "Chief Nurse" • Updated references to Monitor, NHS improvement and NHS England. • Updated Procurement references to tender portals and EU tender regulations.	Matthew Bancroft
Version 10	July 2020	• Update of legislation references to include any subsequent updates relating to the UK's exit from EU. • Removal of all references and detail pertaining to the use of 'Approved Lists' in relation to Works tenders. • Removed references to Prudential Borrowing Limits. • Updated limits with relation to Charitable Funds expenditure. • Includes Appendix 1. Temporary COVID19 Business Continuity Terms of Reference Trust Board, Board Committee and Governor Meetings – Emergency powers section 6.2	Matthew Bancroft

CONTENTS

1 INTRODUCTION

1.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is a Public Benefit Corporation that was established by the granting of Authorisation by NHS England.

1.2 The principal purpose of the Trust is set out in the 2012 Act, and the Trust Constitution.

1.3 The Trust is required to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

1.4 The powers of the Trust are set out in section 4 of the Constitution.

1.5 The Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to NHS England. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.6 Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.

1.7 **Delegation of Powers**
The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation.

1.8 Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 6) the Board of Directors may exercise its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 7 or by an executive director, in each case subject to such restrictions and conditions as the Board of Directors thinks fit or as NHS England may direct.

1.9 Delegated Powers are covered in the Scheme of Delegation, which has effect as if incorporated into the Standing Orders.

2 INTERPRETATION AND DEFINITIONS

2.1 Save as permitted by law, at any meeting the Chair of the Trust, advised by the Chief Executive, shall be the final authority on the interpretation of Standing Orders.

2.2 These Standing Orders shall only be applied in accordance with the Constitution. Where any provision in these Standing Orders contradicts any provision in the Constitution, the Constitution shall be paramount.

2.3 In these Standing Orders:

“the 2006 Act”	means the National Health Service Act 2006 as amended from time to time;
“the 2012 Act”	means the Health and Social Care Act 2012 as amended from time to time;
“the 2022 Act”	means the Health and Care Act 2022 as amended from time to time;
"Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
“Board of Directors”	means the board of directors as constituted in accordance with the Trust Constitution;
“Chair”	means the Chair of the Trust appointed in accordance with the Trust Constitution;
“Chief Executive”	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
“Committee”	means a committee appointed by the Board of Directors;
“Committee members”	means those persons formally appointed by the Board of Directors to sit on or to chair specific committees;
"Constitution"	means the Trust Constitution and all annexes to it;
“Corporate Director”	A non-voting director with executive responsibilities, appointed by the Board of Directors;
“Director”	means a director on the Board of Directors;
“Chief Finance Officer”	means the Chief Finance Officer of the Trust;
“Executive Director”	means an executive director of the Trust appointed in accordance with the Trust Constitution;
“Funds held on Trust”	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
“Member”	means a member of the Trust;
“NHS England”	means the body corporate known as NHS England.
“Motion”	means a formal proposition to be discussed and voted on

	during the course of a meeting;
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Non-Executive Director"	means a non-executive director of the Trust appointed in accordance with the Trust Constitution;
"Officer"	means an employee of the Trust;
"Secretary"	means the Trust Board Secretary or any other person appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary;
"SFIs"	means Standing Financial Instructions;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

3 THE BOARD OF DIRECTORS

3.1 All business of the Board of Directors shall be conducted in the name of the Trust.

3.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to NHS England. Accountability for non-charitable funds held on trust is only to NHS England.

3.4 **Composition of the Board of Directors**
In accordance with the 2006 Act, the 2012 Act, and the Constitution, the composition of the Board of Directors of the Trust shall be:

(a) A non-executive Chair (who shall have a casting vote)

(b) Other non-executive Directors (i.e not including the Chair). One non-executive Director will be nominated by the Chair, and noted by the Council of Governors, as the Senior Independent Director); and

(c) Executive directors (but not exceeding the combined number of non-executive Directors and the non-executive Chair), including;

- the Chief Executive (the Accounting Officer)

- the Chief Finance Officer
- the Executive Medical Director
- the Chief Nurse

3.5 The Board of Directors may appoint non-voting corporate directors to attend meetings of the Board, but shall not have a vote (see SO 5.19).

3.6 **Non-executive Directors**
Non-executive Directors are appointed by the Council of Governors. The appointment shall be in accordance with the Constitution.

3.7 The regulations governing the tenure of office of the Non-executive Directors shall be in accordance with the Constitution.

3.8 **Joint Directors**
Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly and shall count for the purpose of Standing Order 3.4 as one person.

4 CHAIR OF THE BOARD OF DIRECTORS

4.1 The Chair of the Trust is the Chair of the Board of Directors.

4.2 The Chair is appointed by the Council of Governors. The appointment shall be in accordance with the Constitution.

4.3 The regulations governing the tenure of office of the Chair shall be in accordance with the Constitution.

4.4 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair shall preside.

4.5 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside.

4.6 **Deputy Chair**
Where the Chair of the Trust has died or has otherwise ceased to hold office or where they is been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair. In such cases the Deputy Chair shall act as Chair of the Board of Directors.

4.7 The appointment of the Deputy Chair shall be as prescribed in the Constitution.

4.8 The regulations governing the tenure of office of the Deputy Chair shall be in accordance with the Constitution.

5 PRACTICE AND PROCEDURE OF MEETINGS

5.1 All business at meetings of the Board of Directors shall be conducted in the name of the Trust.

5.2 **Annual Members Meeting**
The Trust will publicise and hold an annual meeting of its members in accordance with the constitution and the 2012 Act.

5.3 **Admission of the Public and Press**
The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"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".

5.4 The Chair (or Deputy Chair when acting as Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourns for (the period to be specified) to enable the Board of Directors to complete business without the presence of the public."

5.5 Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair when acting as Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography.

5.6 **Calling Meetings**
Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

5.7 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them such one third or more directors may forthwith call a meeting. In such cases, meetings shall be held at the Trust's designated headquarters (face to face or virtually).

5.8 **Notice of Meetings**
Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Board of Directors to all Directors.

5.9 The notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to him at least three clear days before the meeting.

5.10 Lack of service of the notice on any director shall not affect the validity of a meeting.

5.11 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

5.12 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

5.13 **Chair of Meeting**
At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Chair and Deputy Chair are absent such non-executive director as the directors present shall choose shall preside.

5.14 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

5.15 **Quorum**
No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.

Directors can participate in meetings by telephone or using video conferencing facilities,

where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

5.16 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

5.17 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business i.e. lack of a quorum for specific items will not invalidate the whole meeting.

5.18 The requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting.

5.19 **Voting**

Each executive and non-executive director shall be entitled to exercise one vote. Corporate directors who are not executive directors (as described in SOs 3.4 and 3.5) shall not have a vote.

5.20 Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

5.21 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

5.22 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

5.23 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

5.24 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

5.25 An officer who has been appointed formally by the Board of Directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of

incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

5.26 **Setting the Agenda**
The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

5.27 A director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

5.28 **Minutes**
The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

5.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

5.31 **Record of Attendance**
The names of the directors present at the meeting shall be recorded in the minutes.

5.32 **Notices of Motion**
A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 5.11.

5.33 **Withdrawal of Motion or Amendments**
A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

5.34 **Motion to Rescind a Resolution**
Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signature of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six

months; however the Chair may do so if they consider it appropriate.

5.35 **Motions**
The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

5.36 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(i) An amendment to the motion.

(ii) The adjournment of the discussion or the meeting.

(iii) The appointment of an ad hoc committee to deal with a specific item of business.

(iv) That the meeting proceed to the next business.*

(v) The appointment of an ad hoc committee to deal with a specific item of business.

(vi) That the motion be now put to a vote.*

In the case of sub-paragraphs denoted by * above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.

5.37 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

5.38 **Chair's Ruling**
Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

5.39 **Joint Directors**
Where a post of executive director is shared by more than one person:

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should be cast;

(d) the presence of either or both of those persons shall count as one person for the

purposes of SO 5.15 (Quorum).

5.40 **Suspension of Standing Orders**
Any one or more of the Standing Orders may be suspended at any duly constituted meeting, provided that:

(i) at least two-thirds of the Board of Directors are present, including one executive director and one non-executive director;

(ii) a majority of those present vote in favour of suspension; and

(iii) the variation proposed does not contravene any statutory provision or direction made by NHS England.

5.41 A decision to suspend SOs shall be recorded in the minutes of the meeting.

5.42 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

5.43 No formal business may be transacted while SOs are suspended.

5.44 The Audit & Risk Committee shall review every decision to suspend SOs.

6 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 Subject to SO 1.5 and such directions as may be given by NHS England, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 1.5 or 6.3 or by a executive director of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

6.2 **Emergency Powers**
Those powers of the Trust which the Board of Directors has retained to itself may in urgent circumstances be exercised by the Chief Executive after having consulted the Chair. A decision is urgent where any delay would seriously prejudice the Trust's or the public's interests. The exercise of such powers by the Chief Executive shall be reported to the next formal meeting of the Board of Directors for ratification.

6.3 **Delegation to Committees**
The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

6.4 **Delegation to Officers**
Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

6.5 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

6.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

6.7 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

7 COMMITTEES

7.1 **Appointment of Committees**
Subject to SO 1.5 and such directions as may be given by NHS England, the Board of Directors may and, if directed to, shall appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

7.2 A committee appointed under SO 7.1 may, subject to such directions as may be given by NHS England or the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust or wholly of persons who are not members of the Trust committee).

7.3 The Standing Orders of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

7.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

7.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

7.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined.

7.7 Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by NHS England, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the regulations laid down by NHS England.

7.8 The committees and sub-committees established by the Board of Directors are:

(a) Audit and Risk
(b) Quality
(c) Nominations and Remuneration
(d) Charitable Funds
(e) Finance and Performance
(f) People Committee

7.9 **Confidentiality**
A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

7.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

8 DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

8.1 Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Directors' interests must be kept by the Trust.

8.2 Pursuant to Section 152 of the 2012 Act, Directors have a duty:

a) to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

b) not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

8.3 **Declaration of Interests**
Directors are required to declare interests, which are relevant and material. All existing Directors should declare relevant and material interests. Any Directors appointed subsequently should do so on appointment.

8.4 Interests which should be regarded as "relevant and material" and which, for the guidance of doubt, should be included in the register, are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in any organisation, including charity or voluntary organisations, in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

8.5 If directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

8.6 At the time the interests are declared, they should be recorded as appropriate. Any changes in interests should be declared at the next Board of Directors meeting as appropriate following the change occurring. It is the obligation of the Director to inform the Trust Company Secretary in writing within 7 days of becoming aware of the existence of a relevant or material interest or update personally the interest onto the Trust Declarations of Interest system (CIVICA Declare) as per the Trust Standards of Business Conduct Policy. The Company Secretary will amend the Register upon receipt within 3 working days if sent manually.

8.7 During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

8.8 There is no requirement for the interests of directors' spouses or partners to be declared.

8.9 **Authorisation of Conflict of Interest**
Where a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (in contravention of the duty outlined at SO 8.2), this may be authorised if a majority of directors vote in favour of authorisation. If there is a dispute as to whether a conflict or potential conflict of interest exists, majority will resolve the issue with the Chair having the casting vote.

8.10 If a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust that is not authorised by the Board of Directors, the director in question will be deemed to be in breach of the statutory duty outlined at SO 8.2.

8.11 **Register of Interests**
The details of directors' interests recorded in the Register will be kept up to date by means of a monthly review of the Register by the Secretary, during which any changes of interests declared during the preceding month will be incorporated.

8.12 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

9 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 If a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting

and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.2 The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

9.3 For the purpose of this Standing Order, directors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons, persons in a civil partnership, or unmarried persons living together as partners, the interest of one spouse or partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

9.4 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which they are connected as mentioned in SO 9.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.5 Where a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

9.6 SO 9 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a director of the Trust) as it applies to a director of the Trust.

10 STANDARDS OF BUSINESS CONDUCT

10.1 **Policy**
Directors shall act in accordance with the Nolan Principles Governing Conduct of Public Office Holders at all times.

10.2 The Trust has adopted as good practice the national guidance contained in NHSE (2019) `Standards of Business Conduct for NHS staff' and staff must comply with this guidance. The following provisions should be read in conjunction with this document.

10.3 **Interest of Officers in Contracts**
If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons, or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.4 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

10.5 The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

10.6 **Canvassing of, and Recommendations by, Directors in Relation to Appointments**
Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

10.7 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10.8 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

10.9 **Relatives of Directors or Officers**
Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

10.10 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

10.11 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

10.12 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 9) shall apply.

10.13 In accordance with paragraph 1.1.2 of the Trust's Standards of Business Conduct and Employees Declarations of Interest Policy, any Board member or member of staff who receives or is offered and declines hospitality in excess of £50.00 is required to enter the details of the hospitality in the Trust's Declarations of Interest system (CIVICA Declare) as per Trust Standards of Business Conduct Policy.

11 TENDERING AND CONTRACT PROCEDURES

11.1 **Duty to comply with Standing Orders**
The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 5.40 (Suspension of SOs) is applied).

11.2 **UK Directives Governing Public Procurement**
Directives by the Department of Health (DoH) or any subsequent public procurement legislation following the UKs exit from the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders.

11.3 The Trust shall comply as far as is practicable with the requirements of the Capital Investment Manual and with guidance contained in "The Procurement and Management of Consultants within the NHS".

11.4 Financial Thresholds

The Trust shall set financial thresholds above which competitive quotations and tenders are to be invited. The value to be compared to the threshold is the estimated full amount of the goods and/or services to be paid during the life of the contract exclusive of vat.

11.5 The estimated value of the requirement is calculated with reference to the following:

a) all possible options under the contract need are included;

b) where volumes and prices are known in advance, then the value of the contract is the full amount which will be paid during the life of the contract;

c) where the contract is for an indefinite period, or for a period of time which is uncertain when the contract is entered into, or the volumes are uncertain, then the estimated amount to be paid is the estimated monthly value multiplied by 24;

d) where it is proposed to enter into two or more contracts for goods or services of a particular type, then the estimated value of each of the contracts must be added together. This aggregate value is the one which must be applied and assessed against the threshold. Where the aggregate value is above the threshold, each contract has to be put to competition, even if the estimated value of each individual contract is below the threshold;

e) for building or engineering works this is the estimated value of the whole works project, irrespective of whether or not it comprises a number of separate contracts for different activities. For example if the construction of a new building is divided into three phases, site clearance, construction and fitting out, the threshold must be applied to the value of all three phases, even though the activities are different and different contractors may be used.

11.6 If the estimate proves to have been flawed, for example, because bids or the eventual contract value are significantly higher than estimated, there may be a breach of the Regulations and the competition may have to be stopped and started again. There may, for example, be unfairness to contractors who relied upon a flawed estimate in reaching a decision not to bid for a particular contract.

11.7 The current thresholds (exclusive of vat) are information quotes between £5k and £35k, at least 3 formal quotes via an e-tendering portal between £35k and the UK threshold (Find a Tender Service) (currently £111,750) and above UK Threshold, the UK Find a Tender Service tendering process shall be followed.

11.8 The current thresholds (exclusive of VAT) are that three quotes are needed between £10k and £35k, at least 3 formal quotes via an e-tendering portal are needed between £35k and the UK threshold (Find a Tender Service) (currently £111,750) with one local quote where possible, and for those above the UK threshold (Find a Tender Service) , the UK tendering process shall be followed.

11.9 **Formal Competitive Tendering and Quotations**
The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); where the value is expected to exceed the financial threshold (11.7) and for disposals.

11.10 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the financial threshold (11.7); or

(b) where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with.

11.11 Formal tendering procedures are not required where:

(a) the requirement is covered by an existing contract;

(b) the requirement is covered by an existing framework

11.12 Formal tendering procedures may be waived by the Chief Executive where:

(a) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

(c) specialist expertise is required and is available from only one source; or

(d) the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(f) where provided for in the Capital Investment Manual.

Where it is decided that competitive tendering is not applicable and should be waived by virtue of (b) to (e) above the fact of the waiver and the reasons should be documented and reported by the Chief Executive to the Audit and Risk Committee in the next formal meeting.

11.13 The limited application of the single tender rules (11.9 and 11.10 above) should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

11.14 Quotations are required from at least three suppliers (ideally one local) where formal tendering procedures are waived under SO 11.9 (a) and where the intended expenditure or income exceeds, or is reasonably expected to exceed the financial threshold (11.7).

11.15 If a framework agreement is to be used, the selection of the best supplier for the particular need is to be made on the basis of either:

(a) the supplier offering the most economically advantageous offer (using the original award criteria) for the particular need where the terms of the agreement are precise enough; or

(b) through mini competition between those suppliers on the framework capable of meeting the particular need using the terms of the original terms, supplemented or refined as necessary.

11.16 Works requirements falling below the MTC financial threshold (11.7) can be placed with the measured term contract supplier, following the process set out in that contract.

11.17 Except where SOs 11.10 and 11.11, or a requirement under SO 11.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of suppliers to provide fair and adequate competition as appropriate, and in no case less than three written competitive tenders must be obtained, having regard to suppliers capacity to supply the goods or materials or to undertake the services or works required.

11.18 The number of suppliers to be invited to tender for building and engineering schemes valued above the financial threshold (11.7) will be a minimum of six, of which four written competitive tenders must be obtained, unless the requirement is waived in writing by the Chief Executive or Chief Financial Officer.

11.19 The Board of Directors shall ensure that normally the suppliers invited to tender (and where appropriate, quote) for building and engineering schemes are among those on approved lists (see Annex Section 5). Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

11.20 Tendering procedures are set out in the Annex.

11.21 Quotations should be in writing for quotes above £35,000 unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record. All quotations for goods and services valued between £35,000 and £111,750 quotations should be undertaken by the Procurement Department.

11.22 All quotations should be treated as confidential and should be retained for inspection.

11.23 The Chief Executive or their nominated officer should evaluate the quotations and select the one that is either the lowest cost or is the most economically advantages to the Trust taking into account quality. If this is not the lowest or economically advantages then this fact and the reasons why should be in a permanent record.

11.24 **Where tendering or competitive quotation is not required**
Where tenders or quotations are not required, because expenditure is below the financial threshold (11.7), the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

11.25 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11.8).

11.26 **Private Finance**
When the Board of Directors proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(c) The selection of a private sector partner must be on the basis of competitive tendering or quotations.

11.27 **Contracts**

The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) these Standing Orders;

(b) the Trust's SFIs;

(c) UK Find a Tender Service Directives, their subsequent replacements in UK law and other statutory provisions.

(d) any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

11.28 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

11.29 **Personnel and Temporary Staff Contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of temporary staff.

11.30 **Healthcare Services Contracts**

Healthcare Services Contracts made between two NHS organisations are subject to the provisions of the 2006 Act.

11.31 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

11.32 **Contracts Involving Funds Held on Trust**

Contracts Involving Funds Held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

11.33 **Legality of Payments**

It is the responsibility of the Chief Financial Officer to ensure that all payments made by the Trust fall within its powers.

12 DISPOSALS

12.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the Trust's condemnation policy;

(c) items to be disposed of with an estimated sale value of less than £5,000;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance.

13 IN HOUSE SERVICES

13.1 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

(b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

(c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a non-executive director should be a member of the evaluation team.

13.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

13.3 The evaluation group shall make recommendations to the Board of Directors.

13.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

14 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 **Custody of Seal**

The Common Seal of the Trust shall be kept by the Company Secretary in a secure place.

14.2 **Sealing of Documents**
The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

14.3 The legal requirement to "seal" documents executed as a deed has been removed. The Board of Directors' may however, choose to continue to use the seal.

14.4 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him) and authorised and countersigned by the Chief Executive (or an officer nominated by him). Officers nominated to approve the use of the seal on behalf of either the Chief Finance Officer or Chief Executive shall not be within the originating directorate.

14.5 **Register of Sealing**
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, description of the document, date of sealing, and the directors authorising the use of the seal).

15 SIGNATURE OF DOCUMENTS

15.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

15.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

16 MISCELLANEOUS

16.1 **Standing Orders to be given to Directors and Officers**
It is the duty of the Chair to ensure that existing Governors and all new Directors are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to Directors designated by the Chair. New Directors shall be informed in writing and shall receive copies where appropriate of SOs.

16.2 **Documents having the standing of Standing Orders**
Standing Financial Instructions shall have effect as if incorporated into SOs.

16.3 **Review of Standing Orders**
Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

17 VARIATION AND AMENDMENT OF STANDING ORDERS

17.1 These Standing Orders shall be amended only if:

(i) at least two-thirds of the Board of Directors are present; and

(ii) a majority of those present, including no fewer than half the total of the Trust's non-executive directors, vote in favour of amendment; and

(iii) the variation proposed does not contravene any statutory provision or direction made by NHS England.

Annex - TENDERING PROCEDURE

1 INVITATION TO TENDER

1.1 All invitations to submit a tender on a formal competitive basis by utilising the E-Tender Portal and shall include:

(a) clear instructions of documentation to complete, including pricing information, technical specifications and business continuity plans

(b) details of the closing date, time and place of receipt of submission with a named lead of who to contact should there be submission problems.

1.2 Extensions of time for the period allowed for receipt of tenders shall only be considered where no tenders have been received or, if tenders have been received, on the basis that all parties are notified and all agreed to the proposed extension. Suppliers may re-submit if they wish by the new deadline.

1.3 Each invitation shall include as a minimum (where appropriate) the following:

(a) Instructions to Offer
(b) Terms of offer including Evaluation Criteria
(c) Specification of goods/service
(d) Terms and conditions of contract as appropriate.
(e) Offer schedule(s)
(f) Form of offer

1.4 Other than in exceptional circumstances, all preparation in relation to the specification and the evaluation of product should be conducted prior to invitation to tender.

1.5 Other than in exceptional circumstances, all preparation in relation to the specification and the evaluation of product should be conducted prior to invitation to tender.

1.6 There shall normally be no contact between Officers of the Trust and the candidates invited to tender in relation to the tender or the proposed contract between the issue of the tender documentation and the award of the contract other than via the use of the Electronic Portal to:-

(a) clarify questions relating to the specification, or
(b) clarify questions relating to the completion of the tender documents, or
(c) offer all parties invited to tender a briefing on the Trust's requirements with the opportunity for the Officers of the Trust and such persons as deemed appropriate and parties invited to tender representatives to ask questions of each other at a meeting arranged by the Trust specifically for this purpose: where this happens an electronic record should be made and retained for future inspection, or

(d) arrange trials of supplies and/or equipment.

No clarification by Officers of the Trust shall be sought with candidates in relation to financial matters including pricing until after tenders have been opened.

2 RECEIPT, SAFE CUSTODY AND RECORD OF FORMAL TENDERS

2.1 All communicating with candidates between invitation to tender and receipt of tender by the Trust shall be channelled through the e-tendering portal.

2.1.1 Unsuccessful tenderers will be notified via the e-tendering portal.

2.1.2 All tenders received and associated documents (or copies of) will be retained by those seeking the tender and stored on the E-Tendering Portal against the unique Contract reference number for future reference, inspection and audit where required along with the evaluation scoring and details of the evaluation team.

2.1.3 By utilising the E-Tendering Portal procedures shall be adopted to ensure that all tenders received are retained in the secure electronic Portal and remain unopened until such time as they are officially opened which shall be as soon as is reasonably practicable following the latest date and time set for receipt of tenders.

2.2 The tenders will be opened and recorded electronically in the e-tendering portal by two Procurement officers.

2.3 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

2.4 Where the lowest tender submitted is so much below the estimate it prompts doubts as to whether an error has been made in tendering, especially where it differs substantially from the other tenders, confirmation of price may be sought from the tenderer via the e-tendering portal without disclosing that it is the lowest tenderer, and an assurance that the contractual arrangements and technical documentation have been fully understood. If the tenderer has made an error, they may withdraw their tender. If they stand by their original price, it must be decided whether acceptance would carry too great a risk of subsequent failure before establishing an order of preference.

2.5 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

2.6 Wherever the invitation to tender does not demonstrate sufficient competition by reason of an inadequate response to the invitation, the supervising officer/project manager concerned shall set up a fresh competition, and all tenderers submitting a

tender from the original invitation shall be invited to re-tender.

3 WORKS TENDERS

3.1 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of either the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract or NEC3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers, Electrical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DoH.

3.2 Works should be procured under a UK Public (Find a Tender Service) Procurement compliant process.

4 APPROVED FIRMS

(a) **Building and Engineering Construction Works**

(i) Invitations to tender shall be via compliant procurement routes in conjunction with the procurement team.

(ii) Suppliers that are successful in winning contracts shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of current legislation and regulations.

(iii) All Contractors shall conform with the requirements of the Health and Safety at Work Act etc. 1974, Management of Health & Safety at Work Regulations 1999 and any amending and/or other related legislation concerned with the Health, Safety and Welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution and the Construction (Design & Management) Regulations 2015. Contractors are legally required to provide to the appropriate Estates & Facilities manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested and associated Risk Assessment & Method Statement pertinent to specific projects commensurate with standard Health & Safety methodology.

(b) **Financial Standing and Technical Competence of Contractors**
The Chief Financial Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director of Estates and Facilities will similarly make such enquiries as is felt appropriate to be satisfied as to their technical competence.

5 NEGOTIATED TENDERS

5.1 The use of a negotiated tender leading to a 'continuation' or 'run-on' contract may be appropriate where the need arises for additional work which, if authorised as variation on the existing contract or let to another contractor would be undesirable or unduly disruptive and expensive. This situation can arise in two circumstances:

(a) when the need is for further work of a similar nature to that already being executed and normally on the same or a closely adjoining site; and

(b) when the need is for alteration to the works executed in the original contract which it is important should be carried out by the same contractor in order to safeguard the Trust's rights with regard to defects in the works.

5.2 The following criteria must be observed when considering the use of negotiated tender procedure:

(a) The initial contract must have been awarded as a result of competitive tendering.

(b) The new work must not be of a disproportionately high value (i.e. as a general rule not more than 50%) in relation to the value of the initial contract.

(c) For further work of a similar nature a high proportion (at least 60%) of the value of the new work must be covered by rates included in the initial contract that can be used as basis of negotiation of new rates.

(d) For alteration works, the rates must be based as far as practicable on the same fundamental costing data used for rates in the initial contract.

(e) The aggregate value of contracts awarded for additional works may not exceed 50% of the value of the original contract.

(f) During the negotiations the contractor's agreement must be obtained that the addition of further work will not later be raised by him as a ground for a claim for disruption of the initial contract. (The costs of any necessary reorganisation of the initial contract so as to accommodate the further work must be raised during the negotiations and, if agreed, included in the negotiated amount).

(g) At the conclusion of the negotiations the Trust must have reasonable evidence to show that the negotiated amount is no less favourable than a freshly obtained competitive tender would be.

(h) The procedure must not be used simply to recover time lost during the initial contract or as a means of bringing forward a later scheme, or as a substitute for good planning.

(i) The details of the further work should be fully prepared and meet the normal requirements of readiness to proceed to tender.

(j) The timetable for the negotiations should be linked with the planning of capital expenditure so that this does not place any additional constraint on the Trust's freedom of action.

6 TENDERS NOT STRICTLY IN ACCORDANCE WITH SPECIFICATION

6.1 Tenders not strictly in accordance with the specification may be considered if a marked financial advantage to the Trust would otherwise be lost. A marked financial advantage is a saving in excess of £1000 or 1% of the tender price, whichever is the greater.

6.2 Provided there is no reason to doubt the bona fides of the tenderer, the lowest tenderer to specification may be asked to revise their tender to conform to the revised specification.

6.3 If they are willing to do so but refuses to abide by their original price, their tender must be rejected.

6.4 If they decline to revise their tender to conform with the specification then, in the case of professional Services Contracts or Supplies Contracts, post tender negotiations may be undertaken in accordance with the procedures below. Otherwise, their tender should be rejected and the second lowest (or second highest in the case of a sale) should be considered.

6.5 If so many of the tenderers fail to conform with the specification that the whole basis of the competition is invalidated or post tender negotiations do not take place then consideration should be given to re-commencing competition and inviting further tenders.

7 POST TENDER NEGOTIATION

7.1 At any time prior to acceptance of a tender by the Trust the Chief Executive or any officer authorised by him, may authorise post tender negotiations if it appears that a marked financial advantage as defined above may accrue to the Trust, or, if subsequently there

has been a bona fide change in specification which is not so significant as to warrant abandonment of the procedure and the invitation of further tenders.

7.2 Where the negotiation is carried out by officers of the Trust each tenderer shall be notified that the Trust wishes to enter into post tender negotiations, and at least each of the three lowest (or highest in the case of a sale) tenderers, or all the tenderers if less than three submitted valid tenders, shall be invited to attend a separate meeting at the Trust's offices (unless an adverse financial report has been received from the Director of Finance in respect of any tenderer, in which case that tenderer shall be excluded from the invitation). At each such meeting the Trust shall be represented by at least two officers, one of whom shall write a minute of the meeting, which, as soon as practicable thereafter, shall be confirmed as correct by the other officer and each tenderer shall be given equal opportunity on an equal footing insofar as it is reasonably practicable to negotiate their tender, whether as to price, quality or in any other respect. Negotiations with each tenderer may continue over a series of meetings and any amendment finally negotiated shall be confirmed by the tenderer in writing to the Trust.

7.3 The time during which all negotiations shall be completed by receipt of written confirmation of any amendments shall be specified in the invitation referred to in 8.2 above and may be extended by notice in writing from the Trust to all tenderers at any time.

7.4 Post tender negotiation in relation to Estates contracts shall only take place in accordance with the guidance given in the current edition of the Code of Procedure Single Stage Selective Tendering issued by the National Joint Consultative Committee for Building.

7.5 Upon the expiration of the time for negotiation, or any extended period, any amended tender shall be considered in accordance Section 4 on the Acceptance of Tenders.

8 PRESERVATION AND DESTRUCTION OF DOCUMENTS

8.1 **Estates' Tenders**
Documents relating to the successful tender shall not be destroyed. Documents relating to unsuccessful tenders will be destroyed after six successive financial years following the financial year of origin.

8.2 **Supply of Goods and Services**
Documents relating to the successful tender shall not be destroyed. Documents relating to unsuccessful tenders will be destroyed six years after the end of the financial year of origin.

9 FORMS OF CONTRACT

9.1 Supplies contracts may be executed under hand.

9.2 An Official Order or Letter of Acceptance will be sent to the successful tenderer in respect of contracts for estates services up to and including £250,000 in value. In the case of estates services which exceed £250,000 in value but do not exceed £500,000, contracts may be executed underhand.

9.3 The Common Seal should be used for:

i) All contracts for the purchase/lease of land and/or building
ii) All contracts for capital works exceeding £500,000
iii) All lease estate agreements where the annual lease charge exceeds £50,000 per annum and the period of the lease exceeds beyond five years
iv) Any contract or agreement with organisations with the NHS bodies where annual costs exceed or are expected to exceed £500,000.

9.4 Every contract for building and engineering works (except contracts for maintenance work only, where Estmancode guidance should be followed) shall embody or be in the same terms and conditions of contract as those on the basis of which tenders were invited.

9.5 In the case of Consultants' commissioning agreements relating to building and engineering works, to which a professional service contract for consultant design services relates, the contract shall be evidenced in writing, so far as is possible having regard to the custom and practice of the profession concerned.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Orders Board of Directors 2020 – CORP/FIN 1 (A) v14	CE/Finance	Matthew Bancroft	Existing Policy	September 2024

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box.

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: September 2024

Checked by: Matthew Bancroft **Date: September 2024**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Reservation of Powers to the Board and Delegation of Powers

September 2024

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	Matthew Bancroft – Head of Financial Control Jon Sargeant – Chief Financial Officer
Date written/revised:	September 2024
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2025

Target audience:	Trust-wide

Reservation of Powers to the Board and Delegation of Powers

Amendment Form

Please record brief details of the changes made alongside the next version number.
If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author
Version 13	September 2024	• Updated minor typographical and formatting errors • Included reference to Grip and Control meetings • Updated Procurement terminology from EU to UK law • Clarity on losses and compensation decisions and above delegated limits • Replacing gender referenced language	Matthew Bancroft Richard Somerset Rebecca Allen
Version 12	July 2023	• Resetting Director of Finance and Deputy Chief Executive limits to pre-interim arrangements in 2022 • Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Alex Crickmar Fiona Dunn Richard Somerset
Version 11	July 2022	• Introduction of the Deputy Chief Executive role within the delegation limits • Updated job titles • Removed reference to NHS Improvement • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
Version 10	July 2021	• Replaced DoN with Chief Nurse • Updated references to NHS Improvement/NHS England • Reference to e-signing of contracts • Ensure Directors sign-off levels are consistent	Matthew Bancroft
Version 9	July 2020	Renaming names of structures/meetings	Matthew Bancroft
Version 8	November 2018	Renaming names of structures/meetings	Jon Sargeant
Version 7	September 2017	Various	Jon Sargeant and Matthew Kane
Version 6	September 2016	• Update to ensure consistency with the SFIs • Update for consistency with new committee structure	Maria Dixon / Andrew Thomas

		• Various changes	
Version 5	March 2015	• Updated to reflect changes to Standing Orders relating to e-tendering and Working Together Group thresholds	Andrea Smith
Version 4	November 2013	• References throughout to Director of Finance, Information and Procurement / DoFIP amended to Director of Finance and Infrastructure / DoFI; • References throughout to Director of Human Resources amended to Director of People and Organisational Development; • Updated references and amendments for consistency to revised Standing Orders section 11 and tendering annex; • Clarification added to the posts included in role of 'Senior Officer'.	Robert Paskell

CONTENTS

INTRODUCTION

SO 6.1 of the Standing Orders provides that "subject to such directions as may be given by NHS England, the Trust may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee of directors or by an executive director of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit." The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to provide details of those powers reserved to the Board - generally matters for which it is held accountable to NHS England, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions; even those delegated and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

A. Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated.

All powers delegated by the Chief Executive can be re-assumed by them should the need arise. As Accounting Officer the Chief Executive is accountable to NHS England for the funds entrusted to the Trust.

B. Caution over the Use of Delegated Powers

Powers are delegated to directors on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for public concern.

C. Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

D. Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director to whom powers have been delegated those powers shall be exercised by that director's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive after taking appropriate advice from the Chief Finance Officer.

The Chief Executive, following consultation with the Chair, may authorise any person to act on their behalf and exercise such delegated powers across the full range of duties carried out by the Chief Executive.

1. RESERVATION OF POWERS TO THE BOARD

1.1 The Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 1.2 to 1.9 below:

1.2 **General Enabling Provision**

The Board may determine any matter it wishes in full session within its statutory powers.

1.3 **Regulation and Control**

1.3.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

1.3.2 Approval of a scheme of delegation of powers from the Board to officers.

1.3.3 Suspension of Standing Orders.

1.3.4 Variation or amendment of Standing Orders.

1.3.5 Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

1.3.6 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

1.3.7 Disciplining directors who are in breach of statutory requirements or SOs.

1.3.8 Approval of the disciplinary procedure for officers of the Trust.

1.3.9 Approval of arrangements for dealing with complaints.

1.3.10 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to.

1.3.11 To receive reports from committees including those which the Trust is required to establish and to take appropriate action thereon.

1.3.12 To confirm the recommendations of the Trust's committees where the

committees do not have executive powers. To establish terms of reference and reporting arrangements of all board committees (and other committees if required).

1.3.13 Ratification of any urgent decisions taken in accordance with SO 6.2.

1.3.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

1.3.15 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

1.4 **Appointments**

1.4.1 The appointment and disestablishment of committees.

1.4.2 The appointment and dismissal of executive directors (subject to SO 3.4).

1.4.3 The appointment of members of any committee of the Trust.

1.5 **Policy Determination**

1.5.1 To approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so received shall be listed.

1.6 **Strategy and Business Plans and Budgets**

1.6.1 Definition of the strategic aims and objectives of the Trust, including approval of underpinning strategies that support its delivery.

1.6.2 Approval annually of plans, including the NHS England's annual plan in respect of:-

- Service delivery strategy.
- The application of available financial resources.

1.6.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

1.6.4 Approval and monitoring of the Trust's policies and procedures for the management of risk, through the Audit and Risk Committee.

1.7 **Direct Operational Decisions**

1.7.1 Acquisition, disposal or change of use of land and/or buildings.

1.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £250,000.

1.7.3 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 2 year period or the period of the contract if longer.

1.7.4 Approval of individual compensation payments over £100,000.

1.7.5 To agree action on litigation against or on behalf of the Trust.

1.8 **Financial and Performance Reporting Arrangements**

1.8.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS England and the Charity Commission shall be reported, at least in summary, to the Board of Directors.

1.8.2 Approval of the opening or closing of any bank or investment accounts.

1.8.3 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

1.8.4 Consideration and approval of the Trust's Annual Report including the annual accounts.

1.8.5 Receipt and approval of the Annual Report(s) for funds held on trust.

1.9 **Audit Arrangements**

1.9.1 To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit and Risk Committee meetings and take appropriate action.

1.9.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

1.9.3 The receipt of the annual report received from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

2. DELEGATION OF POWERS

2.1 **Delegation to Committees**

The Board may determine that certain of its powers shall be exercised by committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of NHS England and or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration and Terms of Service Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 7.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

3. SCHEME OF AUTHORISATION TO OFFICERS

3.1 Standing Orders and model Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Chief Finance Office (DoF) and other directors. These responsibilities are summarised below.

[**NOTE** It should be noted that the SFIs generally specify officers responsible for various matters whereas SOs only do this occasionally].

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Chief Finance Officer – with operational responsibility delegated to the Chief Information Officer
Health and Safety Arrangements	Chief Finance Officer – with operational responsibility delegated to the Director of Estates & Facilities

This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each director is responsible for the delegation within his area of responsibility. S/he should produce a scheme of authorisation for matters. In particular the scheme of authorisation should include how budget management and procedures for approval of expenditure are delegated.

A more detailed scheme of delegation including financial limits is given in Section 5.

As part of the scheme of delegation, senior officers are accountable back to the Board of Directors. To enable the Directors to assist with this delegation, Grip and Control meetings have been put in place at a Divisional level. This helps Directors have oversight on the day to day powers that are delegated to senior offices, but also allows for both challenge and support, to help senior officers make decisions that are consistent across the Trust, but also help the Trust to function in a manner that is as efficient as possible.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
2.1	CHAIR	Final authority in interpretation of SOs.
4.1	CHAIR	Chair all board meetings and associated responsibilities.
5.6	CHAIR	Calling meetings.
8.8	CE	Register(s) of interests.
11.18	CE	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
11.20	CE	Best value for money is demonstrated for all services provided under contract or in-house.
11.20	CE	Nominate an officer to oversee and manage the contract on behalf of the Trust.
11.21	CE	Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.
11.23	CE	Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.
12.1(a)	CE OR NOMINATED OFFICER	Determining any items to be sold by sale or negotiation.
14.1	CE	Keep seal in safe place and maintain a register of sealing.
14.4	CE/DOF OR NOMINATED OFFICERS	Approve and sign all building, engineering, property or capital documents.
15.1	CE	Approve and sign all documents which will be necessary in legal proceedings
15.2	CE OR NOMINATED OFFICERS	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
16.1	CHAIR	Existing Directors, Governors and employees and all new appointees are notified of and understand their responsibilities within

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
		Standing Orders and SFIs.
Annex s2	CE	Designate an officer responsible for receipt and custody of tenders before opening.
Annex s3	SENIOR OFFICERS	Open tenders.
Annex s4	DOF	Decide whether any late tenders should be considered.
Annex s5	CE OR DOF	Keep lists of approved firms for tenders.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	CHIEF FINANCE OFFICER (DOF)	Responsible for implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	DIRECTORS	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	DOF	Form and adequacy of financial records of all departments.
2.1.1	AUDIT AND RISK COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF	Monitor and ensure compliance with directions on fraud and corruption.
2.5	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.6	COUNCIL OF GOVERNORS	Appoint external auditors.
3	DOF	Ensuring compliance with NHS England's requirements, ensure loans drawn are for approved expenditure only at time of need, and ensuring adequate system of monitoring.
4	DOF DOF CE	Submit budgets. Monitor performance against budget; submit to Board financial estimates and forecasts. Delegate budget to budget holders and submit monitoring returns.
4.3	DOF	Devise and maintain systems of budgetary control.
5	DOF	Annual accounts and reports.
6	DOF	Banking arrangements.
7	DOF	Income systems.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
8	CE	Negotiating contracts for provision of patient services.
	DOF	Regular reports of actual and forecast contract expenditure.
9.1	NOM. & REMUN. COMMITTEE	Remuneration & Terms of Service Committee
9.2	CE	Variation to funded establishment of any department.
9.3	CE	Staff, including agency staff, appointments.
9.4	CHIEF PEOPLE OFFICER	Payroll
10.1	CE / DOF	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.2	DOF	Prompt payment of accounts.
10.2.5	CE	Authorise the use of official orders.
10.2.7	DOF	Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance.
10.3	CE	Grants for provision of patient services.
11	DOF	Advise Board on borrowing and investment needs and prepare procedural instructions.
12	CE	Capital investment programme
12.3	CE	Maintenance of asset registers.
12.3.8	DOF	Calculate and pay capital charges in accordance with NHS England requirements.
12.4.1	CE	Overall responsibility for fixed assets.
12.4.4	DIRECTORS	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
		Trust procedure.
13	DoF	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supply Chain Warehouses.
14.2	DoF	Prepare procedures for recording and accounting for losses and special payments and informing NHS Counter Fraud Authority and the External Auditor of all frauds and informing police in cases of suspected arson or theft.
15	DoF	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17	DoF	Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Charitable Funds Committee if any).
18	CE	Retention of document procedures
19.1	CE DoF	Risk management programme Insurance arrangements

SECTION 5 - DETAILED SCHEME OF DELEGATION & AUTHORISATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation and authorisation shown below is the lowest level to which authority is given. Delegation and authorisation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising, consult with other Directors as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

Key: CE - Chief Executive, MD - Medical Director, CN – Chief Nurse – DoF – Chief Finance Officer,
CPO – Chief People Officer, COO - Chief Operating Officer,
HoCM Head of Communications and Engagement

Directors for the purpose of SO/SFI and Scheme of Delegation are Executive Directors.

Senior officers are staff employed in the post of Divisional Director, General Manager, Deputy Director or Head of a department.

Delegated Matter	Authority Delegated To	Reference Document
1. Management of Budgets		SFIs Section 4
Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Budget Holder	
b) At service level	Divisional Director or Executive Director	
c) For the totality of services covered by Functional Director	Executive Director or CE	
d) For all other areas:	DoF or Appropriate Delegated Manager	
Budgetary or virement limits - and not part of agreed plan		
a) Up to £250,000 per request	Executive Director	
b) Up to £500,000 per request	DOF	
c) Over £500,000 per request	Executive Committee	
Approval for the carry forward of funds into a different budgetary period, after discussion with the DoF	CE	
Approval of revenue business cases and not part of agreed plan		
a) Cases up to £250,000	Corporate Investment Group	
b) Cases over £250,000	Board of Directors	
2. Maintenance / Operation of Bank Accounts		SFIs Section 6

Delegated Matter	Authority Delegated To	Reference Document
Maintenance / Operation of Bank Accounts	DoF	
3. Quotation, Tendering & Contract Procedures **Authority to obtain at least:** a) To obtain best value for goods/services between £10,000 and £35,000 – three informal quotes b) 3 written quotations via e-tendering portal for goods/services from £35,000 to UK threshold (Find a Tender Service) currently £111,750), with one quote where possible from a local supplier. c) Competitive tenders via e-tendering portal for works goods/services for tenders above UK threshold (Find a Tender Service) d) Single quotation approval between £10,000 to UK Threshold (Find a Tender Service) (single quotation above UK threshold (Find a Tender Service) is not permitted)	 Buyers & Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) or Executive Director DoF	SFIs Section 10 & SOs Section 11 & Annex
4. Non Pay Expenditure/Requisitioning/Ordering/ Payment of Goods & Services Authorisation of requisitions/non pay expenditure: a) Requisitions to £2,000 b) Requisitions to £25,000 c) Requisitions to £50,000 d) Requisitions to £500,000 d) Requisitions between £500,000 to £1,000,000 e) Requisitions over £250,000 Authorisation of contracts for goods & services and subsequent variations to contracts a) Contracts up to £500,000 b) Contracts over £500,000 to £1,000,000 c) Contracts over £1,000,000 (this includes electronic signing of contracts) * These figures are the maximum allowed, but can be lower for staff as agreed within the Financial system	 Authorised Signatory for Budget* Head of Dept. General Manager or Divisional Director* Executive Director* DOF CE CE and DOF DoF CE CE and DOF after approval by the Board	 SFIs Section 10 & SOs Section 11& Annex
5. Capital Schemes Business Cases - not part of agreed plan		SFIs Section 12

Delegated Matter	Authority Delegated To	Reference Document
a) Production of case of need for every capital expenditure proposal	DoF	& SOs Section 11
b) Certification of costs and revenue consequences	DoF	
c) Approval of business cases to £1,000,000 and not linked to new service development and part of agreed capital plan	Corporate Investment Group	
d) Approval of business cases over £1,000,000 or linked to new service development	Board of Directors	
Capital Programme		
a) Production of draft capital programme	DoF	
b) Confirmation of capital funds available	DoF	
c) Approval of capital programme	Board of Directors	
Capital Expenditure		
a) Issue authority to commit expenditure and proceed to tender up to budget approved in capital programme	DoF	
b) Responsibility of keeping expenditure within scheme budget	Scheme Manager	
c) Responsibility of keeping expenditure within total capital budget	DoF	
d) Approval of variations to scheme budgets from plan:		
i) To 10% of original scheme budget, a maximum of £50,000	DoF	
ii) To 20% of original scheme budget, a maximum of £250,000	CE	
iii) Above £250,000 or 20% of original scheme budget	Board of Directors	
e) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within UK regulations	DoF	
f) Financial reporting on all capital scheme expenditure	DoF	
g) Financial monitoring of all capital scheme expenditure	DoF	
h) Granting and termination of leases with annual rent <£100k	DoF	
i) Granting and termination of leases of annual rent >£100k	CE	
6. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	DoF	SFIs Section 7
b) Price of all NHS Contracts	DoF	SFIs Section 8
7. Engagement of Staff Not On the Establishment (Within NHS England price caps)		SFIs Section 9
a) Management Consultancy	DOF	
b) Engagement of Trust's Solicitors	CPO, MD and DoF	

Delegated Matter	Authority Delegated To	Reference Document
c) Booking of Bank or Agency Staff i) Medical Locums ii) Nursing iii) Clerical Outside NHSE price caps	 General Manager or Divisional Director General Manager General / Department Manager or Divisional /Executive Director Executive Director	
8. Expenditure on Charitable and Endowment Funds Up to £25,000 per request Over £25,000 per request	 DoF CEO or DoF after authorisation from the Charitable Funds Committee.	SFIs Section 17
9. Agreements/Licences a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff b) Extensions to existing leases c) Letting of premises to outside organisations d) Approval of rent based on professional assessment	 DoF and CPO DoF DoF DoF	
10. Condemning & Disposal a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively b) disposal of x-ray films c) disposal of controlled drugs	 Divisional Director of Operations (GM)/Department Manager and Condemning Officer Superintendent Radiographer Chief Pharmacist	SFIs Section 14
11. Losses, Write-off & Compensation a) Losses and Cash due to theft, fraud, overpayment & others Up to £50,000 b) Fruitless Payments (including abandoned Capital Schemes) Up to £100,000 c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000 e) Compensation payments made under legal obligation f) Extra Contractual payments to contractors	 Two Executive Directors Two Executive Directors Cash Committee Two Executive Directors Two Executive Directors	SFIs Section 14

Delegated Matter	Authority Delegated To	Reference Document
Up to £50,000 Ex-Gratia Payments g) Patients and staff for loss of personal effects Up to £50,000 h) For clinical negligence up to £1,000,000 (negotiated settlements) i) Negotiate settlement up to £50,000 ii) £50,000 to £100,000 i) over £100,000 iv) Authorise payment (up to £1,000,000) i) For personal injury claims involving negligence where legal advice has been obtained and guidance applied i) Negotiate settlement up to £25,000 ii) £25,000 to £100,000 iii) over £100,000 iv) Authorise payment (up to £1,000,000) j) Other, except cases of maladministration where there was no financial loss by claimant £50,000 Losses, Write-Off & Compensation above delegated limits	Two Executive Directors Two Executive Directors MD CE Board of Directors CE or Nominated Director and DoF CPO CE Board of Directors CE or Nominated Director and DoF CE or Nominated Director and DoF Audit & Risk Committee	
12. Reporting of Incidents to the Police a) Where a criminal offence is suspected (other than theft or fraud) b) Where a theft is involved c) Where a fraud is involved	 Director with managerial responsibility for the area DoF or CPO DoF	SFIs Sections 2 & 14
13. Petty Cash Disbursements (not applicable to central Cashiers Office) a) Not permitted ordinarily, and to be processed through payroll expenses system	 Budget holder	SFIs Section 10
14. Receiving Hospitality Applies to both individual and collective items of hospitality received **or offered and declined**, in excess of £50.	 Declaration required in Trust's Hospitality Register	
15. Implementation of Internal and External Audit Recommendations	DoF	SFIs Section 2
16. Maintenance & Update on Trust Financial Procedures	DoF	SFIs Section 1
17. Investment of Funds (including Charitable & Endowment Funds)	DoF	SFIs Section 17

Delegated Matter	Authority Delegated To	Reference Document
18. Personnel & Pay		
a) Authority to fill funded post on the establishment with permanent staff.	Budget holder (after vacancy control approval or Management Board approval for Consultant posts)	
b) Authority to appoint staff to post not on the formal establishment.	CE and DoF	
c) Additional Increments		
The granting of additional increments to staff within budget	CPO	
d) Upgrading & Regrading		
All requests for upgrading/regrading shall be dealt with in accordance with Trust procedure	CPO	
e) Establishments		
i) Additional staff to the agreed establishment with specifically allocated finance	Budget holder (after vacancy control approval or Management Board approval for Consultant posts)	
ii) Additional staff to the agreed establishment without specifically allocated finance	CE and DoF	
f) Pay		
i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Senior Officer or Executive Director	
ii) Authority to authorise overtime	Senior Officer or Executive Director	
iii) Authority to complete and authorise positive reporting forms	Senior Officer or Executive Director	
iv) Authority to authorise travel & subsistence expenses	Senior Officer or Executive Director	
v) Approval of Performance Related Pay Assessment	Remuneration Committee/CE	
g) Leave		
i) Approval of annual leave	Senior Officer or Executive Director	
ii) Annual leave - approval of carry forward (up to maximum of 5 days).	Senior Officer or Executive Director	
iii) Annual leave - approval of carry over in excess of 5 days.	Executive Director	
iv) Compassionate leave up to 3 days	Senior Officer or Executive Director	
v) Compassionate leave over 3 days	Executive Director	
vi) Special leave arrangements	Executive Director	
paternity leave	Senior Officer or Executive Director	
vii) Leave without pay	Executive Director	
viii) Medical Staff Leave of Absence	MD and CE	
paid and unpaid	General Manager or Divisional Director	
ix) Time off in lieu	Automatic approval with guidance	
x) Maternity Leave - paid and unpaid	Automatic approval with guidance	
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Executive Director in conjunction with CPO	
ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with CPO	

Delegated Matter	Authority Delegated To	Reference Document
iii) Extension of sick leave on full pay	CPO or CE	
i) Study Leave		
i) Study leave outside the UK	CPO or MD	
ii) Medical staff study leave (UK)	Divisional Director	
iii) All other study leave (UK)	Senior Officer or Executive Director	
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by Directors taking up new appointments (providing consideration was promised at interview)	CPO	
k) Grievance Procedure	CPO	
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a the Director of People and Organisational Development must be sought when the grievance reaches the level of Associate/Dept. Manager		
l) Authorised Car & Mobile Phone Users		
Requests for new posts to be authorised as car users	CPO	
Requests for new posts to be authorised as mobile telephone users	CPO	
m) Renewal of Fixed Term Contract	Senior Officer or Executive Director	
n) Redundancy	CPO	
o) Ill Health Retirement		
Decision to pursue retirement on the grounds of ill-health	CPO	
p) Dismissal	Appointing Officers	
q) Development of personnel, industrial relations & training strategies and procedures	Executive Directors	
r) Authorisation of expenditure on recruitment advertising	CPO	
s) Day to day management of Consultants' contracts	MD Divisional Directors	
t) Excellence Awards to Medical staff.	CE	
19. Authorisation of New Drugs		SFIs Section 10
Estimated total yearly cost up to £25,000	Medicines Management Group	
Estimated total yearly cost above £25,000	CE (Subject to consultation with the above)	
20. Authorisation of Sponsorship deals	CE	
21. Authorisation of Research Projects	CE or MD or Chief Nurse	
22. Authorisation of Clinical Trials	CE and MD	
23. Insurance Policies and Risk Management	DoF	SFIs Section 19
24. Patients & Relatives Complaints		

Delegated Matter	Authority Delegated To	Reference Document
a) Overall responsibility for ensuring that all complaints are dealt with effectively under regulations. b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico - Legal Complaints Co-ordination of their management.	CE Senior Officer and PALS Rep. MD	
25. Relationships with Press a) Non-Urgent General Enquiries Within Hours Outside Hours b) Urgent Within Hours Outside Hours	 HoCM Executive Director on call HoCM Executive Director on call	
26. Infectious Diseases & Notifiable Outbreaks	MD or Consultant Microbiologist or Control of Infection Nurse	
27. Extended Role Activities Approval of any professions to undertake duties / procedures which can properly be described as beyond the normal scope of practice.	Clinical Governance Committee	
28. Patient Services a) Variation of operating and clinic sessions within existing numbers Outpatients Theatres Other b) All proposed changes in bed allocation and use (excluding critical care) Temporary Change Permanent Change Contract monitoring & reporting c) Critical Care	 COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director Bed Manager with advice from COO & Chief Nurse CE with advice from COO & Chief Nurse DoF CE or Executive Director on call	
29. Facilities for staff not employed by the Trust to gain practical experience		

Delegated Matter	Authority Delegated To	Reference Document
Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, Work experience students	CPO	
30. Review of fire precautions	CE	
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	CE	
32. Review of Medicines Inspectorate Regulations	Chief Pharmacist	
33. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	CE	
34. Review of Trust's compliance with the Data Protection Act, including GDPR	CE	
35. Monitor proposals for contractual arrangements between the Trust and outside bodies a) Monitor proposals for contractual arrangements between the Trust and other healthcare bodies b) Monitor proposals for contractual arrangements between the Trust and non-healthcare bodies	 DoF DoF	
36. Review the Trust's compliance with the Access to Records Act	MD	
37. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	MD	
38. The keeping of a Declaration of Interests Register	Company Secretary	
39. Attestation of sealings in accordance with Standing Orders	CE and DoF	
40. The keeping of a register of Sealings	CE	
41. The keeping of the Hospitality Register	DoF	
42. Retention of Records	COO	
43. Clinical Audit	MD	
44. Nominated Fire Director		

Delegated Matter	Authority Delegated To	Reference Document
Within Hours Outside Hours	CE Executive Director on call	
45. Agreement of Policies a) To recommend the adoption of new policies to the Board of Directors b) To approve policies where authorised to do so by the Board of Directors	The appropriate sub-committee of the Board e.g. Finance and Performance for finance related policies	
46. Working Together Partnership Committee in Common All functions agreed to be delegated by the Board and listed in the DBTH Committee in Common terms of reference.	Committee in common consisting of CEO and Chair or nominated deputies	DTH CiC TORs
47. Intellectual Property The disposal of intellectual property rights	Executive Committee	

6. ROLES AND RESPONSIBILITIES OF GOVERNORS

The Constitution states that at general meetings, the Council of Governors shall discharge the following responsibilities:

6.1 The appointment or removal of the Chair and the other Non-Executive Directors (section 26).

6.2 Approve an appointment (made by the Non-Executive Directors) of the Chief Executive (section 26).

6.3 The appointment or removal of the Trust's auditors (section 35).

6.4 Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors (section 31).

6.5 Approve any significant transaction, as defined in the constitution (section 42).

6.6 Approve any merger, acquisition, separation or dissolution proposed (section 42).

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Reservation of Powers to the Board and Delegation of Powers – CORP/FIN 1 (C) v.9	CE/Finance	Matthew Bancroft	Existing Policy	September 2024

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department/Secretariat

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: September 2024

Checked by: Matthew Bancroft Date: September 2024

2501 - C10 THE INSIGHTFUL PROVIDER BOARD & DBTH REPORTING

Information Item | Zara Jones, Deputy Chief Executive | 11:50

5 Minutes

REFERENCES

Only PDFs are attached

C10 - The Insightful Provider Board & DBTH Reporting.pdf

C10 - NHSE - The Insightful Provider Board.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**C10**
Report Title:	**The Insightful Provider Board and DBTH Reporting**		
Sponsor:	Zara Jones Deputy, Deputy Chief Executive Office		
Author:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance		
Appendices:	Appendix 1: NHS England - The Insightful Provider Board		

Report Summary

Purpose of the report

This report provides information on the 'insightful Board' documentation (appendix 1), published on 12 November 2024 by NHSE, plus how DBTH will use this to improve its reporting and its Board of Directors focus.

Background

The insightful board guidance provides the information that provider boards should be looking at, how to use it to drive better outcomes, and support better decision-making. The documentation is broken into 6 domains, Strategy, Quality, People, Access and Targets, Productivity and Finance. Each domain lists measures that the board may find useful when considering and reviewing each of these areas both through the IQPR and reports they are presented with.

There is also a focus on Governance and Culture, highlighting the responsibility of the NHS board in this area, and what is expected as part of a well-led board. This is more than the information they receive from information flows through the organisation, but also for the Board of Directors to demonstrate they have the appropriate mix of knowledge, skills, experience, and diversity to reflect their population. There is explicit reference to the requirement to complete an annual internal 'well led review' plus an in-depth external assessment at least every 3-5 years.

The Performance Lead has undertaken a review of the insightful board guidance against the reporting matrix for the data flows for DBTH operational reporting and the IQPR that comes to board. This shows:

Current Review

- 74 metrics identified based on their significance, are presented within the IQPR report to the Trust board. Of these 8 are being further developed, are pending national or local thresholds or have no applicable target and will be included in future reports.
- Statistical Process Control charts have been implemented within the IQPR output on the DERICK dashboard for the Trust IQPR, positive feedback has been received following the most recent Trust Board.
- The IQPR will continue to be developed and improved in line with operational reporting procedures and content.
- Performance Review Meetings are being reviewed for greater transparency and accountability in reporting.

The full data review work will be completed by the end of March 2025.

Next steps

The insightful board is broader than hard metrics and data, it includes the Boards culture and effectiveness. Recommendations from the guidance is in line with the current governance work review and includes:

- The Committee reports should be concise and consider the most appropriate metrics and commentary for the performance or issue being considered. Information that should be considered by boards should often be reviewed first by a committee.
- Boards need relevant and insightful information to inform their decision-making. This information needs to cover the organisation's statutory requirements, quality of care, delivery of services, progress against strategic objectives, use of resources and local intelligence.
- The Information presented needs to be timely, cover both improvement and assurance be valid and subject to review and allow for deep dives to understand care quality and performance within a directorate, department, team, service and at the point of care.
- Integrated reporting enables board members to get a clear picture of successes, failures, and emerging risks, and prepare insightful questions in advance of a meeting. Data tools such as Statistical Process Control should be used to ensure that an organisation does not react unnecessarily to expected variation in regularly reported data.

Cultural and governance aspects of the review are focussed on how a board shapes the culture within the organisation and includes:

- An open and transparent organisation; assessing if there is an open and honest reporting culture at all levels of the organisation and if colleagues feel safe to speak up and raise concerns within a just culture and sharing information with patients when requested.
- Compassionate and inclusive culture; colleagues understand the patient experience and the impact of inequalities on health outcomes, and the trusts policies and procedures and are able to identify and address behaviours that are inconsistent with NHS values.
- A fair and just culture; the trust looks at wider systemic issues when things go wrong, ensuring a culture which balances learning form incidents with accountability for their consequences, and where no-one fears blame.
- A problem-sensing approach; leaders at all levels of the organisation seek out and listen to those they lead, as well as patients, carers, and their families. This is a proactive process that is followed from ward to board and is underpinned by the duty of candour which is followed when things go wrong.
- A continuously improving culture; where the board seeks assurance that quality improvement is embedded to test ideas and solve complex problems, with proactive interest in finding solutions that have worked elsewhere and local innovation.

Conclusions

Some of the above recommendations plus the governance and board accountability aspects overlap with the internal well-led review that will commence in Jan 2025, however the well-led review will focus on the new CQC framework. The well-led review will require full engagement with each board member to get a complete overview and support this process. The learning from this can be used to inform a number of diagnostic areas including the insightful board gap analysis.

The internal performance management process, focussed on the internal governance and information flow structures will be reviewed at Finance and Performance Committee as part of its usual annual review and will use the guidance to support with this.

The NHS England insightful provider board is an additional guide to support improvements in board culture, accountability, supported by open and transparent information flows, and clear roles and responsibility from ward to board. There are a number of frameworks in place, including the CQC well-led review which this approach will completement and expand on, the areas of improvement for the DBTH Board.

Recommendation:	The Board is asked to note the information presented.

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

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

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

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

Date published: 12 November, 2024
Date last updated: 13 December, 2024

The insightful provider board

Publication (/publication)

Content

How to use this guide

This guide will help boards to consider their approach to handling and acting on the information they receive. It considers the leadership behaviours and culture of the board and how these can affect the information it receives and the actions it takes, as well as metrics that can support the board to better understand the organisation's performance.

The 6 domains are indicative areas of oversight and should be read as a collective – for example, information about an organisation's estate could fall within all domains.

The supporting guidance (https://www.england.nhs.uk/long-read/the-insightful-provider-board-supporting-guidance/) includes further metrics and additional considerations which boards may find useful to provide insight into their trust's performance. Boards should also consider performance against the objectives set out in the annual priorities and operational planning guidance, as well how it is contributing to its local system plans.

This guide is not an exhaustive governance resource and should be read alongside the Code of governance (https://www.england.nhs.uk/long-read/code-of-governance-for-nhs-provider-trusts/) for NHS providers and guidance on good governance and collaboration (https://www.england.nhs.uk/publication/guidance-

on-good-governance-and-collaboration/). Also, it is not intended to be used as a checklist; it is to support boards to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively.

The recommendations are best practice advice, not mandatory guidance, and non-compliance is not in itself a breach of any regulatory requirement.

This guide is structured as follows:

- **governance and culture:** the factors that make it challenging for the right information to flow to the board and the role of effective governance in tackling this; how boards should handle and act on information; and the importance of a curious, problem sensing and open culture
- **meaningful information:** the principles that govern the flow of information to the board, and tools to report that information; and a strong focus on outcomes rather than actions and processes
- **6 domains for consideration:** these areas and illustrative metrics can be used by boards to understand if their organisation has a sufficiently comprehensive framework for reviewing trust performance, making decisions and developing strategy
- **putting the framework into practice:** a sample integrated performance report (IPR) (https://www.england.nhs.uk/wp-content/uploads/2024/11/example-provider-integrated-performance-report.pptx) to illustrate how information can be presented and used effectively

1. Governance and culture

The role of an NHS provider board

The board is responsible for ensuring the healthcare and other services the trust provides for patients are high quality and safe. The board also promotes the long-term sustainability of the trust as part of its integrated care system (ICS) serving the wider population and healthcare system. The board has a collective responsibility for:

- ensuring high-quality and effective care for all patients and service users
- setting strategic direction, ensuring the executive has appropriate capacity and capability to monitor and manage quality of care and operational delivery
- adding value to the success of the organisation and its system
- using prudent and effective controls to lead the organisation

- promoting and adhering to the organisation's values
- ensuring the organisation's obligations and duties are met

As set out in the Code of governance, boards are unitary, which means decisions are taken as a single group of executives and non-executive directors, and all members of the board share the same responsibility and liability.

Well-led boards:

- set a challenging but achievable strategic direction
- identify the strategic issues that require discussion or decision and distinguish these from operational detail
- embed the trust's values throughout the organisation to consistently improve the culture
- provide constructive challenge
- make sure all patients and service users receive a consistently high-quality service
- ensure that innovation and transformational change are being delivered and benefits realised
- focus on improving access to services and reducing health inequalities across all the communities they serve
- make sure taxpayers receive value for money by maximising productivity
- identify unwarranted variation in quality and performance
- triangulate signals from different sources to identify underlying issues
- use benchmarking tools and data such as the Model Health System (https://www.england.nhs.uk/applications/model-hospital/) to regularly compare their performance with similar organisations
- embed continuous quality improvement approaches in all aspects of service delivery
- understand and respond to the needs and views of patients, service users and all the communities they serve, listening to their experiences and using their feedback to improve services
- anticipate the potential impact of policy, technological and socioeconomic developments
- protect board agenda time to regularly reflect on learnings from independent reviews
- assure themselves that the organisation is complying with statutory duties, quality and clinical standards, other regulatory requirements and national priorities

To fulfil these duties, run their organisations well and support their system, boards need to have the appropriate mix of knowledge, skills, experience and diversity to reflect their population.

Boards also need to ensure:

- effective governance arrangements are in place across their organisation
- their trust has an open, curious and transparent culture which supports the sharing of information, provides psychological safety and fosters learning and improvement
- insightful information is used to set strategy, oversee the quality of care and delivery of national standards, and monitor the overall health of the organisation and its people

While the need for robust and relevant information and its effective use and interpretation is the focus of this guidance, the other elements above have a significant impact on how information is cascaded through the organisation. It is good practice for boards to conduct in-depth, independently facilitated developmental reviews every 3 to 5 years to assess how well-led the trust is across all areas, and to identify areas where their leadership and governance can improve.

It is important for boards to continually review and understand their trust's performance against guidance and good practice. As part of a continuous development ethos, boards should routinely consider what training and other resources they need to have the required skills and experience.

Effective governance arrangements

Effective governance is essential for the quality and timely flow of information to and from the board. This flow is critical for trusts to make the right decisions based on the correct information. As the factors underpinning effective governance can evolve, for example, as services change, people leave or organisations restructure, regular reviews can help to ensure governance remains fit for purpose.

'Active' governance means issues are considered by the most appropriate people, relevant information is reviewed in the most useful format and at the right time, and the level of scrutiny produces rigorous challenge and an effective response. Findings with a material importance for the organisation should be identified and reported promptly to the board and analysed through a thematic lens.

The unitary board and collective discussions and decisions

All board members should have sufficient understanding of issues and risks across all aspects of the trust's operations to make decisions and ensure there is a culture which supports open debate. Appropriate training for board members,

including on topics such as finance and clinical and financial governance, can be an effective way to enable this. Reports to the board should be concise with issues, risks and mitigating actions clearly set out.

The unitary board and collective discussions and decisions

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Governance – questions for provider boards to consider:

- Are the chair's roles and responsibilities clearly set out?
- Are there rigorous skills-based recruitment and appointment processes for non-executives, and are these independent?
- Does the size of the board, the committee structures and processes reflect the size, services and complexity of the organisation?
- Are there regular performance reviews of the board and its individual members?
- Does the board receive the right information, presented in the right way and at the right time?
- Are there robust internal controls across the trust to support organisation-wide transparency and accountability?
- Are the right structures in place to escalate information through the organisation from the point of care to the board?
- Is the board able to hear patients, service users and staff voices in an authentic way as part of its leadership role?
- Are the roles and responsibilities of the Senior Independent Director clear and agreed by the board (as set out in the Code of governance)?

The board's role in shaping culture

Investigations into care failings continue to highlight the importance of an open culture. Staff, patients and service users should feel able to speak up and share concerns and see them escalated and acted on. Boards need to receive the right information about these to make decisions based on accurate and timely data and intelligence.

Board members need to be regularly visible to provide opportunities for staff to engage and feed back, in addition to Freedom To Speak Up (FTSU) and other channels. It is essential to frequently test whether information presented in board reports matches the reality for patients and staff at service level. Fundamental to good oversight is curiosity and appreciative inquiry and knowing when to seek external review and when to directly address concerns. This is important at all levels of the organisation and especially the board.

The board shapes the culture of its organisation by how it operates and behaves. Boards require diversity of thought to improve decision-making and enable alternative views to be debated and evaluated. No areas should dominate the conversation at the expense of others. In particular, the 'clinical voice' (including that of trainees) should always be heard across all remits of the board. Some important areas (such as estates) may not have individual executive representation on the board; for these areas it is even more important that information flows effectively so the board can understand risks, issues, opportunities and progress.

Transparency and candour

The Care Quality Commission's 'Regulation 20: Duty of Candour' is a statutory duty to be open and transparent with people receiving care.

Boards must develop and foster a safe reporting culture so that staff, service users and family members feel able to report incidents or concerns and have assurance these will be listened to and acted on.

Creating a feedback loop is essential for a transparent culture. The board should ensure that staff, patients and service users are told about what is happening or has happened as a result of their feedback. The board should ensure that staff, patients and service users are told about what is happening and has happened as a result of their feedback.

Board members, through their actions and how they govern, should be visible and approachable role models who lead and promote the organisation's values for their staff and patients and service users.

A positive organisational culture is:

1. **open and transparent** – there is an open and honest reporting culture at all levels. Staff feel psychologically safe to speak up and raise concerns in a just culture which supports continuous The organisation's information, data and decisions are shared with patients, service users and partners when requested
2. **compassionate and inclusive** – staff understand patient experience and the impact of inequalities on health outcomes and they actively promote equity, equality, diversity and inclusion. The trust has policies and procedures to identify and address behaviours that are inconsistent with NHS values
3. **fair and just** – the board and senior managers consider wider systemic issues when things go wrong, ensuring the organisation and individuals learn without fear of retribution. Boards understand why failings occurred and what has led to staff behaviours and poor patient outcomes. A just culture is one which balances learning from incidents with accountability for their consequences – and where no-one fears blame
4. **problem-sensing** – leaders at all levels proactively seek out and listen, not only to the views of those they lead but also to the experience of patients, service users and their families. The board demonstrates an understanding of their role in detecting early – and preventing – closed cultures. When something goes wrong people are informed and supported, and the duty of candour is followed
5. **continuously improving** – there is a genuine and proactive interest in finding out what has worked elsewhere and examples that have been successfully adopted, as well as local innovation to identify ways to improve. The board seeks assurance that quality improvement has been applied to test ideas to solve complex problems

Problem-sensing

Well-led, successful boards should be scrutinising the information and data presented to them. Crucial to this is having a problem-sensing culture, described by Dixon-Woods & Martin (2023) (https://nhsproviders.org/topics/governance/a-guide-to-good-governance-in-the-nhs/organisational-culture-problem-sensing-and-

comfort-seeking) “Problem-sensing involves actively seeking out weaknesses in systems relating to quality and safety, typically using multiple techniques and sources of organisational intelligence.

[This includes] forms of organisational intelligence that offer challenge, disrupting any incipient risk of complacency…As with the collection of “harder” data, though, it is important not to mistake activity for action.

Simply undertaking listening activities or unannounced visits is no substitute for the hard work of analysing and responding to the issues they unearth. The willingness of those at the “sharp end” [frontline] to speak and of those at the “blunt end” (senior leadership) to listen exist in a reciprocal relationship.”

Culture – questions for provider boards to consider:

- Does the board role-model a culture of open and curious challenge?
- Does the board understand when to seek external review and independent input?
- Is most of the discussion at the public board, and with clear justification for any items discussed in private?
- Are issues appropriately escalated from executives and is information presented transparently?
- Does the board balance operational performance with people performance at all levels of the organisation?
- Do all board members undertake 360-degree feedback?
- Does the board proactively seek views, listen to them and demonstrably follow-up, and promote the value of a ‘speaking up’ culture?
- Is Freedom to Speak Up (FTSU) information discussed at the board and is it considered alongside other sources of information on organisational culture?

Corporate governance – processes and structures

An effective and high-performing board needs to be supported by a robust corporate governance structure that enables the seamless flow of information and decision-making up and down the organisation, supported by independent perspective and challenge from non-executive directors. This structure needs to be complemented with effective policies on risk, and risk escalation, and delegation for the board to operate effectively. In addition, given providers' requirements to meet the standards of other healthcare regulators, where there are specific regulatory or other roles set by a statutory body in the trust (for example the Human Tissue Authority's 'Designated Individuals' for mortuaries), these have a clearly defined line of sight to the board.

Board committees

Boards should make the best use of committees, delegating where appropriate functions and responsibilities that are best considered in these forums to allow more dedicated time for detailed review and consideration. These can be standing committees (for example, audit, finance, quality) or time-limited, for example, if a board has a particular aim or programme that requires more detailed oversight and scrutiny, such as significant investments in new buildings or whole-organisation digital systems.

Boards should review committees' effectiveness regularly as well as their structures (at least annually) to ensure they are fit for purpose and support board governance and organisational oversight. Alongside, boards should have clear schemes of delegation and standing financial instructions that clearly set out the functions of these committees and associated responsibilities and accountabilities.

Committees should report regularly to the board in a balanced and insightful way which does not simply repeat the information and discussion that has already taken place at the committee.

Committee reports should be concise and consider the most appropriate metrics and commentary for the performance or issue being considered. The domains included in this guide give an overview of the metrics that should be considered by boards and these should often be reviewed first by a committee.

One of the values non-executive directors (NEDs) can bring to board and committee performance is by providing independent perspectives on how the data and other information are scrutinised. To foster a diverse experience base across NEDs, each NED can sit on multiple committees, for example, quality and finance, so they can gain different perspectives.

The supplement to this guidance (https://www.england.nhs.uk/long-read/the-insightful-provider-board-supporting-guidance/) outlines additional areas which committees may find useful when trying to understand an issue or improve performance.

Using information

The NHS generates a lot of data. Boards do not need to see every metric every month, otherwise they would be overwhelmed. Information needs to be scrutinised at the right level in the organisation and reviewed or escalated accordingly.

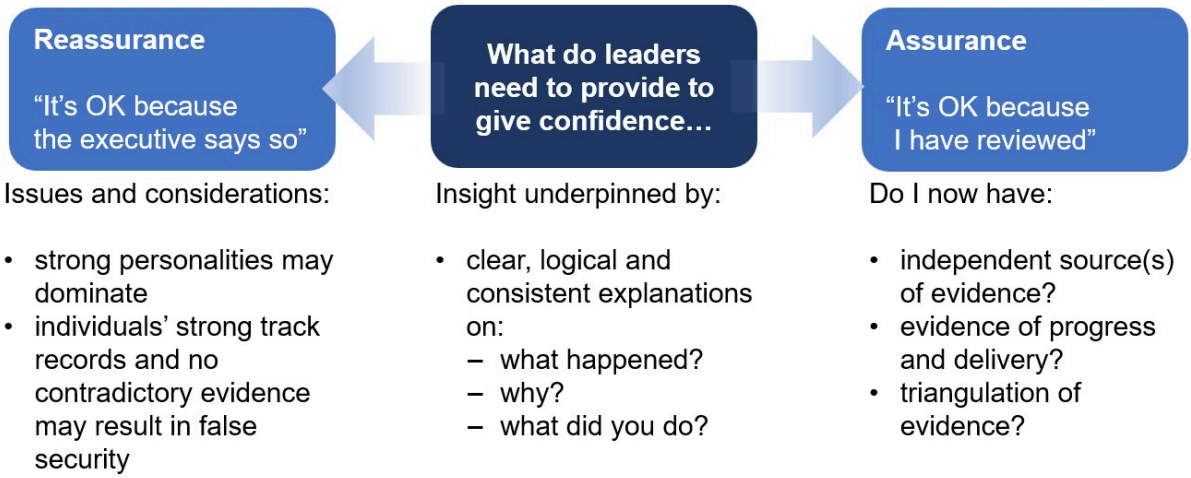
Information presented needs to:

1. be timely, reflecting the most recent data available
2. cover both improvement – using statistical methods to track trends over time, looking at variation and not just comparing against targets at a point in time – and assurance – looking at whether standards are being met and comparing performance against relevant historical trust data or external benchmarks
3. be valid and subject to review – are the measures fit for purpose? How much weight can be placed on the data?
4. allow for deep dives to understand care quality and performance within a directorate, department, team, service and at the point of care.

Confidence in information received – assurance vs reassurance

When receiving reports, the board and its committees should ensure there is a balance of assurance and reassurance in the information it receives. Boards need to have confidence that the information is a true reflection of performance and improvement and there are no other issues or considerations arising that warrant further review. The diagram below outlines the questions and lines of enquiry board members should be pursuing.

Figure 1: lines of enquiry board members should be pursuing



(https://www.england.nhs.uk/wp-content/uploads/2024/11/insightful-icb-board-figure-1.jpg)

Reassurance – "It's OK because the executive says so"
Issues and considerations:
strong personalities may dominate
individuals' strong track records and no contradictory evidence may result in false security
What do leaders need to provide to give confidence…
Insight underpinned by:
clear, logical and consistent explanations on:
what happened?
why?
what did you do?
Assurance – "It's OK because I have reviewed"
Do I now have:
independent source(s) of evidence?
evidence of progress and delivery?
triangulation of evidence?

For example, if a trust has identified a safety or quality issue and sought to resolve and address it internally, it must ensure it has seen evidence and independent validation of the actions taken to assure the board the issue has been resolved.

Board and committees – questions for provider boards to

consider:

- Is the role of each board committee clear, including what areas and organisational risks it covers and how it reports into the board?
- Are there areas and functions of your trust's operations that require specific governance groups (for example Mental Health Act)?
- Are board agendas planned in such a way over the year that all relevant areas of the trust's operations get the appropriate scrutiny?
- Is there the right balance between strategy – developing and delivering it – and day-to-day operations?

Organisational policies and procedures

To validate an organisation's information, it is essential that policies and procedures are in place and these are well understood across the organisation and kept under regular review. For the purposes of board reporting, this is especially important for risk management policies, schemes of delegations and financial instructions. These policies should clearly set out:

- standing orders for how an organisation carries out its business
- nominated/designated individuals where appropriate
- financial instructions which detail the financial thresholds and limits that apply to the organisation and its budget holders
- schemes of delegation which set out where responsibility and accountabilities lie and where they have been delegated to committees, executives or other forums

Schemes of delegation are especially important when organisations consider new models of collaboration, including across systems, to deliver care differently. Boards must be clear where decision-making and accountability sits when making any changes to the organisation's delegated functions.

2. Meaningful information

Boards need relevant and insightful information to inform their decision-making. This information needs to cover the organisation's statutory requirements, quality of care, delivery of services, progress against strategic objectives, use of resources and local intelligence. Boards should look at the organisation's internal priorities as well as those of their local system and national areas of focus.

The amount of data available to organisations and boards continues to increase. Reducing the risk of information overload requires:

- governance structures including board committees to provide more detailed scrutiny of specific areas
- the board to have confidence in the scope and robustness of these committees and the escalations and reports arising from them

Reports to the board should focus on the outcomes and impact of the board's actions to deliver change and improvement, and not just report on processes or progress made against a plan.

This section sets out high-level principles for how information can be prepared and shared at board level.

Board-level information

Boards and teams across the organisation need to distinguish between information that:

- needs to be reported routinely – for operational or statutory reasons – to the board with a certain level of detail
- needs to be reported only if there is demonstrably a problem, for example, where performance significantly diverges from that achieved by peer trusts
- changes relatively slowly and that should therefore be looked at only on a quarterly or 6-monthly basis

In planning agendas and structuring reporting, boards should be mindful of these dynamics. Reports to the board from committees must provide a meaningful summary of the issues and risks that have been discussed, rather than simply noting that discussion took place. There should be a clear process with defined criteria by which teams outside of committees can escalate matters to the board as necessary.

Information should not be repeated unnecessarily in board packs (for example repeated provision of background information) so that board attention can be focused on the key messages, updates and actions. In the final board pack, charts and other data should be in a legible and accessible format and units of time should be presented consistently for comparative purposes. For some data, forecasts and trajectories should be included (for example, revised financial run rates). Consideration should be given to how professional views can complement data to provide greater insight into findings and observations. Papers should always be provided with adequate time for members to review and scrutinise the

information in advance. Boards should regularly review the quality of the information provided to support board discussions and provide assurance, to ensure the information and format is appropriate.

Aggregation

Some quality and performance information is typically reported in aggregate forms to simplify the volume of information seen by the board and allow for easier triangulation – for instance as part of an overall summary to an integrated performance report, performance on a page or integrated balanced scorecard which provides a high-level overview of organisational performance across specified domains.

While these aggregate metrics can help simplify the complex landscape of data and provide an at a glance picture of the organisation's performance, they are also by their nature limited and are not designed to highlight emerging issues at site, specialty or clinical business unit level. The risk of issues being masked within aggregate data is likely to increase with the size and complexity of the organisation and the clinical business units within it.

Integrated reporting enables board members to get a clear picture of successes, failures and emerging risks, and prepare insightful questions in advance of a meeting (at a strategic level rather than becoming too operational). It is essential that integrated reporting describes the reasons for unusual patterns in data and the actions being taken. Many integrated performance reports simply describe the data rather than articulating causes and actions being taken in response.

For integrated reporting, many metrics are reported and calculated monthly. Boards should not require reporting which is calculated more frequently than this and some metrics are not updated frequently, for example, annual survey information. Data tools such as Statistical Process Control (SPC – discussed below) should be used to ensure that an organisation does not react unnecessarily to expected variation in regularly reported data.

Data should routinely be considered from a health inequalities perspective and by ethnicity and deprivation, and to determine which population groups might be missing from data.

Exception reporting

Reports by exception are important and boards need a clear process for escalating matters either within or outside the normal reporting cycle, for example, ad hoc information from third parties such as auditors, professional

bodies like General Medical Council (GMC) and Nursing and Midwifery Council (NMC) or national clinical audits.

Triangulation

Boards will often be presented with a range of information cutting across multiple areas of activity. Seemingly non-related elements can, when taken together, reflect an underlying issue that otherwise may not have been picked up in time. Other information may highlight unintended consequences of policies or decisions that need drilling into.

Boards should always be aware of potential interlinkages, triangulating where necessary to identify and focus in on potential emerging issues. Examples include:

- considering levels of complaints along with their nature and the appropriate response to them, for example, about maternity settings, and correlating with trainee reports, patient safety incident records and information from medical examiners or national audit findings
- agency pay, productivity measures and safe staffing red flags
- patient and family voice and themes from patient safety incident data
- comparing staff survey information with patient and service user experience
- considering potential linkages between the built environment (for example the condition of the trust's estate) and quality and safety metrics
- movements in quality and outcomes with operational productivity measures

Boards should gain assurance from board reports and a range of other information (especially patient, service user and staff feedback) and direct observation. Using listening events, walkarounds, patient stories and narrative accompanying quantitative data at board level is best practice. Boards can gain insights via shadowing, 'mystery shopper' type data gathering, role swaps and clinical simulation. It is important these are carried out with an improvement mindset rather than as a compliance-based activity. Where different sources appear to contradict each other, further investigation may be necessary.

Triangulation

To understand the factors that may be affecting the quality of care patients receive, boards should look at a variety of indicators and sources. Examples include:

- considering, at unit level, staff turnover, grievances, sickness levels and survey data and correlating these with patient experience and quality issues to identify root causes of problems
- correlating Estates Return Information Collection (ERIC) data (https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection), patient and staff experience, and estates related safety incidents as part of a patient safety review across the trust's estate

It is important to scrutinise trends across multiple indicators to understand the source and drivers of key issues and to then implement evidence-based solutions.

Using national and local data

While most data considered by boards is drawn from local systems, boards must also consider national data and reviews. National dashboards and data sources such as the Model Health System, the Office of National Statistics, clinical audits, the Data Quality Maturity Index (DQMI), those from the Healthcare Quality Improvement Partnership (such as MBRRACE-UK) and others provide opportunities for benchmarking and review of progress against national targets and comparable peer trusts. These may draw out themes such as health inequalities which may be less evident from local data alone. Board members can use these alongside the information in board packs to form a broad understanding and triangulate the information they receive. Improvement tools and approaches such as NHS IMPACT and national and local clinical audits also support trusts to understand their data and focus their improvement resource on patient outcomes.

Establishing a framework for data reporting

Information should be framed and presented in a way that enables board members to understand the relevance of it to the agreed strategic objectives and processes for managing risk and gaining assurance. A consistent style of reporting should be adopted for board and committee reports.

Some boards may choose to structure integrated performance reporting according to thematic domains (for example, quality, workforce, finance) while others choose to structure or align reporting to the Care Quality Commission (CQC) domains or well-led quality statements (plus finance), which enables self-

assessment against the domains in an integrated way. For assessing broad areas, such as urgent and emergency care, boards integrate indicators from multiple domains to understand all factors that impact performance.

Reporting can also take the form of a themed dynamic report. This could focus on different, specific areas and themes, for example, across performance data, clinical insight or lived experience. This can be planned periodically through the year as part of a forward plan. This can allow a more holistic view of quality with a limited set of indicators presented.

Analytical tools to guide decision-making

There are several statistical and other analytical tools to guide decision-making. One is Statistical Process Control (SPC), which looks at data over time using a control chart to reveal the type of variation in a process. There is a strong evidence base demonstrating the benefits of SPC.

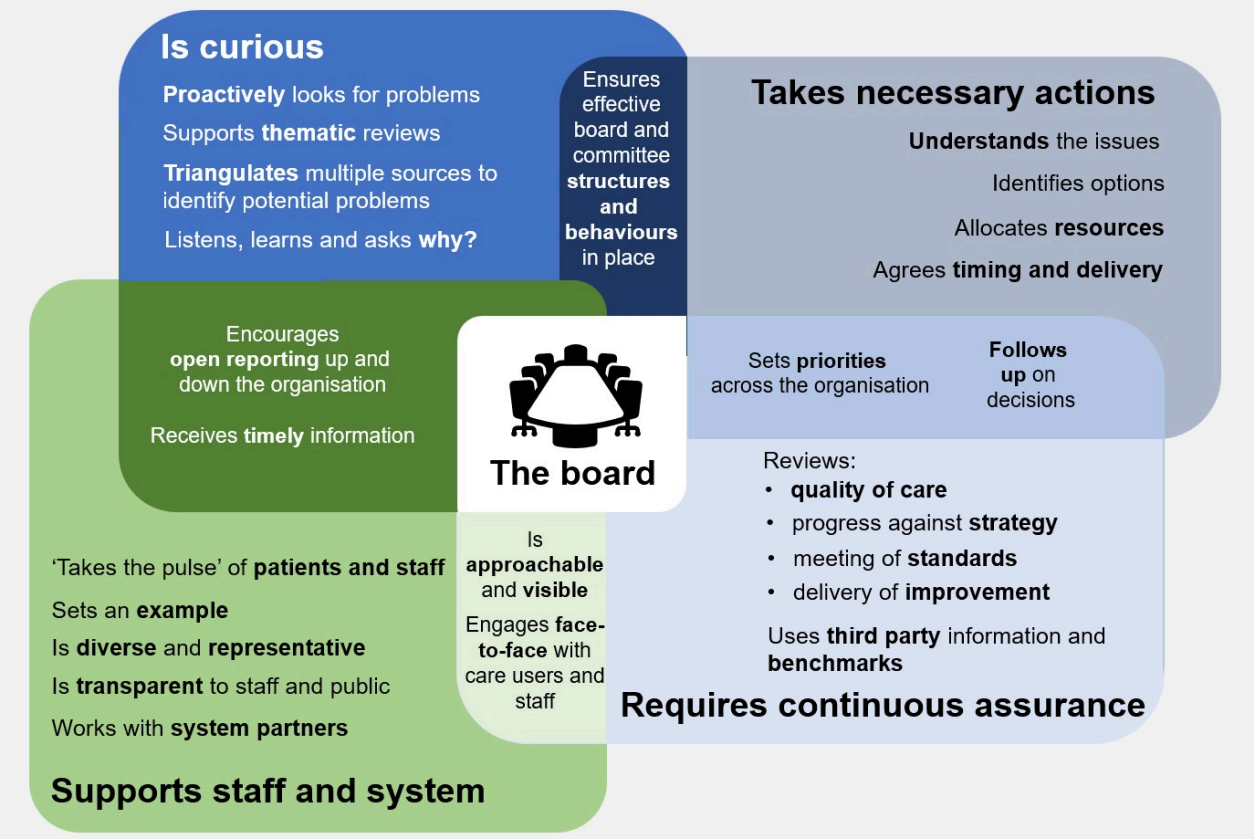
NHS England's Making Data Count programme (https://learninghub.nhs.uk/catalogue/Making-Data-Count/browse#catalogue-details) provides training for boards on the benefits of replacing more traditional methods of analysing data such as Red Amber Green (RAG) reporting with SPC. While RAG reporting provides an at a glance method of understanding performance, it can mask important messages in the data, driving unhelpful behaviours, poor decision-making and potentially wasted time and resources. Many trusts now use SPC as the primary method of analysis to understand quality, performance, workforce and finance data. Boards have reported benefits including:

- a strengthened ability to challenge
- reduced time being distracted by insignificant changes in data
- better governance processes
- greater clarity on where the board should focus its attention

Read more about the benefits of SPC (https://bmjleader.bmj.com/content/leader/early/2021/10/04/leader-2020-000357.full.pdf). This sample integrated performance report (https://www.england.nhs.uk/wp-content/uploads/2024/11/example-provider-integrated-performance-report.pptx) incorporates SPC charts, pareto (also referred to as the 80/20 rule) charts and associated narrative. A pareto chart is a useful analytical tool to demonstrate the key contributors to an issue. It is important to triangulate quantitative data in the integrated performance report with available qualitative data.

Does the trust have, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare

Figure 2: the characteristics of effective NHS provider boards



(https://www.england.nhs.uk/wp-content/uploads/2024/11/insightful-provider-board-figure-2.jpg)

3. 6 domains to consider

This section provides an overview of the types of information and metrics which may be considered by boards. By its nature it is extensive and although it identifies mandatory reporting, the inclusion of metrics in these domains does not mean they, and all related information, should routinely be reported. Similarly, the domains are not the only or best way to frame information provided to the board.

Information overload is a real risk. Minimising it requires a thoughtful consideration of the organisation's risks and priorities and the quality of the data available to develop a bespoke approach to reporting, and which allows the board to have meaningful discussions that support learning and decision-making.

I. Strategy

Questions for boards:

- Does the organisation’s strategy reflect shared priorities across the system and an agreed contribution to the Joint Forward Plan and Capital Plan with integrated care board (ICB) and system partners?
- Is the trust working effectively and collaboratively with system partners and its provider collaborative for the overall good of the system and population served?
- Is the board assured that it is overseeing the delivery of its organisational strategy effectively, and that this is responding to the needs of the local system strategy?
- Is the organisation meeting, and will continue to meet, any regulatory directions placed on it or undertakings?

Boards are focused on collaboration and how best they can work with their local systems and partners to deliver the best outcomes for their local population. Each organisation is a partner in at least one integrated care system (ICS) and one provider collaborative, and the organisation’s own strategy needs to support not just the organisation’s own service delivery, but that of its system and provider collaborative(s). When governance operates collaboratively, all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect each other’s needs, and work together to align their governance arrangements.

The board’s strategy needs to enable the organisation to deliver clinically, financially and operationally sustainable services for the population. Developing strategy involves close consultation with clinical colleagues and staff across the organisation, as well as the ICB and other partners in the local health economy (having regard to the Joint Strategic Needs Assessment), including citizens, patients, and service users, carers, and their families. Boards must set aside time to ensure their strategy is clear and well-developed, with most of their time devoted to strategic objectives that have appropriate goals and ways of measuring progress against their achievement and demonstrating success. Boards also need to ensure they are meeting their organisation’s legal and regulatory requirements.

Board strategies need to take account of national plans for the NHS and associated guidance, priorities set out in operating planning guidance, government commitments such as Net Zero as well as clinical and technological advances which change how care is delivered. The table below outlines some areas of focus and metrics boards should consider when setting their strategy and evaluating the delivery and impact of it.

Area: Trust’s own strategic objectives

Relevant indicators and measures (quantitative and qualitative):

- Locally defined

Area: Local system objectives including forward plans

Relevant indicators and measures (quantitative and qualitative):

- Developed with local ICB
- Whole system measures developed through co-design

Area: Organisational development

Relevant indicators and measures (quantitative and qualitative):

- Assessments of local health needs and inequalities in access and outcomes
- Referral rates by diagnosis and procedure from local GPs to the trust
- Benchmarking analysis from GIRFT and Model Health System
- Strategic development indicators such as:
- o commercial priorities
- o digital and data priorities (such as digital transformation and cyber security threats)
- o technology opportunities
- Progress in delivering transformational change

Area: Pan-organisational activity and resource planning

Relevant indicators and measures (quantitative and qualitative):

- Identifying priorities and converting these into clear and quantifiable targets
- Ensuring capacity and demand projections inform workforce, activity and financial planning

Area: Key trends and forecasts

Relevant indicators and measures (quantitative and qualitative):

- Trends in income and expenditure against budget including run rate analysis
- Projected activity growth by service line
- Cash-flow forecast over 6, 12 and 24-month horizons

Area: National priorities

Relevant indicators and measures (quantitative and qualitative):

- For example, indicators relating to:
  - quality oversight and improvement
  - national planning guidance
  - reducing health inequalities
  - Greener NHS (net zero) – progress in delivery (see Annex B of the Green Plan guidance for suggested metrics)
  - NHS Long Term Workforce Plan commitments
  - patient safety
  - Sexual Safety Charter

Area: Statutory duties, regulatory ratings, and compliance with regulatory requirements

Relevant indicators and measures (quantitative and qualitative):

- For example:
  - Public Sector Equality Duty
  - CQC ratings
  - meeting ongoing statutory duties plus any trust-specific regulatory requirements such as CQC improvement notices, statutory undertakings
  - compliance with 10% social value weighting across contracts
  - Violence prevention and reduction standard

Area: Key external developments

Relevant indicators and measures (quantitative and qualitative):

- Locally defined, but may also include:
  - nationally set targets and indicators
  - local system targets for local population. These should be aligned with provider collaborative, ICB and public health indicators to avoid inconsistency and duplication
  - changes and trends in local health needs, how they are addressed and any impact on future workforce (for example, care closer to home and virtual wards)

Area: Compliance and risk

Relevant indicators and measures (quantitative and qualitative):

- Highest rated estates and facilities compliance risks including analysis of service impact of non-compliance and infrastructure failure
- Premises Assurance Model Self-Assessment

II. Quality

Questions for boards:

- Does the trust have, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on safety intelligence, patterns of complaints, and including any further metrics it chooses to adopt)?
- Are systems in place to monitor patient experience, and are there clear paths to relay safety concerns to the board?

The quality of care provided, and its continued improvement, is a core responsibility of boards. They must be able to identify and act in response to early warning signs of poor-quality care, and where harm has occurred this needs to be understood and addressed. Over the last 15 years, a series of national reviews and programmes have made recommendations to strengthen boards' visibility of quality, and the reporting of certain types of quality information to the board is also now mandatory.

Staff, patient and service user feedback and insights are vital indicators about the quality of services and care. To improve patient experience and outcomes, boards need a whole systems approach to collecting, analysing, using and learning from feedback for quality improvement. This feedback should cover the care and the physical environment in which services are delivered. Triangulating data from different sources is vital. All trusts have a legal duty to involve the public in their decision-making about NHS services and boards need to be assured this duty has been met.

Area: Experiences of care

Relevant indicators and measures (quantitative and qualitative):

- All providers:
    - Triangulating staff experience at ward and site level with patient experience
    - Friends and Family Test
    - reviewing the patient experience improvement framework

    - Patient-Led Assessments of the Care Environment (PLACE) (https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place) annual appraisals
    - national and local patient and carer survey results
    - patient reported experience measures
    - availability of advocacy, peer advocacy, culturally competent advocacy
    - knowledge of how patients are involved in quality improvement and who takes part, for example in patient forums or advisory groups
    - local Healthwatch and the insight it gathers on the provider's services (for example, Enter and View reports)
- **Mental health:**
    - Patient and carers race equalities framework (PCREF)
    - Patient and Carer Feedback Mechanism

Area: Mandatory board information Patient Safety Incidents

Relevant indicators and measures (quantitative and qualitative):

- Learning from Deaths (quarterly)
- Perinatal Quality Surveillance mandatory measures

Area: Safety

Relevant indicators and measures (quantitative and qualitative):

- Selected Patient Safety Incident reporting rates and analysis
- Organisations should use the Framework for Measuring and Monitoring Safety where applicable. The choice of metrics will be informed by the services provided and should link clearly to the local Patient Safety Incident Reporting Plan (PSIRP)
- Boards should consider the timeliness of the intelligence they are reviewing, and ensure historical data is balanced with real-time information including direct engagement between board, staff and patients and service users:
    - feedback from board walkarounds and safety huddles (visible leadership)
    - patient safety partner feedback
    - patient safety specialist engagement
- Generic incident and safety related metrics may include:
    - whether all national patient safety alerts are actioned by deadline – particularly those issued by the Central Alerting System (CAS)
    - duty of candour compliance percentages

    - patient safety incident reporting patterns, paying particular attention to changes over time and looking across harm severity, location, services involved, contributory factors and other relevant information
    - patient safety incident investigation and other learning response action implementation and the impact on service safety
    - staff survey safety culture metrics
- Relevant outcome metrics linked to safety of care should be used to identify trends which would in turn trigger more thematic reviews
- **Mental health providers** may wish to consider metrics such as patient self-harm; all forms of Restrictive Practice (including Long Term Segregation); sexual safety incidents; homicides and attempted homicides; crisis response times; up to date risk assessments. This must include reporting against the requirements set out in the Mental Health Units (Use of Force) Act
- **Ambulance providers** may wish to consider metrics such as:
    - quality alerts where partner organisations have raised a concern
    - care provided to patients experiencing a cardiac arrest, ST elevation myocardial infarction (STEMI) or stroke – for example call to hospital arrival mean
- **Acute and community providers** may wish to consider metrics related to:
    - healthcare associated infections (HCAI)
    - falls
    - pressure ulcers
    - hospital associated venous thromboembolism (VTE)
    - Anti-microbial resistance (AMR)
    - medication optimisation and administration
    - maternity outcomes
    - implementation of physiological scoring and appropriate response
    - post-operative outcomes
    - readmission rates, for example, within 7 days or 30 days
    - unplanned activity, for example, return to theatre, out of hours operating, unplanned admission to ITU
    - missed clinical review / ambulance had to be called
    - missed therapy or time sensitive medication

Area: Mortality

Relevant indicators and measures (quantitative and qualitative):

- **For all trusts**:
    - Summary Hospital-level Mortality Indicator (SHMI)
    - selected standardised mortality rates by specialty, division or pathway as appropriate.

- **Ambulance trusts** may wish to split mortality into key pathways, for example, cardiac arrest survival rates. As ambulance trusts cover a large geography, boards may wish to consider whether there is unwarranted variation in quality metrics between different ICBs.
- Mental health, learning disability and autism, and community trusts will want to consider:
    - premature mortality for the populations they serve
    - suicide prevention data including inpatient suicides
    - compliance with Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
- **Mortality reporting should draw on and triangulate data from several other sources**:
    - Medical Examiners intelligence
    - Coroners' Regulation 28 Reports
    - mortality related outliers noted in audits, reviews and national programmes
    - patient safety incident records where the incident is thought to have contributed to the death, and the subsequent investigation report
    - insights from investigations into patient perpetrated homicides
- **For trusts operating mortuaries**: HTA Reportable Incidents (HTARIs) – incidents which must be reported to the Human Tissue Authority, rather than being captured through the Learn from patient safety events (LFPSE) service.

Area: Infection prevention and control (IPC)

Relevant indicators and measures (quantitative and qualitative):

- Number of healthcare associated infections (HCAI) (for example per 1000 bed days or expressed as total numbers) split out by:
    - MRSA
    - C.diff
    - E Coli
    - MSSA
    - other gram-negative infections
    - nosocomial Covid – relevance to be determined locally
- Ambulance trusts may wish to focus on IPC process measures such as:
    - hand hygiene compliance rates
    - deep clean compliance

Area: Safeguarding

Relevant indicators and measures (quantitative and qualitative):

- Number of safeguarding referrals subject to:
  - CPIS alerts
  - Prevent
  - Female Genital Mutilation
  - Initial and Review
  - Health Assessments for Looked After Children
  - Child Death Reviews
  - Domestic Homicide Reviews
  - Safeguarding Adult Reviews
  - Deprivation of Liberty Safeguards.
- Percentage of safeguarding training compliance, as per the Royal College intercollegiate competencies and standards for child and adult safeguarding.
- Providers of mental health, learning disability and autism care will want to pay specific attention to safeguarding referrals for all people placed in a hospital setting.

Area: CQC

Relevant indicators and measures (quantitative and qualitative):

- Ratings, regulatory breaches and other activity, including CQC Well Led Rating and findings from CQC surveys (for example, UEC, maternity, adult inpatient, community mental health).

Area: Audits and independent reviews

Relevant indicators and measures (quantitative and qualitative):

- CQC red flags
- Internally commissioned reviews and audits (for example Cancer Patient Experience Survey)
- Externally commissioned reviews and audits, for example:
  - any outliers identified through national clinical audits e.g. MBRRACE, NNAP
  - National patient safety alerts and reporting
  - Health Services Safety Investigations Body
  - Maternity and Newborn Safety Investigations programme
  - Coroner Regulation 28 notices
  - Parliamentary and Health Service Ombudsman complaints and reports
  - Medical examiner intelligence

Area: Staff indicators on quality (also covered under People below)

Relevant indicators and measures (quantitative and qualitative):

- Staff survey feedback – including:
  - staff engagement
  - staff confidence and security in reporting unsafe clinical practice
  - violence prevention and reduction performance
  - staff reporting unwanted behaviour of a sexual nature
- Staff turnover rate and staff who leave within 12 months of starting – all staff groups (including nurses, midwives, medical and dental, allied health professionals, operational and administrative staff)
- Skill mix of registered to support staff
- Safe staffing levels – red flags and themes in red flags
- Whistleblowing alerts; Freedom to Speak Up – bullying and harassment cases reported to FTSU Guardian per 1,000 whole time equivalent (WTE); percentage of FTSU concerns that have resulted in change
- National Education and Training Survey (NETS) feedback
- Level of quality voice from clinical leaders and people using services at board level, action and improvement plans to mitigate risks and improve services and evidence of their sustainability
- Quality improvement activity – percentage of staff trained leading QI projects; percentage of local improvement projects scaled up; percentage of projects co-produced (staff, service users, carers) based on what matters to people in experiences of care; evidence of QI activity based on safety and other quality intelligence (for example, linked to PSIRF)
- Percentage of staff completing ‘Essentials of Patient Safety, Level 1’ online training
- Percentage of staff completing the ‘Understanding sexual misconduct in the workplace’ training

Area: Mixed sex accommodation breaches

Relevant indicators and measures (quantitative and qualitative):

- Total number of unjustified breaches in the reporting period

Area: Complaints, concerns and compliments

Relevant indicators and measures (quantitative and qualitative):

- Number of PALS concerns received and resolved, and number of complaints received

- Response time for complaints
- Complaints referred to the Parliamentary and Health Service Ombudsman
- Re-opened complaints
- Deeper analysis of complaints:
    - themes
    - follow-up action
    - how learning has been incorporated
    - tone and content of responses (experiences of people making a complaint)
- Compliments

III. People

Questions for boards:

- Is staff feedback used to improve the quality of care provided by the trust?
- Do staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels?
- Are staff able to express concerns in an open and constructive environment?
- Are staff metrics used to improve productivity, staff satisfaction and patient care?

Boards need to:

- listen to their staff and make the best use of their skills and experience
- use information to inform strategic decisions on how to improve employee experience, to retain and attract staff and ensure the trust's services are sustainable
- gain assurance that staff have the relevant skills and capacity to undertake their roles
- ensure workforce inequalities are identified and addressed
- ensure succession planning is carried out

Board members should routinely consider employee experience, including the health and wellbeing of staff, ensure the working environment is safe and secure, and proactively manage and mitigate risks. They should also listen to and support staff to be appropriately empowered to be advocates for themselves, their colleagues, patients and service users.

Area: Headcount, salary bill, skill mix Total headcount

Relevant indicators and measures (quantitative and qualitative):

- Total WTE
- Gross salary bill
- Staff mix (including volunteers)
- Nurse Staffing Fill rate
- Deployments
- Effective workforce
- Proportion of Apprenticeship Levy spent

Area: Use of agency and bank

Relevant indicators and measures (quantitative and qualitative):

- Total cost by month and area (including off framework and above cap)
- Demographic mix of bank staff

Area: Staff health and wellbeing

Relevant indicators and measures (quantitative and qualitative):

- Percentage sickness absence, presenteeism (percentage reporting coming to work while unwell in staff survey)
- Long term sickness absence
- Average number of sick days per full time equivalent (FTE)
- Reason for sickness (themes)
- Perceived manager and organisational support for staff wellbeing (NHS staff survey)
- Whether staff felt unwell because of work-related stress (NHS staff survey)

Area: Vacancy Number of vacancies by area

Relevant indicators and measures (quantitative and qualitative):

- Vacancy rate (ratio of vacancies to all posts)
- Staff turnover rate

Area: Staff turnover and leaver rates

Relevant indicators and measures (quantitative and qualitative):

- Number of leavers by staff group, ward site, organisation benchmarked vs entire NHS

- Common themes on why people are leaving the organisation (including those leaving within 12 months of joining)

Area: Diversity

Relevant indicators and measures (quantitative and qualitative):

- NHS Equality Delivery System (EDS)
- NHS Workforce Race Equality Standard (WRES) data and responses to returns
- NHS Workforce Disability Equality Standard (WDES) data and responses to returns
- Percentage of staff in senior positions that are Black and Minority Ethnic (BME) or have a disability
- Gender Pay Gap reporting

Area: Staff speaking up (FTSU)

Relevant indicators and measures (quantitative and qualitative):

- Number of Freedom To Speak Up (FTSU) Guardians (including number in senior bands)
- Number of FTSU reports
- Number of FTSU reports that have led to actions being delivered and changes implemented
- Deeper analysis of FTSU data:
    - percentage of reports made anonymously vs named
    - themes from FTSU and specific divisions and departments they relate to
    - time taken to respond to FTSU: initial response and to conclusion
    - details of learning and improvement from speaking up
    - percentage of staff that have completed the 3 FTSU training modules (if included on MaST)
    - percentage of people that would speak up again
    - details of actions taken to understand and reduce barriers to speaking up
    - analysis of the protected characteristics of those speaking up
    - time taken to resolve employee relations issues

Area: Staff engagement

Relevant indicators and measures (quantitative and qualitative):

- NHS Staff Survey results for staff engagement theme and sub-themes of involvement, advocacy and motivation
- National Quarterly Pulse Survey (NQPS) results (staff engagement theme and sub-themes as above)

Area: Employee experience

Relevant indicators and measures (quantitative and qualitative):

- People Promise scores and sub-scores
- Staff engagement and morale theme and sub-theme scores
- Triangulation of staff experience and ward and site level with patient experience

Area: Lived experience workforce

Relevant indicators and measures (quantitative and qualitative):

- Mental health, learning disability and autism trusts may want to consider the number of lived experience staff who are employed to provide peer support, peer advocacy and other roles.

Area: Grievances

Relevant indicators and measures (quantitative and qualitative):

- Internal complaints / staff grievances / disciplinaries open
- Employment tribunal claims

Area: Staff screening

Relevant indicators and measures (quantitative and qualitative):

- NHS Employment check standards: Staff recruited need to have the relevant pre-recruitment checks carried out:
    - identity
    - criminal record
    - work health assessment
    - professional registration and qualifications
    - right to work
    - employment history and reference(s)

IV. Access and targets

Questions for boards:

- Are plans in place to improve performance against the relevant access and waiting times standards?
- Is the trust able to identify and address inequalities in access and waiting times to NHS services across its patients?
- Have appropriate population health targets been agreed with the Integrated Care Board?

Trust boards will need to track how their organisations are delivering against national commitments. In general, this performance should be viewed in conjunction with individual partner providers in the system and across the ICB itself. Board members should look at trends using Statistical Process Control and other appropriate tools to identify situations where there might be significant negative or positive movements. Analysing data with a particular focus on ethnicity and deprivation is key to reducing health inequalities.

This information is likely to change. Trusts should always refer to the latest updates to the relevant NHS England guidance on the specific NHS indicators and targets by which it will be assessed nationally.

Area: Community services

Relevant indicators and measures (quantitative and qualitative) :

- Community service waiting times
- Proportion of Category 4 calls resulting in ambulance response

Area: Urgent and emergency care

Relevant indicators and measures (quantitative and qualitative):

- A&E waiting times, percentage of patients seen within 4 hours
- Category 2 ambulance response times
- 999 call answer mean time
- Number of emergency admissions for ambulatory care sensitive conditions
- Number of emergency admissions for people with multiple long-term conditions

Area: Elective care

Relevant indicators and measures (quantitative and qualitative) :

- Number of long waits (as defined nationally)
- Delivery of local system specific activity targets
- Proportion of outpatient appointments as first or follow-up appointments
- Ambition: Patient experience of choice at referral
- Under 18-year-old elective activity rate compared to baseline

Area: Cancer

Relevant indicators and measures (quantitative and qualitative):

- Performance against national wait standard
- Performance against national diagnosis standard
- Ambition: Proportion of diagnosis at an early stage (1 and 2)

Area: Diagnostics

Relevant indicators and measures (quantitative and qualitative):

- Diagnostic 6-week performance

Area: Maternity

Relevant indicators and measures (quantitative and qualitative):

- Midwifery fill rate in line with Birthrate plus

Area: Mental health (to consider as appropriate as not all of these will apply to all mental health providers)

Relevant indicators and measures (quantitative and qualitative):

- Patient flow performance
- Out of area placement reduction performance
- Number of people accessing:
    - adult community mental health services
    - perinatal health services
    - children and young people's mental health services
- Number of adults and older people accessing and completing a course of NHS Talking Therapies
- Percentage of people with a severe mental illness receiving a full annual physical health check

- ICB-wide Dementia Diagnosis Rate performance
- Number of mental health patients spending less than 12 hours in an emergency department

Area: People with a learning disability and autistic people

Relevant indicators and measures (quantitative and qualitative):

- Proportion of people aged 14 and over with a learning disability on the GP register receiving a full annual physical health check
- Number of people with a learning disability and number of autistic people in mental health inpatient care

Area: Prevention and health inequalities

Relevant indicators and measures (quantitative and qualitative):

- Percentage of patients with hypertension treated
- Percentage of patients with a CVD risk score greater than 20% on lipid lowering therapies
- Myocardial infarction admission rate deprivation gap
- Proportion of frontline healthcare workers who have had Covid-19 and influenza vaccinations

Area: Workforce

Relevant indicators and measures (quantitative and qualitative):

- Number of clinical placements and apprenticeship pathways provided

V. Productivity

Question for boards:

- Are plans in place to deliver productivity improvements as referenced in, for example, the Model Health System, this guide and other relevant guidance?

In recent years, tools like Getting it Right First Time (GIRFT) and the Model Health System have shone a light on how data can help trusts provide a more effective and consistent quality of care for patients and service users. These tools can also identify opportunities to improve operational productivity and efficiency

and reduce unwarranted variation. There are a range of measures – for each type of trust – that boards can look at to assure themselves they are delivering health and care services and using assets as effectively as possible.

Productivity considerations

Consider productivity in terms of how the outputs of healthcare are growing in comparison to the inputs required, or put another way, the total inputs required to get each unit of output. These are typically:

- **outputs** – the healthcare services provided, such as emergency admissions, outpatient appointments and treatments from waiting lists
- **inputs** – the resources required to deliver healthcare services, including the number of staff (including bank and agency), direct and indirect staff costs and time, capital required, and goods and services used, such as medicines and equipment

Productivity and efficiency denote different things. Productivity is focused on the quantity of outputs and achieving a greater number of these with the inputs (resources) available. Efficiency measures the quality of the inputs and specifically how well the inputs (resources) are being used, so requiring fewer resources (such as time or money) to achieve the same or greater number of or quality of outputs.

Productivity improvements can be supported by robust demand and capacity modelling, to ensure affordable workforce growth to meet demand, and connected to operational planning (see access and targets section). Boards should refer to the Model Health System for core productivity and efficiency metrics in conjunction with local intelligence to assess the key drivers of productivity, and benchmark performance with peers. Provider collaboratives may also choose to develop their own metrics to measure productivity.

More information to support trusts to assess their productivity is on the Model Health System.

Area: Headline productivity

Relevant indicators and measures:

- Implied Productivity Growth (year-to-date compared to 2019/20) (percentage): Implied Productivity Growth is calculated by comparing output growth (activity) to input growth (based on expenditure costs) against a

baseline period. The measure examines a trust's current year-to-date activity and costs to the same period in 2019/20

Area: Operational and clinical productivity

Relevant indicators and measures:

- Average Length of Stay (ALOS) – non-elective (1+ days): The average length of stay for all non-elective admissions (spells) where the patient has stayed in hospital for at least one night
- Bed occupancy classed as clinically ready for discharge from hospital (percentage): The proportion of acute patients who do not meet the criteria to reside, and therefore are clinically ready for discharge, but continue to reside in acute hospitals against the total occupied beds
- Capped theatre utilisation (percentage): Total touch time within the start and end time of the planned session, in proportion to planned theatre session/list duration
- Day case rates (percentage): Proportion of activity carried out as a day case compared to an overnight admission for British Association of Day Case Surgery procedures

Area: Workforce productivity

Relevant indicators and measures:

- Implied workforce productivity growth (year-to-date compared to 2019/20): This is calculated by comparing output growth (activity) to input growth (workforce) against a baseline period. The measure examines a trust's current year-to-date activity and costs to the same period in 2019/20
- Outpatient per consultant WTE (whole-time equivalent): Number of outpatient attendances per clinical WTEs (nursing plus consultants)
- Elective admissions per clinical WTE: Number of elective admissions per clinical WTEs (nursing plus consultants)
- Non-elective admissions per clinical WTE: Number of non-elective admissions per consultant WTEs
- A&E attendances (Type 1 and 2) per emergency medicine consultant: Number of A&E attendances per (Type 1 and 2) per emergency medicine consultant
- Care hours per patient day: Care hours per patient day (CHPPD) total nursing and midwifery staff

Area: Workforce drivers

Relevant indicators and measures:

- Overall temporary staff spend as a percentage of total spend: Spend on bank and agency staff as a proportion of total staff spend
- Registered nurses: Sickness absence rate (percentage): Registered nurses who are absent because of sickness
- Percentage of registered medical and dental staff who are absent because of sickness (percentage): Medical and dental sickness absence rate
- All staff: NHS turnover rate (percentage): Staff leaving the organisation – retirement or new job – out of total staff numbers
- Non-pay efficiency Non-pay Efficiency – Medicines (cost): National medicines optimisation opportunity size
- Non-pay Efficiency – Corporate Services (cost): Cost of running corporate services per £100 million turnover
- Non-Pay Efficiency – Estates and Facilities: (£ per m2) The total estates and facilities running costs to the total occupied floor area

VI. Finance

Questions for boards:

- Does the trust have a robust financial governance framework and appropriate contract management arrangements?
- Is financial risk managed effectively, and financial considerations (such as efficiency programmes) do not adversely affect patient care and outcomes?
- Does the trust actively engage with system partners regarding the optimal use of NHS resources and supports the system's delivery of its planned financial out-turn?

When planning services, improvements, investments or efficiency changes, boards must understand the impact on workforce, quality and financial sustainability, including for the wider health and care system.

Finance should not be considered in a silo – it is a significant factor in how the trust prioritises resources and the impact this has on the services provided for patients and service users, and the wider finances of the system. In addition to the data below, boards should be mindful of other information, such as internal and external audit reports and implications these will have for financial controls.

Area: Organisational performance

- income and expenditure

- cash flow Performance against budget (including filled posts versus total funded establishment)

Relevant indicators and measures (quantitative and qualitative):

- Financial stability (variation from breakeven)
- Financial efficiency
- Variance analysis to planned financial efficiency from current position
- Trust cash flow forecasts and analysis

Area: Business unit information

Relevant indicators and measures (quantitative and qualitative):

- Cash flow
- Gross margin

Area: Debtors and payments to suppliers

Relevant indicators and measures (quantitative and qualitative):

- Value of 30, 60 and 90-day debtors
- Trust compliance with Better Payment Practice Code (BPPC)

Area: Liquidity

Relevant indicators and measures (quantitative and qualitative):

- How many days' operating cash requirement the trust has available

Area: Interest cover

Relevant indicators and measures (quantitative and qualitative):

- How much headroom the trust has over fixed interest payments (including PFI unitary payments)

Area: Financial run-rate

Relevant indicators and measures (quantitative and qualitative):

- Current financial performance versus plan

Area: Risk and mitigations

Relevant indicators and measures (quantitative and qualitative):

- Risks and mitigations to the reported financial position

Area: Phasing of efficiency schemes

Relevant indicators and measures (quantitative and qualitative):

- Analysis on whether efficiency schemes are phased realistically

Area: Capital

Relevant indicators and measures (quantitative and qualitative):

- High quality and regular reporting on progress toward delivery of capital plan
- Main risk areas for capital projects with associated mitigations and timings
- Variance analysis showing planned capital spend compared to capital allocation per system (CDEL) allowance

Area: System financial performance

Relevant indicators and measures (quantitative and qualitative):

- High quality and regular reporting on:
    - the organisation's contribution to system breakeven
    - current system financial projections vs ICB's Joint Forward Plan
- For mental health trusts this should also include analysis of the system delivery of the Mental Health Investment Standard.

Area: Productivity

Relevant indicators and measures (quantitative and qualitative):

- Productivity trends per WTE
- Cost per weighted activity unit (WAU) outliers (by specialty and staff group [clinical and non-clinical staff])

Area: Estates and facilities management running costs

Relevant indicators and measures (quantitative and qualitative):

- Benchmarked to other organisations
- Analysis of achievable efficiencies
- Annual Estates Return Information Collection (ERIC) returns (https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection)

Date published: 12 November, 2024
Date last updated: 13 December, 2024

2501 - D STATUTORY & REGULATORY

2501 - D1 MATERNITY & NEONATAL UPDATE

Discussion Item | Karen Jessop, Chief Nurse & Lois Mellor, Director of Midwifery | 11:55

15 Minutes

REFERENCES

Only PDFs are attached

- D1 - Maternity & Neonatal Update.pdf
- D1 - Appendix 1 - PMRT Q2 Report.pdf
- D1 - Appendix 2 - Neonatal Medical Workforce Action Plan.pdf
- D1 - Appendix 3 - Maternity Dashboard.pdf
- D1 - Glossary of Terms - Maternity.pdf
- D1 - Bi-annual Workforce Report.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**D1**
Report Title:	**Maternity & Neonatal Update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse - Paediatrics Danielle Bhanvra, Deputy Director of Midwifery		
Appendices:	1. Q2 PMRT Report (Appendix 1) 2. The neonatal medical workforce action plan (Appendix 2) 3. Trust Quality Metrics (Appendix 3)		

Report Summary

Purpose of the report & Executive Summary

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

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

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

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

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

n.b. patient level detail of the PMRT reviews have been removed from this report.

Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this maternity and neonatal safety report and to record in the Trust Board minutes to provide evidence for the maternity incentive scheme the following:- • That Trust Board have been sighted on the number of MNSI / ENS cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place. • Reviewed and approved Q2 PMRT report (Appendix 1) • Reviewed and approved the neonatal medical workforce progress update (Appendix 2)

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

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

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

Bi Monthly Board Report

October / November 2024

1. Report Overview

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

2. Perinatal Mortality Rate

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

2.1 Stillbirths and late fetal loss > 22 weeks

There were 2 stillbirths in October and 0 in November reportable to MBRRACE.

2.2 Neonatal Deaths

There was 1 neonatal deaths in October and 0 in November.

2.3 Perinatal Mortality Review Tool (PMRT) 1.10.2024 to 30.11.2024

Date	Type of Death	Antenatal / Intrapartum / Neonatal	Information
June	Stillbirth	Antenatal	Report published since last update
Sept	Stillbirth	Antenatal	Planned for review in Nov
Oct	Stillbirth	Antenatal	In report writing stage

2.4 Learning from PMRT reviews

Issues
None identified, all care grade A and B.

Learning
Q2 PMRT report is attached in Appendix 1.

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

3.1 Investigation Progress Update

Table 1 MNSI cases

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

There were no cases referred to MNSI in October and November 2024.

3.2 Reports Received since last report

None.

3.3 Current investigations

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

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

3.4 Coroner Reg 28 made directly to the Trust

None.

3.5 Maternity Patent Safety Incident Investigations (PSII)

There is one PSII in progress;

- Related to care provided when a pregnant woman attended the emergency department, a number of providers are involved and the LMNS is involved in the review. The report is in final draft and is with the family.

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

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

There is a continued focus on improving the culture and relationships in the maternity service. A number of sessions are being planned in the next few months facilitated by the

Nursing and Midwifery Council, the General Medical Council and the Royal College of Midwives.

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

- Programmed Activity (PA) allocations for lead obstetric consultant roles related to the single delivery plan, Ockenden and particularly leadership. All roles have now been recruited to with the exception of the deputy CD.

5. Training Compliance for all staff groups

Training figures as at October 2024 and November 2024 are detailed below:-

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

October 2024

Staff Group	K2 / CA Compliance Oct 24	Study Day Compliance Oct 24
90% of Obstetric Consultants & SAS Drs	**84.13%**	**94.73%**
90% of all other obstetric doctors contributing to the obstetric rota	**55%**	**61.11%**
90% of midwives including bank & agency staff	**84.24%**	**92.51%**

November 2024

Staff Group	K2 / CA Compliance Nov 24	Study Day Compliance Nov 24
90% of Obstetric Consultants & SAS Drs	**94.7%**	**94.7%**
90% of all other obstetric doctors contributing to the obstetric rota	**94.44%**	**94.44%**
90% of midwives including bank & agency staff	**96.34%**	**95.65%**

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

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

Table 3 & 4 - PROMPT figures

October 2024

Staff Group	Prompt Compliance Oct 24
90% of Obstetric Consultants & SAS Drs	**84.21%**
90% of all other obstetric doctors contributing to the obstetric rota	**55.56%**
90% of midwives including bank & agency	**96.85%**
90% of maternity support workers and health care assistants	**87.50%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**87.50%**
90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity	**72.73%**

November 2024

Staff Group	Prompt Compliance Nov 24
90% of Obstetric Consultants & SAS Drs	**100%**
90% of all other obstetric doctors contributing to the obstetric rota	**94.29%**
90% of midwives including bank & agency	**97.6%**
90% of maternity support workers and health care assistants	**94.44%**
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	**100%**
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	**100%**

Table 5 & 6 - NLS figures

October 2024

Staff Group	NLS Compliance Oct 24
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**100%**
90% of neonatal junior doctors (who attend any births)	**100%**

90% of neonatal nurses (Band 5 and above who attend any births)	**100%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of midwives including bank & agency	**90.9%**

November 2024

Staff Group	**NLS Compliance Nov 24**
90% of neonatal Consultants / SAS Drs or Paediatric consultants / SAS covering neonatal units	**100%**
90% of neonatal junior doctors (who attend any births)	**97%**
90% of neonatal nurses (Band 5 and above who attend any births)	**97%**
90% of advanced Neonatal Nurse Practitioner (ANNP)	**100%**
90% of midwives including bank & agency	**95.25%**

6. Safety Champion meetings

A meeting was held on 28th November 2024, where the board safety champion and non-executive director meets with the perinatal quadrumvirate leadership team.

6.1 Positive Points recognised

The unit at Bassetlaw was very busy on the day however staff were able to briefly speak to the team. There was clear evidence that the team worked together in emergencies and supported each other.

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

6.2 Concerns raised by the visit and staff

Previous concerns were raised regarding the leadership and environment on M1/2. The ward now has a permanent band 7 manager in post and the plan is to reopen M2 in stages is in place.

The ante-natal clinic environment remains a concern with the gynaecology and maternity services sharing a clinical area. There are explorations underway to identify an area to move the gynaecology service into.

6.3 Concerns raised by service users

Ongoing work continues with the LMNS and ICB as the Trust remains without an MNVP chair. An interim solution has been agreed with the LMNS and ICB, with the Rotherham MNVP chair supporting DBTH and as previously described she has already attended the Safety Champions

Walk round and subsequent meeting. The funding for the MNVP remain in place, and an ICB/LMNS representative is expected to attend agreed meetings where possible. The service continues to strive to ensure that service user's voice is heard by working closely with changing lives.

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

It is recognised that there is still work to do related to the culture in the maternity service, the perinatal quad and board safety champion are working closely together for continued and sustained improvements.

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

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

Nothing identified for the Trust Board at present.

7. Saving Babies Lives V3

7.1 Update

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

The following outlines specific improvement work being undertaken for each element of SBLCBv3, including evidence of generating and using the process and outcome metrics for each element. The tool then calculates the percentages for each element and provides an overall percentage of compliance with the bundle.

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.

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

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

The Trust has achieved 9/10 of the safety actions. Requirement 3 in safety action 1 - PMRT was not met due to an error with electronic submission. The Trust has discussed the issue with NHS Resolution (MIS) and MBRRACE (PMRT), and this will be reviewed as part of the

external verification process at the end of the scheme in March 2025 when MIS hope to upgrade the status to compliant for year 6.
There is a presentation today included in board about the planned submission on 3rd March 2025.

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

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

The other 10 are variable reasons including third degree tears, and one intrauterine death which was identified during ante-natal check.

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

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

10. Safe Maternity & Neonatal Staffing

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 219.12 WTE contracted midwives (Band 3-7), against 221.07 WTE recommended. This includes 18 newly qualified midwives who commenced on 7th October 2024, with a further 3 commencing in December 2025.

All rotas were planned to have a supernumerary coordinator on every shift for October and November 2024.

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

10.1 Neonatal Nursing - Fill rates planned versus actual

Neonatal staffing is 84% recruited with 82% of establishment at work. All vacancies are out to advert. The Qualified in Speciality ratio is below the 70% standards at 65% on the Neonatal Unit (NNU) at DRI. Overall across BDGH and DRI the QIS ratio is 74%. During November there

were 9 shifts at DRI and 3 shifts at BDGH below BAPM standards. At DRI this was due to there not being a supernumerary co-ordinator and at BDGH due to being over acuity.

A review was undertaken in September 2023 showed the BAPM standards for neonatal nursing workforce were not met in year 5 of CNST. An action plan was developed and agreed by Trust Board with a 4 year proposed plan to meet the BAPM standards. A business case has been supported for year 1 and 2 of the proposal. Recruitment has commenced with the recruitment of 6 new band 6 Sisters and the other vacancies currently out to advert. Below is a summary of the 4 year plan and current progress;

Year	Investment	Progress Update
2023/2024	Increase clinical roles to 25% uplift at SCBU and NNU	Business case approved - recruitment in progress
2024/2025	Quality roles on SCBU and coordinator at night NNU	Business case approved - recruitment in progress
2025/2026	24 hr coordinator for SCBU at night	We need to review the activity and acuity as this is a significant investment for a unit which has low activity. As part of this we need to understand the impact of transitional care on cot days.
2026/2027	AHP at recommendations	Not progressed as we review year 3 as described above

10.2 Obstetric Staffing

A new consultant obstetrician has been recruited, and will be commencing in the service soon.

Ongoing monthly monitoring of compliance of short-term locums and engagement of long term locums is continuing. In October / November 2024 there were no episodes of non-compliance.

Compensatory rest is continuing to be monitored and there have been no recorded incidents of consultant non-attendance in an emergency in October / November 2024.

10.3 Neonatal medical staffing

A review has been undertaken against the year 6 requirements and the new BAPM standard requirements have not been met at DRI due to not being funded for a separate dedicated night resident doctor for neonates.

An action plan to address this has been developed and approved by Trust Board in September 2024. Progress against the approved action plan is attached for review and approval in Appendix 2.

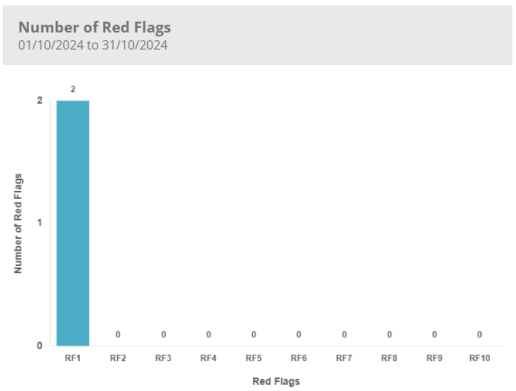
10.4 Anaesthetic Workforce

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

10.5 Red Flags

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

Table 7 & 8 - DRI



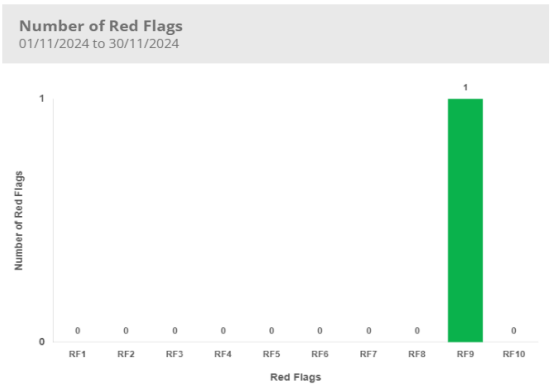
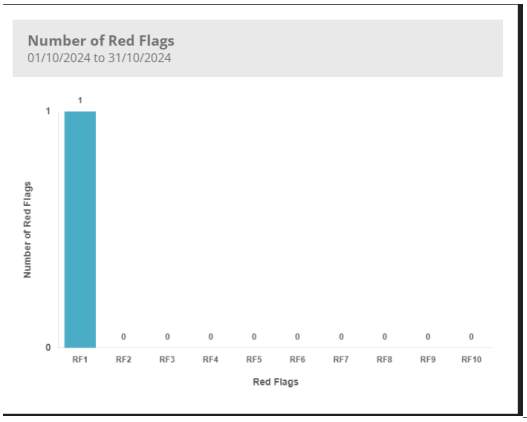
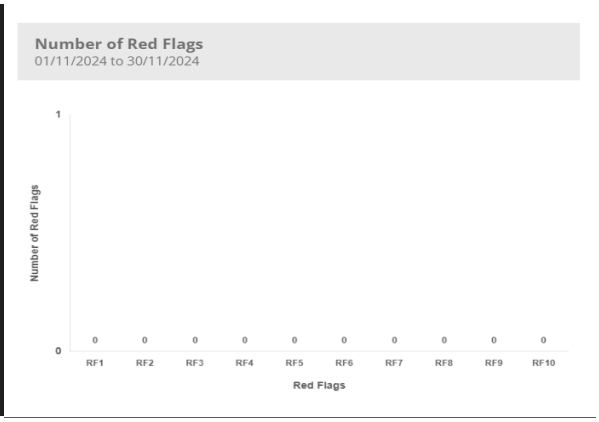


Table 9 & 10 - BDGH





Key

RF1 - Delayed or cancelled time critical activity
RF2 - Missed or delayed care
RF3 - Missed medication during an admission to hospital and midwife led care
RF4 - Delay in providing pain relief
RF5 - Delay between presentation and triage
RF6 - Full clinical examination not carried out when presenting in labour

RF7 - Delay between admission for induction and beginning the process
RF8 - Delayed recognition of and action on abnormal vital signs
RF9 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour
RF10 - Coordinator unable to maintain supernumerary status providing 1:1 care

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

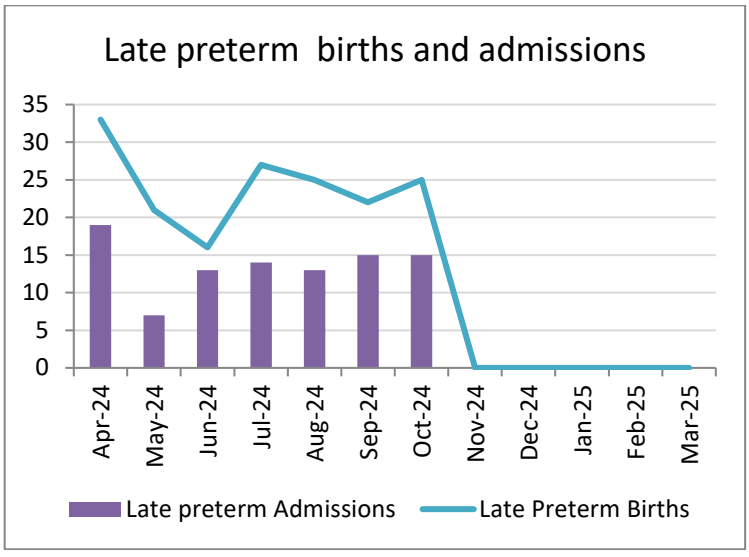
The service has an annual plan that has been developed in conjunction with the MNVP, and this work is ongoing.

12. Avoidable Admission into the Neonatal unit (ATAIN)

12.1 The national ambition

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

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



All elements of the current action plan are on track.

12.2 DBTH transitional care

The transitional care project progress has been shared at the Board Safety Champion meeting, and governance meetings. The neonatal and maternity services are working together to improve the provision of transitional care. The opening of a bay ward M2 will assist in creating a transitional care area, and this is planned in early 2025.

13. Red Risks / Risk Register Highlights

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

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

14. Neonatal Services

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

15. Perinatal Metrics

The Trust maternity dashboard has been included in Appendix 3.

Metrics with significant deterioration:

- PPH > 1500mls
- Neonatal death rate

There has been a review of PPHs and a recent change to guidance about stopping aspirin in pregnancy earlier has been implemented. This has been potentially identified as contributing to the increase in rates of PPH, the plan is to observe the rates over the next few months post the change in practice.

The number of neonatal deaths is very small, and the service is considering if the current SPC charts are the most appropriate format for identifying trends. Each neonatal death is reviewed using the perinatal mortality review tool, and this is peer reviewed for learning opportunities.

Metrics with no significant change are:

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

Metrics with a significant improvement:

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

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

16. Recommendation

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

The Board of Directors is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme that the following have been reviewed and approved:

- Q2 PMRT Report (Appendix 1)
- Bi annual midwifery report (separate paper)
- Neonatal medical workforce action plan progress update (Appendix 2)

And formally record that:

- the Trust Board have been sighted on the number of MNSI / ENS cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place.
- Board Safety Champions are meeting with the perinatal leadership team bi monthly and any support required of the Trust Board has been identified and is being implemented
- Progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support.

PMRT - Perinatal Mortality Reviews Summary Report

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

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

Quarter 2 period: 01/07/2024 to 30/09/2024

1. Introduction

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

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

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

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

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

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

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

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

The definition of labour used by HSIB is

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

- Induction of labour (when labour is started artificially).

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

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

The latest MBRRACE Report for births 2022 gives a national stillbirth rate of 3.35 per 1000, a minimal increase from the 3.33 figure for 2020 births. This figure is calculated from births at 24 weeks or over, and excluding terminations of pregnancy.
The Trust annual stillbirth rate for 2023 **from 24+0 weeks** of pregnancy and above across both sites is to 3.12 stillbirths per 1,000 births. In numerical values this was 14 stillbirths. During this same period from **22 weeks of pregnancy to full term** there were in addition to the 14 stillbirths there was 1 late fetal loss.

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

During the second quarter of 2024-2025, from 1st July 2024 to 30th September 2024 there have been **4** stillbirths of the 1,090 births across both sites (2 at DRI, 2 at BDGH) and **1** medical termination of pregnancy (MTOP) for fetal abnormality above 24 weeks gestation. Of this time period, there were a total of 1,090 births, of which 735 births at DRI and 355 Births at BDGH.

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

This provides a trust adjusted stillbirth rate of **3.7 per 1000 births for this quarter 2**, from 24 weeks gestation; which is a decrease from last quarter (quarter 1 of 2024-2025 adjusted stillbirth rate of 1.8 per 1000 births).

Combining the figures from quarters 3 and 4 of 2023-2024 and quarters 1 and 2 of 2024-2025 the rolling adjusted stillbirth rate is **3.9** per 1000 births. This equates to 17 stillbirths from 24 weeks of gestation (total births for this period is 4,414 for both sites).

3. NEONATAL DEATHS

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

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

During the second quarter of 2024-2025, from 1st July 2024 to 30th September 2024 there has been **0** Neonatal and post-Neonatal deaths of the 1,090 births across both sites. 735 births being at DRI and 355 Births being at BDGH.

This provides the Trust with a stabilised and adjusted rate for this quarter 2 of 2024-2025 of **0** per 1,000.

Combining the figures from quarters 3 and 4 of 2023-2024 and quarters 1 and 2 of 2024-2025 (excluding the deaths under 22+0 and MTOP resulting in NND) the rolling adjusted neonatal and post-neonatal deaths rates of 0 equates to a rate of **0** per 1000 births from 22 weeks of gestation (total births for this period is 4,414 for both sites).

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

CNST requirements - Safety Action 1

Requirements	CNST requirement compliance	CNST Trust Compliance
a) All eligible perinatal deaths from 8 December 2023 should be notified to MBRRACE-UK within seven working days.	**100%**	**100%**
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions / comments they have sought from 8 December 2023 onwards.	**95%**	**100%**
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8th December 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	**95%**	**75% *** ***Questioned with MBRRACE as opened within the 2month deadline awaiting response**
	60%	**100%**
d) Quarterly reports should be submitted to the Trust Executive Board from 8 December 2023.		**Q3 submitted and presented –including 1 case in December 23 27/02/24** **Q4 submitted and presented 02/07/24** **Q1 submitted and presented –including 2 cases in May/June 24 In September**

		Q2 detailed within this report to be presented January 2025

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

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *6*

Summary of reviews**

Stillbirths and late fetal losses

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

Neonatal and post-neonatal deaths

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

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

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

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

Social, economic and deprivation data (SB)		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25			1				1
	26-35			1		2		3
	36-45		1					1
	46+							
Smoking status	Never smoked			2		1		3
	Non-smoker stopped before conception		1			1		2
	Non-smoker stopped after conception							
	Smoker							
	Unspecified							
Ethnicity	White		1	2		2		5
	Black							
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4		1					1
	5-7			1				1
	8-10					2		2
	Not available			1				1
Employment	Employed			2		2		4
	Not employed							
	Student							
	Homemaker		1					1
	Sick/Disabled							
	Unknown							
Marital status	Married / Civil Partner					1		1
	Single							
	Cohabiting		1	2		1		4
Learning or communication difficulties	Yes							
	No		1	2		2		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							
	26-35							
	36-45							
	46+							
Smoking status	Never smoked							
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker							
Ethnicity	White							
	Black							
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4							
	5-8							
	8-10							
Employment	Employed							
	Not employed							
	Homemaker							
	Sick							
	Not stated							
Marital status	Married							
	Single							
	Cohabiting							
Learning or communication difficulties	Yes							
	No							

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 4)

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	2	0	4
Antepartum stillbirths	*0*	*0*	*2*	*0*	*2*	*0*	*4*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	2	0	2	0	4
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	0	2	0	2	0	4
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	2	0	2	0	4
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	2	0	2	0	4
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

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

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 4)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	2	0	2	0	4
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	2	0	2	0	4
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	2	0	1	0	3
Limited and targeted post-mortem	0	0	0	0	1	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	2	0	2	0	4
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	2	0	2	0	4
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 = 4)

Role	Total Review sessions	Reviews with at least one
Chair	5	100% (4)
Vice Chair	4	100% (4)
Admin/Clerical	2	50% (2)
Bereavement Team	11	100% (4)
Community Midwife	2	50% (2)
External	9	100% (4)
Management Team	23	100% (4)
Midwife	51	100% (4)
Neonatal Nurse	5	100% (4)
Neonatologist	21	100% (4)
Obstetrician	52	100% (4)
Other	6	100% (4)
Risk Manager or Governance Team	14	100% (4)
Safety Champion	8	100% (4)

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

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

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 4)

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	1	0	1	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	0	1	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	1	0	1	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	1	0	1	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	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 4)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**4 causes of death out of 4 reviews**
	The cause of death was undetermined
	The cause of death was undetermined
	Tight true knot in the umbilical cord.
	Asymmetrical growth restriction, caused by placental insufficiency.
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
Although indicated this mother was not offered RhD gammaglobulin	1	No action entered as issue not relevant. Mother Rh Pos, fetalmaternal haemorrhage identified on bloods. No option on MBRRACE for this
This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out	1	Communications to be sent out to all staff in relation to the correct pathways to follow when a baby is below the 1st centile and abnormal dopplers are highlighted to ensure the correct pathway is known by all - ensure the current posters which are visible are in every consultation room, direct feedback to the registrar's who were involved with the patients care and no FMU referral was made
This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) which was not managed according to national or local guidelines, this was an effect of changes to services due to COVID-19	1	Communications to be sent out to all staff in relation to the correct pathways to follow when a baby is below the 1st centile and abnormal dopplers are highlighted to ensure the correct pathway is known by all - ensure the current posters which are visible are in every consultation room, direct feedback to the registrar's who were involved with the patients care and no FMU referral was made
This mother had other during her pregnancy which was not managed according to national or local guidelines	1	Communications to be sent out to all staff in relation to the correct pathways to follow when a baby is below the 1st centile and abnormal dopplers are highlighted to ensure the correct pathway is known by all - ensure the current posters which are visible are in every consultation room, direct feedback to the registrar's who were involved with the patients care and no FMU referral was made

*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
The baby had to be transferred elsewhere for the post-mortem	3	No action entered
		No action entered
		No action entered
This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth the baby but serial scans were not planned.	1	Learning to be shared directly with staff involved and wider to capture all midwives and doctors serial scan pathway policy
This mother's progress in labour was not monitored on a partogram	1	No action entered

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

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

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out
		This mother had other during her pregnancy which was not managed according to national or local guidelines
		This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) which was not managed according to national or local guidelines, this was an effect of changes to services due to COVID-19
Task Factors - Decision making aids	1	N/A as this mother was not offered RhD Gammaglobulin as she was Rhesus Positive. No relevant selection on MBRRACE to correctly input this.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Neonatal Medical Workforce

Action plan to meet BAPM standards at DRI, Tier 1

Progress Update – October 24

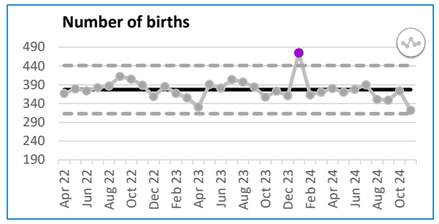
Gap	Actions	Lead	Timescale	Progress Update
Increase SHO compliment to allow for a 2nd SHO at night time to provide dedicated cover for neonatal services.	Complete rota options appraisal	Dr Rao	31/08/24	Rota options now completed and agreed. Need 3 more tier 1 resident doctors to make the rotas compliant
	Draft and seek approval of business case	Nigel Brooke/ Sarah Plowman/ Helen Burrows	~~30/09/24~~ 30/11/24	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
	Commence recruitment	Sarah Plowman	~~30/10/24~~ 31/12/24	Will commence once business case agreed revised timescale December 24.
	SHO in place	Sarah Plowman	31/03/25	Aiming for 31/05/25 but will depend on the length of the recruitment process

Maternity overview

Trust Total

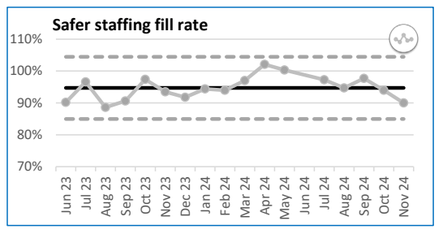
Latest month 01/11/24
Number of births **322**

No significant change



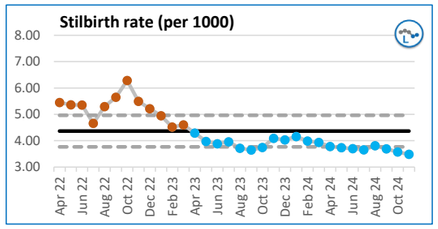
Latest month 01/11/24
Safer staffing fill rate **90%**

No significant change



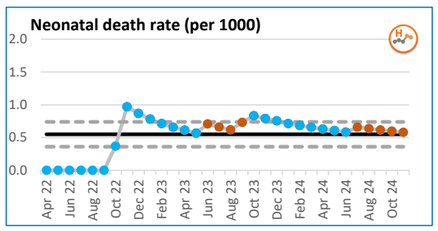
Latest month 01/11/24
Still birth rate/1000 **3.5**

Significant Improvement



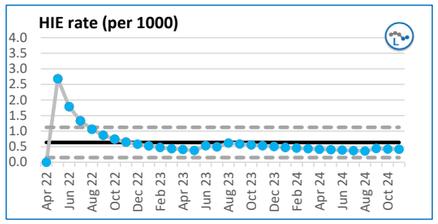
Latest month 01/11/24
Neonatal Death rate/1000 **0.6**

Significant deterioration



Latest month 01/11/24
HIE rate/1000 **0.4**

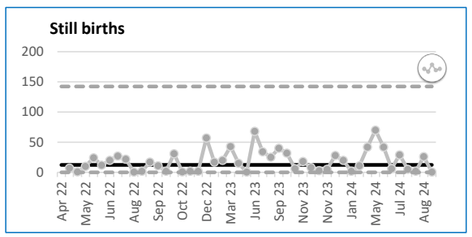
Significant Improvement



Date of last stillbirth 29/08/24

Average days between stillbirths **12.3**

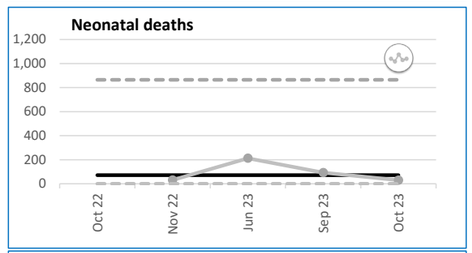
No significant change



Date of last neonatal death 01/10/23

Average days between deaths **71.6**

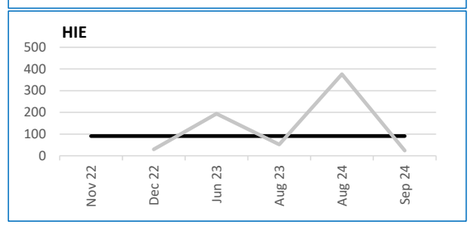
No significant change



Date of last HIE 11/09/24

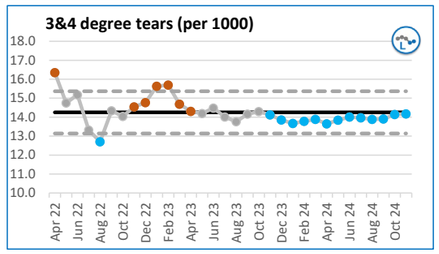
Average days between HIE **90.8**

No significant change



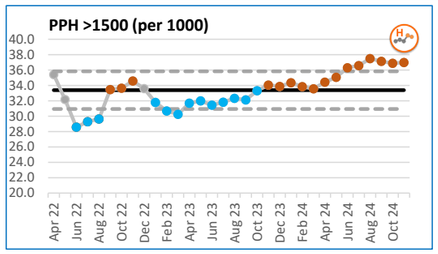
Latest month 01/11/24
3&4 degree tears (per 1000) **14.2**

Significant Improvement



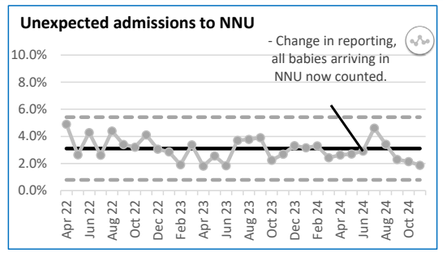
Latest month 01/11/24
PPH >1500 (per 1000) **37.0**

Significant deterioration



Latest month 01/11/24
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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**D1**
Report Title:	**Midwifery Workforce Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Danielle Bhanvra, Deputy Director of Midwifery		
Appendices:	None		

Report Summary

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.

Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this workforce report.			
Action Required:	~~Approval~~	~~Review and discussion~~	**Take assurance**	~~Information only~~

Healthier together – delivering exceptional care for all

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

Implications

Relationship to Board assurance framework:			
	x	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action
	x	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way
		BAF3	If demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards
		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions

			and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal/ Regulation:	CQC - Regulation 12 Potential high impact *Clinical Negligence Scheme for trusts - High impact*		
Resources:			
Assurance Route			
Previously considered by:	Governance Meetings Children's & Families Board (verbal updates) now changed to the maternity and neonatal safety quality committee.		
Date:	Monthly/ Bi monthly		
Any outcomes/next steps	Support to continue improvements in maternity & neonatal service, and achieve CNST standards		
Previously circulated reports to supplement this paper:			

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 Q1/2 of 2024/245 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 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	202.41	- 18.66 *
Managerial & Specialist excluding 8a and above	22.34	22.57	+0.23
HCA Band 2	30.2	28.65	-1.55

*Numbers do not include newly appointed Early Career Midwives to start in October 2024

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 11.15%. 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 22.57 WTE.

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	0.4	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	1.0	7
Birth Afterthoughts midwife	0.6	7 *
Trainee Advanced Clinical Practioner	0.8	7
Safeguarding Midwife	1.3	7
Total	22.57	

***externally funded posts**

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
April 2024	1:21.79
May 2024	1:21.76
June 2024	1:22.18
July 2024	1.21.86
August 2024	1:21.84
September 2024	1:21.98

The recommended midwife to birth ratio nationally is 1:28 with the ratio used as a guide and needs to be used 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
April 24	**60**	**60**	**60**	**60**	**100%**
May 24	**62**	**62**	**62**	**62**	**100%**
June 24	**60**	**60**	**60**	**60**	**100%**
July 24	**62**	**62**	**62**	**62**	**100%**
August 24	**62**	**62**	**62**	**62**	**100%**
September 24	**60**	**60**	**60**	**60**	**100%**

There was a supernumerary coordinator rostered on every shift throughout the 6-month period with the red flags below evidencing that there were two occasions at the Doncaster site and seven occasions at the 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 to prompt review of 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	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024
RF1	Delayed or cancelled time critical activity	4	5	2	1	1	2
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	1	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	5	5	3	8	4	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	1	1
RF10	Coordinator unable to maintain supernumerary status-providing 1:1 Care	0	0	0	1	0	1

Bassetlaw

NICE 2015	Red Flags	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
RF1	Delayed or cancelled time critical activity	0	0	0	0	1	0
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	1	0	0	0
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	3	2	2	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. There may be clinical, or management actions taken.

The following table outlines compliance by Month

Month	Doncaster	Bassetlaw	Trust
April 2024	100%	100%	100%
May 2024	100%	100%	100%
June 2024	100%	100%	100%
July 2024	100%	100%	100%
August 2024	100%	100%	100%
September	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.

- As per CNST requirements Birthrate Plus® should be repeated three yearly. The current **Birthrate** Plus® expires in August 2022 with a plan to repeat it during 2025.

- 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 the 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.

2501 - D2 YEAR 6 CLINICAL NEGLIGENCE SCHEME FOR TRUSTS BOARD DECLARATION

Decision Item | Karen Jessop, Chief Nurse | 12:10

10 minutes

REFERENCES

Only PDFs are attached

- D2 - Clinical Negligence Scheme for Trusts Board Declaration.pdf
- D2 - CNST Presentation.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	7 January 2025	**Agenda Reference:**	**D2**
Report Title:	**CNST Board Declaration**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery		
Appendices:	None		

Report Summary

Purpose of the report & Executive Summary
The presentation explains the position against the Year 6 CNST Standards, and the risk and issues identified. Together with the planned final position for the board declaration on 3rd March 2025.

Recommendation:	The Board is asked: - to confirm it is satisfied with the evidence provided to achieve the nine maternity safety actions - to delegate authority to the Chief Executive to sign-off the Board Declaration, prior to submission to NHS Resolution on 3 March 2025 - to note that the Chief Executive will appraise the Integrated Care Board's Accountable Officer (ICB Executive Chief Nurse, Cathy Winfeld) of the Maternity Incentive Scheme (MIS) safety actions

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

Healthier together – delivering exceptional care for all

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

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

Implications

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

		BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues
		BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term
	x	BAF6	If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw
	x	BAF7	If DBTH does not deliver continual quality improvement, research, transformation, and innovation then the organisation won't be sustainable in long term
Risk Appetite Statement compliance	Where appropriate, refer to the DBTH Risk Appetite Statement and indicate whether the matter has been subject to an assessment of DBTH risk appetite **YES/NO**		
Legal/ Regulation:	CQC - Regulation 12 Potential high impact *Clinical Negligence Scheme for trusts - High impact*		
Resources:			
Assurance Route			
Previously considered by:	Maternity and Neonatal Quality and Safety Committee CNST Oversight Committee Divisional Governance Meeting		
Date:	16th December 2024		
Any outcomes/next steps	Support to continue improvements in maternity & neonatal service, and achieve year 7 CNST standards going forward		
Previously circulated reports to supplement this paper:			

NHS 75

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

CNST Board Declaration Presentation

Lois Mellor, DOM & Tomas Barani, CD

We care

DBTH vision

Healthier together – delivering exceptional care for all.

Patients

We deliver safe, exceptional, person-centred care

People

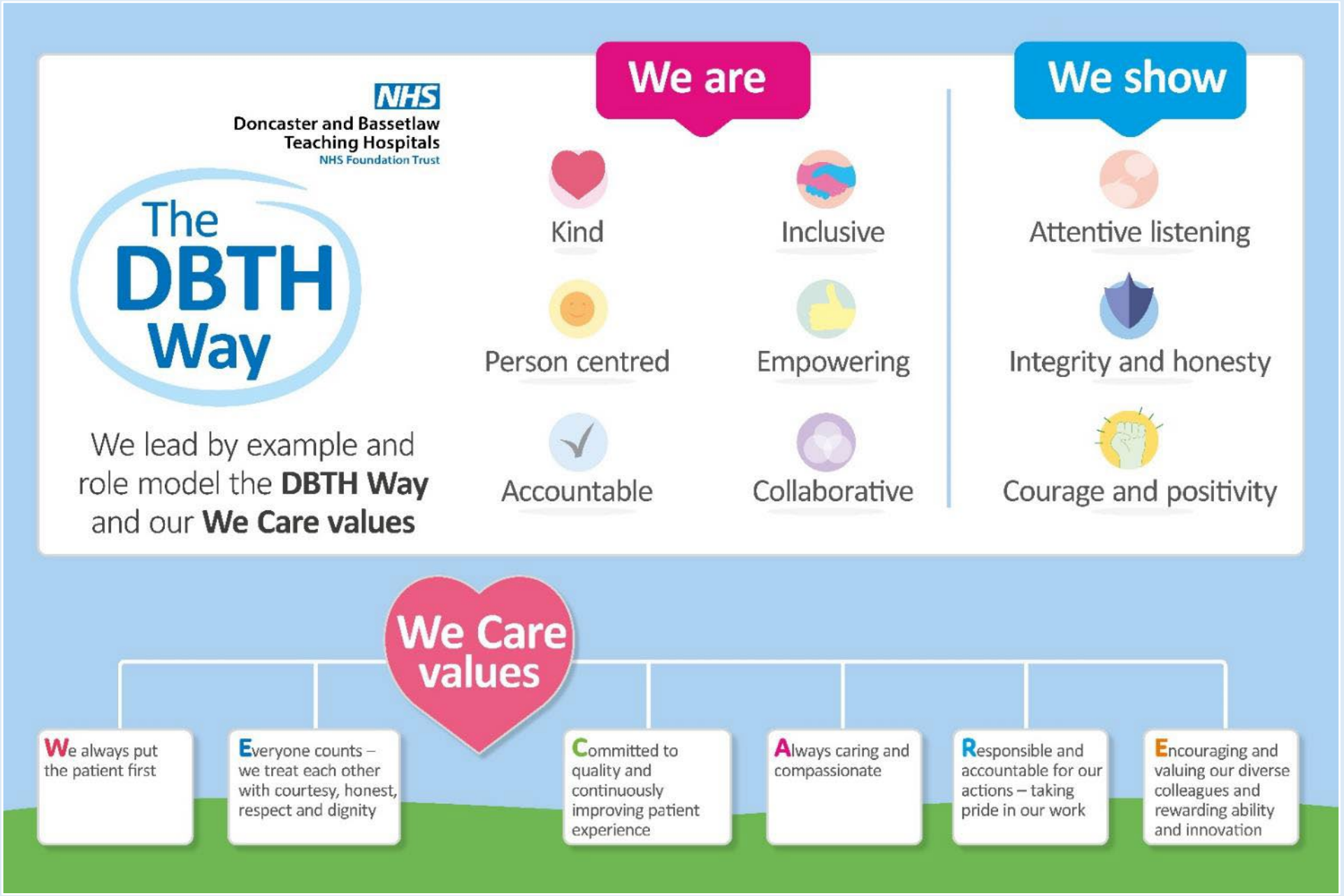
We are supportive, positive and welcoming

Partnership

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

Pounds

We are efficient and spend public money wisely


NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
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
We Care values
We always put the patient first
Everyone counts – we treat each other with courtesy, honest, respect and dignity
Committed to quality and continuously improving patient experience
Always caring and compassionate
Responsible and accountable for our actions – taking pride in our work
Encouraging and valuing our diverse colleagues and rewarding ability and innovation

Board Declaration Overview (Final position)

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	5	1	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	14	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	19	0	0	0	0
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0	0	0	0

LMNS Overview

- 2 CNST deep dives held 16/10/24 & 10/12/24
- Following LMNS Collaborative Board 17/12/24 recommending to ICB Executives that they can sign off DBHT's CNST for 9/10 of the safety actions noting non compliance with safety action 1 PMRT.

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Comments / Evidence still required
SA1 – PMRT	30th November 2024	5/6	Requirement 3 was not met. The Trust has identified the issue with NHS Resolution (MIS) and MBRRACE (PMRT), and this will be reviewed as part of the external verification process at the end of the scheme in March 2025 when MIS hope to upgrade the status to compliant for our Trust Evidence required:- TB minutes November and TB paper & minutes January

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Comments / Evidence still required
SA2 – MSDS	30th November 2024	2/2	All completed
SA3 – Transitional Care / ATAIN	30th November 2024	3/3	Evidence required:- Minutes from November TB & LMNS deep dive 10/12/24

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Comments / Evidence still required
SA4 Clinical Workforce	30th November 2024	14/14	Evidence required:- Minutes from November TB Papers & minutes from January TB
SA5 – Midwifery Workforce	30th November 2024	6/6	Evidence required:- Six monthly report completed to go to January TB and then send to LMNS TB minutes November and TB paper & Minutes January

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Comments / Evidence still required
SA6 – Saving Babies Lives	30th November 2024	6/6	Evidence required : November's TB minutes / LMNS Collaborative Board papers & minutes December Q2 review toolkit and minutes
SA7 – Listening / Co production	30th November 2024	6/6	All completed

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Comments / Evidence still required
SA8 – Training	30th November 2024	19/19	All completed
SA9- Board Safety	30th November 2024	9/9	Evidence required:- November BSC notes / TB Minutes

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Comments / Evidence still required
SA10 – HSIB	30th November 2024	2/2	Evidence required:- TB minutes November and TB paper & minutes January

Risks and Actions

RISK			
Description	**Owner**	**Comments/Actions**	**Rating**
SBLV3 - not achieving full implementation by 31 March 24	Emma Merkuschev	Working towards increasing the percentage compliance for each element with the leads	*10*
ISSUE			
PMRT	Emma Merkuschev	Requirement 3 not met MIS / MBRRACE informed	

Current Outstanding Evidence

- Minutes from formal meetings for November, December and January

Board Declaration Overview (submission on 3rd March 2025)

- That the service will be fully compliant with 9 of the 10 safety actions.

Next Steps

- The Trust Board to confirm they are satisfied with the evidence provided to achieve the nine maternity safety actions
- The Trust Board to give their permission for the CEO to sign the Board Declaration form prior to submission to NHS Resolution on 3rd March 2025.
- The CEO to ensure that the Accountable Officer for the Integrated Care System (ICB) is appraised of the MIS safety actions (Cathy Winfield, ICB Executive Chief Nurse who attends the LMNS Collaborative Board)

Thank you, any questions?

NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2501 - E INFORMATION

2501 - E1 BOARD OF DIRECTORS WORK PLAN

Information Item | Rebecca Allen, Director of Strategy, Partnerships & Governance | 12:20

REFERENCES

Only PDFs are attached

E1 - Board of Directors Workplan.pdf

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
ANNUAL WORK PROGRAMME FOR THE BOARD OF DIRECTORS

AGENDA ITEM/ACTION	LEAD PERSON / DOCUMENT ORIGINATOR	FREQUENCY	NEXT DUE	07/05/2024	02/07/2024	03/09/2024	05/11/2024	07/01/2025	04/03/2025	06/05/2025	01/07/2025	02/09/2025	04/11/2025	COMMENTS
OPENING ITEMS														
Welcome, apologies for absence and declarations of interest	Chair of the Board	Every Meeting	Every Meeting											
Actions from Previous Meetings	Chair of the Board	Every Meeting	Every Meeting											
Chair's Report	Chair of the Board	Every Meeting	Every Meeting											
Chief Executive's Report	Chief Executive	Every Meeting	Every Meeting											
MONITORING & REFLECTION														
Various (topics to be agreed by Executive Team)	Executive Lead & Presenter	As Req'd	As Req'd	H&WB		Wendy's Story	Frailty Services							
STRATEGY, PLANNING & PARTNERSHIPS														
Winter Plan	Chief Operating Officer	Annual	Sep-25											
Annual Business Plan	Chief Financial Officer	Annual	Mar-25											
Financial Plan	Chief Financial Officer	Annual	May-25											
~~(Annual Corporate Objectives for Approval)~~ 2024/2025 Strategic Priorities Success Measures	Deputy Chief Executive	Annual	TBC - March 25											
~~Corporate Objectives - Quarterly Outcomes~~ Delivery Update 2024/25 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	Mar-25											Change in reporting from Exec Directors Qtly Objectives to Strategic Priorities Success Measures
Board Risk Appetite	Deputy Chief Executive	Annual	May-25											
Review of Strategic Risks	Deputy Chief Executive	Annual	May-25											
Doncater & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	Mar-25											
Partnership Updates (details TBC)	Deputy Chief Executive	TBC	TBC											
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Executive	TBC	TBC											
Nursing, Midwifery & Allied Health Professionals Strategy 2023/27	Chief Nurse		2027											
People Strategy 2023/27	Chief People Officer		2027											
Research & Innovation Strategy 2023/28	Chief People Officer		2028											
Speaking Up Strategy 2024/28	Chief People Officer		2028											
Tackling Health Inequalities 2023/28	Director of Recovery,		2028											
ASSURANCE & GOVERNANCE														
Board Work Plan (approval)	AD of Strategy, Partnerships & (	Annual	May-24											
Board Effectiveness	AD of Strategy, Partnerships & (	Annual	Mar-25											
Integrated Quality & Performance Report	COO/CN/EMD/CPO	Every Meeting	Every Meeting											
Financial Posiiton	Chief Financial Officer	Every Meeting	Every Meeting											
Staff Survey Results	Chief People Officer	Annual	Mar-25											
Research & Innovation Bi-annual Report	Chief People Officer	6 monthly	Mar-25											
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	May-25											Zoe Lintin & FTSU Guardian agreed new reporting schedule in May 2024 October 2024 (PC) and November 24 (BoD) and then six months later
Chair's Assurance Log - Finance & Performance Committee	F&P Chair	Post Committee	Jan-25		verbal									
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Jan-25											
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Jan-25											
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Jan-25											
Chair's Assurance Log - Charitable Funds Committee	CFC Chair	Post Committee	Jan-25											
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	Jan-25											
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships & (	Annual	May-25											Revert to May 2025/committee review
Tems of Reference - Quality & Effective Committee	AD of Strategy, Partnerships & (	Annual	May-25											Revert to May 2025/committee review
Terms of Reference - People Committee	AD of Strategy, Partnerships & (	Annual	May-25											Revert to May 2025/ committee review
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships & (	Annual	May-25											
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	May-25											
Annual Report - Chartable Funds Committee	Chair of CFC	Annual	Jan-25											Revert to July 2025
CORP/FIN 1 - A Standing Orders - Board of Directors	AD of Governance	Annual	Jan-25											Revert to July 2025
CORP/FIN 1 - B Standing Financial Instructions	AD of Governance	Annual	Jan-25											Revert to July 2025
CORP/FIN 1 - C Reservation of Powers to the Board and Delgation of Powers	AD of Governance	Annual	Jan-25											Revert to July 2025
CORP/FIN 1 - D Fraud, Bribery and Corruption Policy and Response Plan	Chief Financial Officer	2 Yearly	Mar-26											
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships & (	3 yearly	Sep-25											
CORP/COMM 11 - Management of Reviews, Visits, Inspections and Accreditations Policy	AD of Strategy, Partnerships & (	2 yearly	Dec-25											
CORP/COMM 25 - Establishment and Administration of Committees Policy	AD of Strategy, Partnerships & (	3 yearly	Feb-26											
CORP/FIN 4 - Standards of Business Conduct and Employees Declarations of Interest Policy	AD of Strategy, Partnerships & (	3 yearly	Jun-26											
CORP/RISK 30 - Risk Identification, Assessment, and Management Policy	AD of Strategy, Partnerships & (	3 yearly	Oct-26											
CORP/COMM 1 - Approved Procedural Documents (APDs) Development and Management Policy	AD of Strategy, Partnerships & (	3 yearly	Mar-27											
STATUTORY & REGULATORY														
Maternity & Neonatal Update	Director of Midwifery	Every Meeting	Jan-25											
Maternity Workforce	Director of Midwifery	Bi-annual	Jan-25											
Learning from Deaths	Executive Medical Director	Quarterly	Mar-25		verbal									
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Mar-25											Next due March 2026
Workforce Race Equality Standards	Chief People Officer	Annual	May-25											
Workforce Disability Equality Standards	Chief People Officer	Annual	May-25											
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annual	Nov-25											
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Jul-25											
Quality Reoport	Chief Nurse	Annual	Jul-25											
Going Concern	Chief Financial Officer	Annual	Mar-25											
Trust Seal	AD of Strategy, Partnerships &	As Req'd	Mar-25											
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-25											currently reports directly to BoD
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-25											currently reports directly to BoD
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-25											
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships & (	Annual	May-25											
Safeguarding Annual Report	Chief Nurse	Annnual	Sep-25											
INFORMATION														
Work Plan	AD of Strategy, Partnerships & (	Every Meeting	Every Meeting											
Appointment of External Auditors	Chief Financial Officer	As Req'd	Sep-24											
Appointment of Internal Auditors	Chief Financial Officer	As Req'd	Sep-24											
CLOSING ITEM														
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting											
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting											
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting											
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting											
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd											

LEGEND KEY - (ensure reason entered in comments column or cell as appropriate)

Presented as planned
Planned for future meeting(s)
Rescheduled for valid reason(s) - as stated
Not considered as planned
Items added to the work plan post agreement - ensure reason entered in comments column

Process for administration of actions logs/work plans:
A review of the work plan administration process has been undertaken. Each Year a Board work plan MUST be assigned a separate worksheet (plan) for each Year. Once agreed, ***no changes to workplan must be added without correct audit trail tracking and comments****. If an item has been identified for addition to a workplan then this* ***must*** *be added to the appropriate board/board committee meeting action log so full audit trail is available. Full annotation of whether a report has been to committee or not MUST be logged on to the workplan with appropriate comments as to why and when it will be presented and appropriate colour coding used identified in the legend (see above legend key). An additional column has been added to each work plan at the end headed "comments" to log any required supplementary information for audit/tracking purposes.*

2501 - F CLOSING ITEMS

2501 - F1 MINUTES OF THE MEETING HELD ON 05 NOVEMBER 2024

Decision Item | Suzy Brain England OBE, Chair of the Board | 12:20

5 minutes

REFERENCES

Only PDFs are attached

F1 - Draft Public Board of Directors Minutes - 5 November 2024.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 5 November 2024 at 09:30 via MS Teams

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

In attendance:
Rebecca Allen - Associate Director of Strategy, Partnerships & Governance
Dr Victoria Barradell – Consultant Geriatrician (agenda item B1)
Jon Ginever – Freedom to Speak Up Guardian (agenda item D4)
Paula Hill – Freedom to Speak Up Guardian (agenda item D4)
Dr Mohammad Khan – Guardian of Safe Working (agenda item E1)
Lois Mellor - Director of Midwifery
Angela O'Mara - Deputy Company Secretary (minutes)
Emma Shaheen - Director of Communications & Engagement

Public in attendance:
Laura Brookshaw - 360 Assurance
Marjorie Moores - Doncaster & Bassetlaw Teaching Hospitals
Tim Noble - Doncaster & Bassetlaw Teaching Hospitals Dave Northwood - Public Governor
Mandy Tyrrell - Staff Governor
Sheila Walsh - Public Governor

Apologies:

P24/11/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

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

P24/11/A2 **Actions from Previous Meetings**

Action 1 - Integrated Quality & Performance Report – action closed
Action 2 - L2P Medical Appraisal System – written update provided
Action 3 - Refresh of Board Assurance Framework (BAF) & Action 4 Board Assurance Framework 3 (Operational Performance) – action closed
Action 5 – Progress Report – Strategic Priority Success Measures – action closed
Action 6 – Immediate Safety Concerns Exception Reports – included within the Guardian of Safe Working Report @ agenda item E1

P24/11/A3 **Chair's Report (Enclosure A3)**

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

The significant contribution of colleagues in making the annual Star Awards a showcase event was recognised, with a record number of nominations received and excellent attendance.

The Trust had been awarded the Green Flag Award for the Rainbow and Butterfly Gardens at Doncaster Royal Infirmary and the Rainbow Garden at Bassetlaw Hospital. The national accreditation programme recognised the provision of on-site green space, which offered a haven for colleagues and members of the public to visit. Special thanks were extended to estates colleagues who maintain the gardens.

Colleagues and members of the public were encouraged to share their views on changes required in the NHS to help shape the new 10 Year Health Plan for England.

The Board:

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

P24/11/A4 **Chief Executive's Report (Enclosure A4)**

The Chief Executive's report provided an overview of items of interest at a local, system and national level connected to the work of the Trust and aligned to its strategic priorities.

The Trust had been selected as one of four sites across the country to pilot genetic testing in stroke patients. Through continued efforts to support the recruitment and retention of midwifery colleagues the Trust was expected to secure levels of staffing close to the Birthrate Plus® standards.

Non-executive Director, Mark Bailey recognised the excellent patient feedback relating to the collaborative service provision at Mexborough Elective Orthopaedic Centre and welcomed the Trust's involvement in the stroke patient pilot, which the Acting Executive Medical Director clarified was part of a national roll out of testing linked to research activity.

The Chief Executive acknowledged the importance of research in the advancement of medicine and in support of the Trust's ambition to be a University Teaching Hospital.

Since its opening in January 2024, the development of the Mexborough Elective Orthopaedic Centre was in line with other established specialist units. Discussions were ongoing with partner organisations to maximise activity.

The Board:

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

P24/11/B1 **Frailty Services at DBTH (Enclosure B1)**

The Chief Executive welcomed Dr Barradell, Consultant Geriatrician to the meeting to provide an insight into the Trust's current frailty service and future opportunities. Frailty was defined as a syndrome of increased vulnerability to stressor events associated with adverse outcomes.

Nationally 60% of all hospital beds were occupied by patients aged 65+ and whilst the life expectancy of Doncaster residents was broadly in line with the national average, there were fewer healthier years, with frailty experienced at a younger age than the national average.

Considering the population served, the Trust operated on a limited resource, when compared to neighbouring organisations, with a relatively small bed base, restricted virtual ward capacity and just six substantive consultants at the Doncaster site and one part time consultant at Bassetlaw. Despite this the quality of service provided was good.

Dr Barradell recognised the need for proactive care before the point of crisis and the importance of a senior decision maker to assess the risk between care provided in the community as compared to an acute hospital setting. The challenges experienced in the Emergency Department in discharging a patient with frailty when there was no clinical need to admit were recognised, with admittance often the pathway of least resistance, but not necesssarily the most appropriate environment with the potential for a loss of autonomy, deconditioning and a prevalence of delirium.

There was a desire for service improvement and innovation with a daily geriatric consultant presence in the Emergency Department, consultant referrals, same day emergency care and an orthogeriatric model. With an aspiration to provide the majority of level one hospital care in the community, supporting oxygen, IV antibiotics, pre-operative assessments and timely rehabilitation.

Recruitment and retention of colleagues was challenging, with a lower level of remuneration when compared to other organisations, the service had an excellent reputation for training and education.

In response to a question from Non-executive Director, Jo Gander regarding opportunities as part of the Getting It Right First Time (GIRFT) programme or system projects, Dr Barradell confirmed her involvement in system working, however, in view of the limited number of consultants and extensive job plans it was difficult to explore GIRFT initiatives. Consultant oversight of care would be the aspiration , this was currently not possible to deliver within the current resource.

The Chief Executive acknowledged the issues associated with different pay bandings and recognised the benefits of a consistent approach. With an aging population there was a need to consider the strategic opportunities for care of the elderly and the importance of partnership working at Place to support the interface between acute and community care, which aligned with the Secretary of State for Health's priorities. Should funding become available a partnership model of care would be fundamental to success.

Non-executive Director, Hazel Brand acknowledged the reference to frailty in NHS Nottingham & Nottinghamshire's Joint Forward Plan. Dr Barradell confirmed she had recently become involved in the Integrated Care Board's frailty workstream, the Trust was recognised as an outlier compared to its peers.

The Chief Operating Officer recognised the various aspects of service improvement, which would be captured as part of 2025/26's planning. Frailty was also a pillar of the Urgent and Emergency Care Improvement Plan and the division was working closely with Dr Barradell to develop a shared vision to ensure patients come to hospital when required but were discharged in a timely manner.

Non-executive Director, Emyr Jones recognised provision of care in the community could include nursing in a care home which may be more appropriate than admission to a hospital, however, as many care homes were independent he enquired of opportunities to work collaboratively. Whilst Rotherham, Doncaster & South Humber NHS Foundation Trust had a care home liaison team it was noted their colleagues were not trained in acute frailty. The Chief Executive confirmed the importance of partnership working at Place to remove barriers and place the patient at the centre of the service. Dr Nabeel Alsindi, GP and Medical Director for South Yorkshire Integrated Care Board had recently joined the Trust's Medical Director's Office to enhance the interface between primary and secondary care to ensure resources were targeted in a joined up way. Progress in the implementation of virtual wards was noted, with excellent feedback, however, the step down model was utilised to a greater extent than step up.

The Chief Nurse confirmed that the Trust had not been an outlier on pay until recent months and work linked to the Advanced Clinical Practice framework was underway to ensure a consistent approach across organisations, which would feed into business planning.

The Chair of the Board recognised the current service provision and urged the future strategic direction of the Trust to align with an increasingly aging population, providing safe care closer to home.

The Board:

- ***Noted and took assurance from the Frailty Services presentation***

P24/11/C1 **<u>Winter Planning 2024/25 (Enclosure C1)</u>**

Following consideration at the October meeting of the Finance & Performance Committee, the Chief Operating Officer presented the recommended 2024/25 Winter Plan for approval.

Since the initial draft, further confirm and challenge meetings had taken place with clinical and corporate colleagues. The plan included priority schemes to support patient flow and maximise the bed base at a cost of c.£675k.

The Chief Executive confirmed the robust plans supported delivery of a safe service within the resources available to the Trust and in the absence of additional funding. The importance of the Influenza and Covid vaccination programmes was highlighted and those in attendance were encouraged to take up the vaccination offer and encourage others to do so.

Non-executive Director, Hazel Brand enquired of the current colleague flu vaccination rate, in view of the local and national take up rates the Chief People Officer confirmed the matter had been discussed at the recent People Committee. The current vaccination rate stood at 15%, a programme was in place to support delivery through drop in clinics and roving vaccinators. The Trust had also received support from the Rapid Relief Team whose volunteers provided refreshments and relief packs, including health and wellbeing items.

In response to a question from the Chair of the Board, the Chief Financial Officer confirmed that the costs of the 2024/25 Winter Plan were included within the forecast and did not represent a cost pressure.

The Board:

- ***Approved the Winter Plan 2024/25***

P24/11/C2 **Doncaster & Bassetlaw Healthcare Services (DBHS) Update (Enclosure C2)**

The Chief Financial Officer provided an overview of Doncaster and Bassetlaw Healthcare Services' financial position, forecast and operational activity as at September 2024. The business was performing well, and the forecasted profit for 2024/25 was the highest annual profit to date. At its latest Board meeting DBHS had resolved to make a dividend payment to the Trust of £200k. Since the report had been written the issues relating to the Quality Improvement Medical Education and Training (QiMET) contract had been resolved.

In response to a question from Non-executive Director, Kath Smart regarding the wider use of SmartER, the Chief Financial Officer confirmed that options to utilise this in primary care were being explored, due to a nationally mandated platform in Emergency Departments.

The Board:

- ***Noted and took assurance from the Doncaster & Bassetlaw Healthcare Services Update***

P24/11/C3 **NHS Nottingham & Nottinghamshire Integrated Care Board Joint Forward Plan Update (Enclosure C3)**

The Deputy Chief Executive shared with the Board an in-year update on delivery against Nottingham and Nottinghamshire Integrated Care Board's Joint Forward Plan which focused on; prevention, proactive management of long-term conditions and frailty,

improving navigation and flow to reduce emergency pressures and the timely access and early diagnosis for cancer and elective care. The key deliverables were assigned a level of confidence, many of the areas where there was a lower level of confidence related to population health and emergency care.

In line with the Trust's strategy, there would be increased visibility of Bassetlaw Place Partnership's work at the Board. The importance of the Trust's voice remaining active across both systems was noted.

Non-executive Director, Hazel Brand confirmed the Trust had participated in the judging of the Nottingham & Nottinghamshire Integrated Care System 2024 Awards and would be represented at tomorrow's event.

The importance of remaining actively involved in the ongoing work and prominent in discussions was acknowledged by Non-executive Director, Emyr Jones who along with other colleagues had attended a non-executive system event.

The Board:

- ***Noted the NHS Nottingham & Nottinghamshire Integrated Care Board Joint Forward Plan Update***

P24/11/D1 **Integrated Quality & Performance Report (Enclosure D1)**

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

The Deputy Chief Executive reflected on the Making Data Count Board development session, delivered by NHSE and was encouraged by the feedback on reporting and opportunities for further improvements, feedback on which was welcomed.

The Executive Directors summarised their respective key performance indicators. Non-executive Director, Kath Smart welcomed the use of the tools and techniques from the session, including the at a glance view, which provided a clear focus for efforts. The number of standards not being met were higher than hoped and assurance was sought that a SMART action plan to address improvements was being scrutinised at the Performance Review Meetings. The Chief Operating Officer acknowledged a variable level of detail in plans and recognised there was a need for more granular detail in the Doncaster Place Urgent and Emergency Care improvement plan. The Deputy Chief Executive recognised the need to consider the flow of information between non-executive and executive led meetings to understand the action plans in train.

The Chief Executive highlighted the difference between meeting national standards and achieving a performance in line with peers, with an improvement trajectory.

In response to a question regarding the Hospital Standardised Mortality Ratio (HSMR), the Acting Executive Medical Director confirmed it should not be assumed that clinical coding was the sole contributory factor. A review of case notes had identified anomalies

between elective and emergency pathways and a review of coding for all elective deaths was to be implemented.

Non-executive Director, Lucy Nickson enquired if the delay in administering antibiotics within one hour of a positive sepsis screening related to a system or people issue. The Acting Executive Medical Director acknowledged the short time frame in which to receive and administer the antibiotic, with a verbal handover supporting the urgency in view of the system alert being in time order. In view of the impact on mortality rates it was recommended that an improvement trajectory be determined.

The Chief Executive welcomed the use of statistical process control charts to support identification of a change in process/practice to establish if the associated impact was delivered. Where a change in process did not deliver the required outcome the Acting Executive Medical Director confirmed the change should be stopped.

The Board:

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

P24/11/D2 **Financial Position (Enclosure D2)**

The Chief Financial Officer reported a month six deficit of £1.8m, £800k favourable to plan and a year to date deficit of £19.8m, £500k adverse to plan, £600k adverse to forecast. The Trust's year to date position was mainly driven by elective recovery fund underperformance, which was £4.9m adverse to plan, this was offset by a favourable variance of £2m on independent sector expenditure. Pay was £1.7m adverse to plan, with a one-off benefit of £1.3m identified across pay and non-pay spend.

The total year to date capital spend, excluding donated assets and charitable funds, was c£8,600k, against a plan of £7,200k, with a charitable funds capital spend of £2.4m related to the da Vinci® and stroke rehabilitation robots.

The cash balance at month six was £17.7m.

In month, the Trust had delivered £1.5m of savings against a plan of £1.8m, £6m of savings had been delivered year to date, against a plan of £6.2m.

The month six position had been adjusted in line with guidance from NHS England relating to non-recurrent deficit funding of £23.8m. The deficit financial plan had been reduced by £23.8m from £26.2m to £2.4m

The Board:

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

P24/11/D3 **Audiology Service Update (Enclosure D3)**

The Chair of the Board confirmed this agenda item would be recorded to allow the update to be made available using British Sign Language on the Trust's website.

A governor question had been received related to the audiology service and would be responded to as part of this update. *"With satisfaction in the audiology department being at a low point and there being increased concern shared by communities what actions are the trust taking to actively seek to improve the service and the outcomes of the patients within the service"?*

The Deputy Chief Executive confirmed a summary of the report would be provided, which would include national context, specifically related to paediatric audiology, as well as wider service challenges related to adult audiology. There was a need to resolve the current service issues for patients, their families, and local communities, recognising the quality and associated outcomes did not meet the standard the Trust would wish to deliver and on behalf of the Trust, the Deputy Chief Executive offered a sincere apology.

As part of NHSE's paediatric audiology improvement programme, the Trust undertook a self-assessment of its service which identified some areas of concern around safety and quality. A subsequent independent review led by South Yorkshire Integrated Care Board (ICB) and involving regional NHSE colleagues resulted in immediate service mitigations which allowed the Trust to continue to deliver a safe service with the support and oversight of subject matter experts.

As part of this process a review of case notes over the previous five years was completed, which resulted in 40 children being recalled. 37 of the families had been seen at Sheffield Children's Hospital, the outcomes were being reviewed with external support and to date no harm had been identified. The remaining three cases were being followed up and the Trust had undertaken duty of candour.

In recent months, a decision was taken to seek external assurance on the mitigating actions, which confirmed that the actions were not fully embedded and the IT issues presented a significant level of risk to service delivery. A careful assessment of the risk resulted in a difficult decision being taken by the executive team to limit the service. This change was expected to continue into 2025 to ensure that service changes were fully embedded and development work was undertaken to be able to keep patients safe. Alongside the existing relationship with Sheffield Children's Hospital, mutual aid was sought from neighbouring providers, with the support of South Yorkshire Acute Federation for baby fittings and paediatric and adult repairs. A consistent approach to the prioritisation of patients was being established and with the agreement of the ICB referrals would continue to be accepted by the Trust, which allowed the organisation to maintain oversight, ensuring prioritisation of the most appropriate patient pathway.

There was an extensive programme of work underway and in addition to mutual aid the Trust had also outsourced some adult diagnostic work to the private sector and capital investment had been made available for the physical estate and equipment, which would be governed through executive processes.

Senior leaders were driving forward the work and alongside the current co-ordination role undertaken by the Deputy Chief Executive, the Acting Executive Medical Director was leading on the clinical aspects and the Chief Operating Officer on access, waiting times and mutual aid. A new Head of Service for Audiology had been appointed into the Division of Clinical Specialities and there was a need to consider management capacity and a dedicated resource for this focused work. An incremental approach to restoring

service provision was expected, in the most appropriate and timely way possible. The Board, its committees and management structures would be appraised of progress.

From discussions with the Doncaster Deaf Trust, it was apparent there was an opportunity for the organisation to learn from those with lived experience to ensure that the Trust was supporting its deaf community.

Non-executive Director, Kath Smart and the Acting Executive Medical Director had recently visited the ENT secretaries and recognised the importance of communicating with patients on the waiting list. The Deputy Chief Executive advised that at the time the service had been limited appointments had been cancelled on a rolling basis and patients were advised of next steps based upon their personal circumstances, with priority one and two patients being supported though the mutual aid pathway. Understandably, the Trust was receiving concerns and complaints because of the service limitation and a comprehensive communications package had been developed to support patients and stakeholders.

Non-executive Director, Emyr Jones thanked the Deputy Chief Executive for the comprehensive update which had been shared with the Board's Quality & Effectiveness Committee and he recognised the challenging position.

Non-executive Director, Lucy Nickson welcomed the opportunity to learn from those with lived experience.

The Chief Executive offered his personal apology to patients and the community served by the Trust, recognising the standard of service did not meet the Trust's expectations, or what patients had a right to expect. In his capacity as Chief Executive it was important that he acknowledged this and provided a commitment, as described, to address the identified challenges. Post pandemic the service had experienced significant challenges around waiting times and the Trust would consider what earlier opportunities there may have been to understand the reasons for this and identify any associated learning. In terms of addressing the challenges it was clear that the capacity to provide mutual aid across South Yorkshire was limited and with an aging community and increased demand there would be a need to consider as a trust and across the system a long term strategic solution to provide a revised model of care.

The Board:

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

P24/11/D4 **Freedom to Speak Up (FTSU) Bi-annual Report (Enclosure D4)**

The Chair of the Board welcomed the Freedom to Speak Up Guardians to the meeting.

A comprehensive overview of the report and its supporting appendices was provided, which included an insight into Speaking Up activity, ongoing work to support delivery of the 2024-2028 Speaking Up Strategy, the national themes of Speaking Up and a comparison to the Trust's activity. The Board's People Committee had scrutinised the detail of this report at its October meeting.

A comparison of Speaking Up data was provided for 2023/24 and 2024/25 to date. Nursing and midwifery colleagues continued to be the highest cohort of colleagues Speaking Up. No anonymous concerns had been raised, which could be an indicator of colleagues confidence in the process. To date there appeared to be a shift from patient safety and quality matters, with worker safety and wellbeing reports representing the greatest number. The number of colleagues who would Speak Up again remained high, historical feedback was being sought for the period 2022 to 2024 following the updated strategy and views shared in the Care Quality Commission (CQC) report.

Non-executive Director and FTSU Non-executive Champion, Hazel Brand recognised the volume of work undertaken and welcomed the oversight provided to the Board.

The Chief Executive reflected on earlier observations and discussions as part of the Thirlwall Inquiry, regarding the importance of information flow between the Ward and the Board and vice versa and the importance of colleagues following the correct procedure to ensure Board oversight. The FTSU Guardian recognised the importance and confirmed that following colleague feedback revisions had been made to the process. Colleagues were actively encouraged and supported to follow the process. The Chief Executive confirmed the Trust was keen to hear colleagues concerns, in order that they could be investigated and the necessary action taken when learning was identified. He was not aware of any instances where this had not occurred and sought assurance that the FTSU Guardian would ensure matters were escalated when required. The FTSU Guardian indicated that feedback was always provided to individuals and more recently the publication to share awareness of learning across the organisation had been introduced. In terms of raising awareness information relating to the Speaking Up process was being shared with all divisions and corporate areas.

Non-executive Director, Kath Smart shared her appreciation of the comprehensive update and data pack, in respect of the review of cases during the period 2022-2024, the FTSU Guardian confirmed initial feedback had always been sought at the time the case was closed. Nationally there was an ask for feedback to be followed up at three, six and twelve months and it was this aspect that was to be addressed going forwards.

In response to a question from Non-executive Director, Mark Bailey regarding any aspects of learning from FTSU activity that indicated an issue which may not have been apparent through other sources. The FTSU Guardian recognised blind spots were naturally more worrying and there may need to be a need to consult and consider other evidence to build a picture. Where it was apparent that a positive view of Speaking Up was not held the FTSU Guardian would engage with colleagues to understand, appreciate the impact, and offer support.

Non-executive Director, Jo Gander noted the volume of cases from nursing and midwifery colleagues and enquired if this related purely to the size of the workforce, or if there were underlying issues. The Chief Nurse welcomed the use of the service by nurses and midwives and recognised that on occasions there may be clusters of reporting related to specific challenges in the service. From a patient safety perspective, it would be expected that some of the conversations then triangulated with other evidence and data.

In respect of the CQC action plan, the Chief Nurse highlighted that the review, evaluation and subsequent reporting of experiences and Board oversight provided good evidence.

Whilst the FTSU work was ongoing in terms of evidence to address the CQC action plan this was now closed and captured on Monday.com.

The Chair of the Board thanked the FTSU Guardian for the comprehensive update and improvement work and welcomed the debate and questions. In the first instance the Chair of the Board suggested that colleagues could raise matters with their line manager unless they felt unable to do so.

The Board:

- ***Noted and took assurance from the Freedom to Speak Up Bi-annual Report***

P24/11/D5 **Board Assurance Framework & Trust Risk Register (Enclosure D5)**

The Board received the updated Board Assurance Framework (BAF) which had been reviewed by the respective Board Committees.

The Deputy Chief Executive confirmed a Board workshop would take place in December 2024, when the BAF would be considered alongside the Trust's strategic priorities and risks.

The majority of the risk scores remained the same, with a change related to strategic risk three recommended by the Finance & Performance Committee. The highest rated risk related to the Trust's estates, with a risk score of 20.

Following a detailed conversation at the Audit & Risk Committee there was a continued need to strengthen risk management, with actions on operational risks reflected on the risk register and mapped across to strategic risks.

The Deputy Chief Executive suggested oversight of strategic risk six (partnerships) be assigned to the Board of Directors. Partnership activity should continue to be developed appropriately and partnership risks relevant to the business of Board committees would continue to be considered by the relevant committee. The controls and actions had been updated to reflect the current position and ongoing partnership work.

The Chief Operating Officer confirmed that further to discussions at October's Finance & Performance Committee, the risk score for strategic risk three had been amended to sixteen, this reflected the risk associated with operational risk 3437 related to timely access to emergency care.

The Chief People Officer confirmed that the Board Assurance Framework for strategic risk two had been reviewed by the People Committee in October, when all five key controls had been considered as part of the agenda. The risk associated with the inability to recruit and ensure colleagues had the right skills had been on the operational risk register for some time at a score of 16. In view of the successful recruitment in nursing and midwifery and following agreement at Risk Management Board the risk score had been reduced to 12. Since the update, two internal audit reports had been considered by the Audit & Risk Committee and would be included in the next iteration of the BAF as a source of external assurance.

The Chief Financial Officer confirmed that the Board Assurance Framework related to strategic risk four (estates) could now be updated to reflect that the Memorandum of Understanding had been signed for the Department of Critical Care work.

The Chief Nurse confirmed that strategic risk one remained under review, an updated Board Assurance Framework would be presented to December's Quality & Effectiveness Committee and would include external assurance received.

Non-executive Director, Kath Smart confirmed that the Audit & Risk Committee had reviewed the cyclical review of the Board Assurance Framework through the Board and its Committees. Changes to the meeting schedule for the Audit & Risk Committees had been made to ensure the Committee could review the BAF prior to its presentation at Board. There were opportunities to improve the consistency of presentation in line with the Risk Management policy and this would be incorporated in Committee work plans and it was proposed that changes to the Board Assurance Framework were more easily identifiable.

The Finance and Performance Committee were supportive of the increased risk score for strategic risk three and despite a risk score of 20 on strategic risk four, positive external assurance had been received through the significant assurance Planned Preventative Maintenance internal audit report.

Reflecting on the content of the Integrated Quality Performance Report and the reference in the Deloitte drivers of deficit report, Non-executive Director, Kath Smart enquired if the risk and associated action plan relating to sickness absence should be captured in the Board Assurance Framework for strategic risk two. The Chief People Officer acknowledged absence did not currently feature on the BAF and agreed to give this some thought. **ZL**

Non-executive Director, Jo Gander enquired how the changes to clinical governance would be assessed. With regards to clinical audit, it would be helpful to receive an update on actions to close the current gaps. The Chief Nurse confirmed an update on progress against clinical audit had been received at the August meeting and this would be reflected in the next iteration of the Board Assurance Framework.

In her capacity as Chair of the Audit & Risk Committee, Kath Smart confirmed she would make enquiries outside of the meeting related to overdue risks on the Trust Risk Register, which had not been available at the time of Audit & Risk meeting.

The Chair of the Board recognised that work was ongoing and encouraged the timely update of records.

The Board:

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

P24/11/D6 **Committee Terms of Reference & Dates Proposal (Enclosure D6)**

The Associate Director of Strategy, Partnerships & Governance advised the terms of reference had been reviewed by their respective committees and with the support of

internal audit colleagues. The usual annual review of governance documents would take place in early 2025 and would allow an early opportunity for amendments.

Dates for the Board and Committee meetings were proposed for 2025/26 and 2025/27 for agreement in principle.

The Board:

- ***Approved the Committee Terms of Reference & Dates Proposal***

P24/11/D7 **Chair's Assurance Log – Finance & Performance Committee (Enclosure D7)**

In the absence of the Chair of the Finance & Performance Committee, Non-executive Director, Emyr Jones provided an overview of the four quadrants of the assurance log, positive assurance, areas of major works, areas of focus and decisions made.

The Board:

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

P24/11/D8 **Chair's Assurance Log – Quality & Effectiveness Committee (Enclosure D8)**

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

The Board:

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

P24/11/D9 **Chair's Assurance Log – People Committee (Enclosure D9)**

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

Non-executive Director and Chair of the Committee, Mark Bailey brought the Board's attention to the assurance provided in the health and wellbeing annual report and highlighted the regional and national recognition of the Trust's innovative health initiatives.

The Committee had received the 2023/24 annual report and statement of compliance for medical revalidation and appraisals and had recommended this to the Chief Executive for sign-off and submission to NHSE.

The Committee was assured by the understanding of areas of risk within its workforce, the efforts and ongoing assessment to close the gap and the connection between budgets and workforce requirements.

The Chief Executive confirmed that the statement of compliance had been approved, subject to some minor non-material amendments and submitted ahead of the agreed deadline.

The Board:

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

P24/11/D10 **Chair's Assurance Log – Audit & Risk Committee (Enclosure D10)**

The Chair of the Audit & Risk Committee, Non-executive Director, Kath Smart provided a summary of the assurance logs from September and October's committee meetings which included positive assurance, areas of major works, areas of focus and decisions made.

The Board was informed of limited assurance internal audit reports relating to mortality data quality assurance, bank and agency controls and business continuity which all contained a series of recommendations and agreed management actions. Delivery of the recommendations would be monitored by the Audit & Risk Committee and the reports were referred to the relevant Board Committees for oversight. In addition, a number of significant assurance internal audit reports had been received, a positive outcome for the Trust. An extensive programme of work had been commissioned, which included the Board Assurance Framework, risk management and ensuring an efficient and effective process for the production of 2025/26 financial accounts, incorporating lessons learnt from the prior year.

The Board:

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

P24/11/D11 **Chair's Assurance Log – Charitable Funds Committee (Enclosure D11)**

The Board received the Charitable Funds Committee Chair's assurance log, which provided an overview of the four quadrants; positive assurance, areas of major works, areas of focus and decisions made. The recently appointed Head of Charity had attended his first Committee meeting, where an extensive paper was presented seeking the trustees approval of the approach to develop the Charity. The Committee's 2023/24 annual report was approved and it was agreed that the Committee would review the working arrangements between the Trust and Doncaster & Bassetlaw Healthcare Services in March 2025.

The Board:

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

P24/11/D12 **Charitable Funds Committee Annual Report 2023/24 (Enclosure D12)**

The Board received the 2023/24 Charitable Funds Committee Annual Report.

The Board:

- ***Noted and took assurance from the 2023/24 Charitable Funds Committee Annual Report***

P24/11/E1 **Guardian of Safe Working Report (Enclosure E1)**

The Chair of the Board welcomed the Guardian of Safe Working to the meeting.

During the period 1 May to 6 August 2024 a total of 32 exception reports were received from trainee doctors working across General Surgery, ENT, General Medicine and Obstetrics/Gynaecology. The majority of reports related to additional hours worked, with just one report relating to a missed training opportunity and the Board was assured that the majority of trainee doctors were able to work safely.

The cost of locum cover had increased during this period, due to the number of vacant shifts, compounded by sickness absence, industrial action and cover for on call and ward duties.

The Acting Executive Medical Director highlighted investment in the surgical workforce last year and hoped to see the number of exception reports reduce in future reports.
Non-executive Director, Kath Smart noted that 15% of the exception reports resulted in no change or action and enquired if this was a cause for concern. The Guardian of Safe Working confirmed this related to a missed break and when reviewed by the trainee and their supervisor there was no appropriate action to be taken, as the colleague had been paid for the time and the exception was closed with no action. Repeated missed breaks would be subject to further scrutiny.

The Board:

- ***Noted and took assurance from the Guardian of Safe Working Report***

P24/11/E2 **Maternity & Neonatal Update (Enclosure E2)**

The report provided an overview of the progress made against the single delivery plan, maternity self-assessment tool and the requirements of the Clinical Negligence Scheme for Trusts (CNST). The review and learning from patient safety events, perinatal mortality reviews and patient safety investigations.

The Director of Midwifery highlighted an error in the reported number of still births during August and September, which should have read a total of three. Where investigations had been finalised, all care was graded as good, with no concerns identified. The Board was informed of two ongoing Maternity & Newborn Safety Investigations (MNSI) and two Patient Safety Incident Investigations (PSII). The report confirmed appropriate engagement with the families as part of the MNSI process, including duty of candour.

Work continued towards achievement of safety action eight on the CNST standards, with trajectories in place to support 90% training compliance by 30 November 2024. The most challenging element of compliance related to trainee doctors who had only started at

the Trust in August/September. Should it not be possible to meet this standard a revised timeframe could be defined, with the agreement of the Board.

As Board Safety Champion, the Chief Nurse and Non-executive Maternity Safety Champions had met with the perinatal quadrumvirate leadership team on 26 September 2024. No support from the Board of Directors had been identified, although there remained a focus on continuous and sustained improvements to the culture with progress against the maternity and neonatal cultural improvement plan (SCORE survey) monitored and reported to the Maternity and Neonatal Safety Quality Committee.

The Director of Midwifery confirmed that both Chairs of the Maternity & Neonatal Voices Partnership (MNVP) had stood down, work was ongoing with the Integrated Care Board and the Local Maternity & Neonatal System to ensure that the service user voice continued to be heard until a solution was agreed. Despite the Trust being without MNVP Chairs, the Chief Nurse confirmed that the LMNS had been assured through its confirm and challenge meetings that the Trust was utilising alternative sources of engagement to ensure the service users' voice was heard through the work of the specialist midwife.

The neonatal nursing and medical workforce were not fully complaint with the British Association of Perinatal Medicine (BAPM) national standards. A business case had been approved to support delivery of year one and two of the four year nursing workforce action plan referenced in the paper, the Board noted and approved the progress made.

The Quarter two dashboard for avoiding term admissions in the Neonatal Unit (ATAIN) and transitional care action plan were appended to the report, the Board was asked to review and approve, noting the progress made against the action plan. In respect of the perinatal metrics appendix, the Director of Midwifery confirmed an alternative means of displaying neonatal deaths would be considered instead of the statistical process control charts, in view of the small numbers.

The Chief Executive recognised the potential for a variable impact of the BAPM standards on organisations and suggested that should there continue to be difficulties in meeting the standards that a system approach be considered to agree more realistic action plans for smaller units.

The Board:

- ***Noted and took assurance from the Maternity & Neonatal Update***
- ***Noted the number of Maternity and Newborn Safety Investigation (MNSI) / Early Notification Scheme (ENS) cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place***
- ***Noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal nursing workforce are not met and approved the progress update against previously approved action plan***
- ***Reviewed and approved Q2 ATAIN***

- ***Reviewed and approved the transitional care progress update against previously approved action plan***

- ***Noted the Board Safety Champion meetings with the perinatal leadership team and any support required of the Trust board has been identified and is being implemented***

- ***Noted progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support being considered and implemented***

P24/11/E3 **Learning from Deaths (Enclosure E3)**

The Learning from Deaths report provided an updated Trust position related to the Learning from Deaths Framework.

The Acting Executive Medical Director acknowledged the work undertaken during the last twelve months to increase the completion of structure judgment reviews, undertake thematic reviews, and establish associated learning. Whilst the number of structure judgement reviews was improving there remained some way to go to scrutinise 15% of in hospital deaths and a delivery plan would be agreed to support this.

The Chief Executive enquired if an internal standard had been agreed for the return of structured judgement reviews, including an improvement trajectory. The Acting Executive Medical Director confirmed this had been agreed through the Mortality Working Group. Structured Judgement Reviews would be completed via a central team, as well as in the divisions, a software solution would be implemented shortly to track completion, with performance reported via the Effective Committee.

The Board:

- ***Noted and took assurance from the Learning from Deaths Report***

P24/11/E4 **Emergency Preparedness, Resilience & Response – Compliance against the National Core Standards (Enclosure E4)**

The Chief Operating Officer confirmed the Trust's self-assessment against the national core standards had previously been considered by the Audit & Risk Committee. Later this month South Yorkshire Integrated Care Board would review the Trust's self-assessment and in due course a final position would be reported back to the Board. **DS**

The self-assessment confirmed full compliance with 34 standards and partial compliance with 28 standards, an overall compliance rate of 55% was declared, as compared to last year's rate of 31%. The overall rating was non-compliant.

Following consideration by the Audit & Risk Committee three compliant ratings were reduced to partial compliance, one related to a lack of approval on a policy and reassessment of two ratings following receipt of the business continuity internal audit report.

The Chief Operating Officer recognised that whilst progress was slower than hoped, impacted by significant industrial action, there had been an improvement in year. A reduction in resource had also been seen but as of December 2024 the team would be fully recruited to.

Non-executive Director, Lucy Nickson enquired of the impact of non-compliance in terms of the Trust's ability to respond. The Chief Operating Officer confirmed no individual standard was non-complaint, to achieve an overall compliance rate a high standard of full compliance was required. In terms of the response to incidents, the Trust responded well, including debriefs and lessons learnt and benchmarked well with peers across South Yorkshire.

The Board:

- ***Noted and took assurance from the Emergency Preparedness, Resilience & Response – Compliance against the National Core Standards***

P24/11/E5 **Board of Directors Register of Interests & Fit & Proper Person Test (Enclosure E5)**

The Associate Director of Strategy, Partnerships & Governance confirmed that the Fit and Proper Persons Test for the Board of Directors had been completed, with no identified issues. The return would be shared with NHSE's Regional Director in accordance with NHSE's Fit and Proper Person Test Framework for Board members.

The Board:

- ***Noted and took assurance from the Board of Directors Register of Interests & Fit & Proper Person Test***

P24/11/E6 **Use of the Trust Seal (Enclosure E6)**

The Associate Director of Strategy, Partnerships & Governance confirmed the use of the Trust Seal in accordance with the Board of Directors' Standing Orders.

The Board:

- ***Noted the use of the Trust Seal***

P24/11/F1 **Board of Directors Workplan (Enclosure F1)**

The Board received the Board of Directors workplan, its structure would be revised to align with the strategy going forwards.

The Board:

- ***Received the Board of Directors Workplan for information***

P24/11/G1 **Minutes of the meeting held on 3 September 2024 (Enclosure G1)**

The Board:

- ***Approved the minutes of the meeting held on 3 September 2024***

P24/11/G2 **Pre-submitted Governor Questions regarding the business of the meeting (verbal)**

The following governor question was received and answered as part of the audiology update at agenda item D3.

"With satisfaction in the audiology department being at a low point and there being increased concern shared by communities what actions are the trust taking to actively seek to improve the service and the outcomes of the patients within the service"?

P24/11/G3 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

P24/11/G4 **Date and time of next meeting (Verbal)**

Date: Tuesday 7 January 2025
Time: 9:30
Venue: MS Teams

P24/11/G5 **Withdrawal of Press and Public (Verbal)**

The Board:

- ***Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

P24/11/H **Close of meeting (Verbal)**

The meeting closed at 13:03

2501 - F2 PRE-SUBMITTED GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:25

10 minutes

2501 - F3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:35

10 minutes

2501 - F4 DATE AND TIME OF THE NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 12:45

Date: Tuesday 7 January 2025
Time: 09:30
Venue: MS Teams

2501- F5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Suzy Brain England OBE, Chair of the Board | 12:45

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.