Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 15 June 2021 at 09:30
Via StarLeaf Videoconferencing

Enc		Purpose	Time
A	**MEETING BUSINESS**		**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *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*		15
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	
B	**True North SA1 - QUALITY AND EFFECTIVENESS**		**09:45**
B1	Maternity Update - Ockenden Report - Perinatal Mortality Dashboard *David Purdue, Chief Nurse*	*Assurance*	30
C	**OTHER ITEMS**		**10:15**
C1	Minutes of the meeting held on 18 May 2021 *Suzy Brain England OBE, Chair*	*Approval*	5
C2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	
C3	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10
C4	**Date and time of next meeting:** **Date:** Tuesday 20 July 2021 **Time:** 09:30 **Venue:** StarLeaf Videoconferencing	*Information*	

I5	**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*	*Note*

J	**MEETING CLOSE**	**10:30**

***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 questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Hazel Brand, as Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Hazel to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Hazel directly prior to the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

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

- Questions at the meeting must relate to papers being presented on the day.
- Questions must be submitted in advance to Hazel Brand, Lead Governor.
- Questions will be asked by Hazel Brand, Lead Governor at the meeting.
- If questions are not answered at the meeting Fiona Dunn will coordinate a response to all Governors.
- 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

Action notes prepared by: Katie Shepherd
Updated: 9th June 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	18th May 2021

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**P21/03/C3**	**Committee Structures** Following the discussion of the Clinical Governance meeting structure. It was agreed that work would be undertaken with the Communications and Engagement Team to devise a clear and understandable outline of the committee structure and each committees purpose.	**TN / ES**	**May 2021**	
2.	**P21/03/E2**	**Service Changes** A report would be provided on the service changes made during the COVID-19 pandemic, and any fundamental changes that would form how services would be delivered in the future.	**RJ**	**April 2021**	**Closed 18/05/2021.** This has been added to the Finance and Performance Committee work plan.
3.	**P21/04/C2ii**	**Glossary of Acronyms** A glossary of acronyms used in reports should be provided as an appendix.	**All**	**N/A**	**Closed 18/05/2021:** The Lead Governor advised that there continued to be many acronyms used in Board papers and asked that the first time an acronym was used, that it was written in full first. The Head of Communications and Engagement circulated guidance on the Trusts house style to management teams.

Action notes prepared by: Katie Shepherd
Updated: 9th June 2021

No.	Minute No.	Action	Lead	Target Date	Update
4.	P21/04/G3	**COVID-19 Business Continuity Terms of Reference – Trust's SO's** When the Standing Orders are reviewed in July 2021, the COVID-19 Business Continuity Terms of Reference addendum would be removed.	FD	July 2021	
5.	P21/05/C2i	**Implementation of e-Observations** The review undertaken on the implementation of e-Observations would be reported to the Quality and Effectiveness Committee.	DP	August 2021	**Closed.** Added to the Quality and Effectiveness Committee action log.
6.	P21/05/C2ii	**Challenges with the completion of the Friends and Family Test** It was agreed that that Quality and Effectiveness Committee would review the challenges seen with the completion of the Friends and Family Test (FFT).	DP	August 2021	**Closed.** Added to the Quality and Effectiveness Committee action log.
7.	P21/05/C3i	**Review of National Examiners Report** The Medical Director would review the National Medical Examiners report, which would include a review of the cases scrutinised by the Medical Examiner, to identify how this could be reported as a key performance indicator in future reports.	TN	July 2021	
8.	P21/05/C3ii	**Inclusion of Culture and Communication as part of Medical Director Report** It was agreed that future Medical Director reports to Board would include an update on culture and communication with the medical workforce.	TN	July 2021	
9.	P21/05/D2i	**Long Term Sickness Absence** The number of colleagues on long-term sickness absence would be reviewed at the People Committee with a consideration of those with COVID-19 related absence.	KB	July 2021	**Closed.** Added to the People Committee action log.

Action notes prepared by: Katie Shepherd
Updated: 9th June 2021

No.	Minute No.	Action	Lead	Target Date	Update
10.	P21/05/D2iii	**Benefits of the Emergency Department Organisational Development Programme** Assurance was to be provided to the People Committee on the tangible differences and benefits which have been created throughout the Emergency Department Organisational Development Programme.	KB	July 2021	**Closed.** Added to the People Committee action log.
11.	P21/05/D2iii	**Access to the COVID-19 Vaccination** Assurance to be provided to the People Committee that colleagues who were unable to access the COVID-19 vaccination as part of the Trust's vaccination programme were aware of how to access the COVID-19 vaccination should they wish to have it.	KB	July 2021	**Closed.** Added to the People Committee action log.
12.	P21/05/E2	**Bed Plan** The bed plan would be presented at the Finance and Performance Committee.	RJ	July 2021	**Closed.** Added to the Finance and Performance Committee action log.
13.	P21/05/E4	**Quality Accounts** The Quality and Effectiveness Committee would receive the Quality Accounts.	FD	June 2021	**Closed.** On the agenda for the Quality and Effectiveness Committee for 14th June 2021.
14.	P21/05/I3	**Digital Transformation Team** The digital transformation team would be invited to showcase the implementation and use of Nerve Centre at a national committee such as the Governor Advisory Committee.	FD	September 2021	

Report Cover Page					
Meeting Title:	*Board of Directors*				
Meeting Date:	*15th June 2021*	**Agenda Reference:**	**B1**		
Report Title:	*Perinatal Maternity Dashboard*				
Sponsor:	*David Purdue – Chief Nurse and Deputy Chief Executive*				
Author:	Lois Mellor, Director of Midwifery David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:	*0*				
Report Summary					
Purpose of report:	*To provide information and assurance on the Maternity Service*				
Summary of key issues/positive highlights:	• Good progress is being made in relation to objectives. • Outstanding elements waiting for the National Pathways • Learning areas from reports and incidents				
Recommendation:	None				
Action Require:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** ***To provide outstanding care for our patients***	**TN SA2:** ***Everybody knows their role in achieving the vision***	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	*None*
Corporate risk register:	*None*
Regulation:	*CQC – Safe Care and Treatment and Patient Centred Care. Achievement of Outstanding.*
Legal:	*Trusts licence to operate*
Resources:	*Nil*

Assurance Route			
Previously considered by:	*Board of Directors*		
Date:	*February 2021*	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		
Previously circulated reports to supplement this paper:	None		

Perinatal Dashboard for May 2021

Findings of review of all perinatal deaths using the real time data monitoring tool

During the quarter from 1st October to December 31st 2020 there were 3 stillbirths with gestations ranging from 22 weeks to post term.

Lessons learnt are discussed and shared at the Perinatal Mortality, Morbidity and Maternal Morbidity Meeting (PN5M). Minutes of the PN5M meeting are received by the Maternity and Gynaecology Clinical Governance Group. Further details of the stillbirths can be found within these minutes. Whilst the PN5M meeting was suspended, due to Covid19, lessons learnt were circulated via the 'What's Hot Newsletter'. This meeting has now been recommenced.

Antenatal /Intrapartum	Initial review findings	PMRT and investigation /review outcome
Intrapartum	G8 P3, CLC, Smoker, DFM x2 IUD in latent phase	PMRT Grading C, A. **SI – Awaiting HSIB report** Met CNST requirements
Antenatal	G1 P0, CLC, Smoker (E- Cig)	PMRT surveillance performed awaiting MDT review scheduled for next meeting in March
Antenatal	G4 P3, CLC, Type 2 DM on insulin, Booking BMI 49. Known congenital abnormality. Cord Prolapse	PMRT surveillance performed awaiting MDT review scheduled for next meeting in March

Action Plan for Quarter 3

Issue	Action	Implementation Plan	Person responsible & role	Target completion date
This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mother and crying babies because the facilities were not available	Review of bereavement facilities has begun	Ongoing review	Julie Humphries Intrapartum Matron And Bereavement Midwives	11.11.2021
The opportunity to take their baby home was not offered to the parents	It is planned that this will be offered and a further Cold Cot is being obtained for this purpose. Guideline and supporting information for parents also required	Obtain further cold cot and complete required guidelines and supporting information	Julie Humphries Intrapartum Matron Carol Lee Bereavement Support midwife	11.11.2021
Admission CTG in latent phase of labour not conducted	Guideline to be reviewed	To review and clarify guideline. Escalated to Labour ward co-ordinator and CTG specialist midwife	Maria Swiers Amy Smith	01.05.2021

Quarter 4 – 1st January 2021 to 31st March 2021

Antenatal	Initial review findings	PMRT and investigation

/Intrapartum		/review outcome
AN	P2 x C/S known PET. Planned elective C/S. No FHHR on the day of C/S 2155g.**SI HSIB**	For review April 2021
AN	P0 BMI 39 GDM Metformin Polyhydramnios 2700g	For Review April 2021
AN ?NND	P0. Concealed pregnancy. Delivered at home. 614g	Coroner accepted case. Awaiting review May 2021
AN	CLC Smoker CO 77 at booking. 999 transfer – foot outside of vagina. MGSO4 and Dex. FHHR on arrival. Head Entrapment. Cervical Incisions. No Signs of life 500g	For Review May 2021

Action Plan for Quarter 4

Issue	Action	Implementation Plan	Person responsible & role	Target completion date
This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mother and crying babies because the facilities were not available	Review of bereavement facilities has begun	Ongoing review	Julie Humphries Intrapartum Matron And Bereavement Midwives	11.11.2021
Admission CTG in latent phase of labour not conducted	Guideline to be reviewed	To review and clarify guideline. Escalated to Labour ward co-ordinator and CTG specialist midwife	Maria Swiers Amy Smith	01.05.2021

Findings of review all cases eligible for referral to HSIB.

Reports Received since last report

Recommendations

1. The Trust to ensure that intermittent auscultation is carried out in line with national guidance ensuring early consideration is given for to monitoring a baby's heart rate by CTG when IA is not possible.
2. The Trust to ensure that guidance and training supports staff in recognising the immediate transfer of mothers from the birthing pool in emergency situations.

Both recommendations had been addressed prior to the receipt of the report as these were identified during the initial scoping before presentation to the SI panel.

An email was sent to all midwives from the Director of Midwifery about immediate evacuation from the pool is a shoulder dystocia is identified when the scope identified this as an issue.

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

PROMPT Compliance

MDT Role	Number of staff available to train	Number of staff that have attended	Compliance

		PROMPT	
Consultants & Staff Grades	18	18	**100%**
SPRs + SHOs	21	17	**80.9%**
Midwives	182	151	**82.9%**
Anaesthetists	32	23	**71.8%**
Maternity Theatre ODPs	14	2	
HCAs/MSWs	67	30	**44.7%**
DIVISIONAL	**320**	**239**	**74.6%**

CTG compliance

MDT Role	Number of staff available to train	Number of staff undertaken Intrapartum CTG training	Compliance %
Consultants & Staff Grades	18	15	83.3%
SPRs + SHOs	20	17	85%
Midwives	182	145	79.6%
DIVISIONAL	**220**	**177**	**80.4%**

Service User Voice feedback

The maternity service Facebook page receives lots of positive feedback.

Matrons are actively working with complainants to improve the service for women and their families.

A recent media case has resulted in an increase in question posed on the maternity Facebook pages and this has been proactively managed. Individual reassurance has been provided for women concerned about the safety of maternity service by the Matrons and Deputy HOM

There are discussion with the newly formed MVP's on both sites and there has been feedback and work ongoing on the following:

Doncaster MVP
Chair has stepped down and interim plan in place, no meeting since last report

Bassetlaw MVP
No meeting since last report

HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust None
Coroner Reg 28 made directly to Trust None
Progress in achievement of CNST 10 The service is on target to achieve the 10 safety actions

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2021

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1:26	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
April			
May			
June			

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			April	May	June
Caesarean Section rate	Elective	<10.4 %	10.5%	14.7%	
	Emergency	<15.2 %	25.6%	25.6%	
Preterm birth rate	≤26+6 weeks		0	0	
	≤36+6 weeks		30	16	
Massive Obstetric Haemorrhage	≥1.5l	<3%	5%	2.8%	
Term admissions to NICU			6	7	
3rd & 4th degree tear	SVD (unassist'd)	<2.6%	3 2.2%	0 0%	
	Instrumental (assisted)	<5.6%	0	0	
Right place of birth		All			
Smoking at time of delivery		<11%	13.1%	6.8%	
Percentage of women placed on CoC pathway					
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME				
	Area of deprivation				

Month/Quarter		Red flag alert	Unactioned Datix / Open > 30 days		Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	April	2	0	0	1	0	1	1	0	0	1	0	0	1	0	0
	May	11	4	0	0	0	0	0	0	0	0	0	0	0	0	0
	June															
	Qu1 T															

Maternity Red Flags (NICE 2015)

		A	M	J
1	Delay in commencing/continuing IOL process	2	10	
2	Delay in elective work	0	1	
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2021

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1:26	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
April			
May			
June			

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)	Measurement / Target		Bassetlaw Rate		
			April	May	June
Caesarean Section rate	Elective	<10.4 %	15.7%	12.2%	
	Emergency	<15.2 %	18.5%	21.4%	
Preterm birth rate	≤26+6 weeks	<6%	0	0	
	≤36+6 weeks		8	5	
Massive Obstetric Haemorrhage	≥1.5l	<3%	1.9%	1.5%	
Term admissions to NICU			8	6	
3rd & 4th degree tear	SVD (unassist'd)	<2.6%	1	0	
	Instrumental (assisted)	<5.6%	1	1	
			2	1	
Right place of birth		95%	100%	100%	
Smoking at time of delivery		<11%	14.2%	6.9%	
Percentage of women placed on CoC pathway		35%			
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%			
	Area of deprivation				

Month/Quarter		Red flag alert	Unactioned Datix / Open > 30 days		Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	April	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	May	0	2	0	1	0	1	0	0	0	1	0	0	1	0	0
	June															
	Qu1 T															

Maternity Red Flags (NICE 2015)

		A	M	J
1	Delay in commencing/continuing IOL process	0	0	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

Assessed compliance with10 Steps-to-Safety

		April	may	June
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training	80%	80%	
9	Safety Champions			
10	Early notification scheme (HSIB)			

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance

		A	M	J
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing pre-term birth			

Assessment against Ockenden Immediate and Essential Action (IEA)

	April	May	June
Audit of consultant led labour ward rounds twice daily			
Audit of Named Consultant lead for complex pregnancies			
Audit of risk assessment at each antenatal visit			
Lead CTG Midwife and Obstetrician in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	80% of staff	80% of staff	
Plan in place to meet birth rate plus standard (please include target date for compliance)			
Flowing accurate data to MSDS			
Maternity SIs shared with trust Board			

Please include narrative (brief bullet points) relating to each of the elements:

Maternity unit	April	May	June
Freedom to speak up / Whistle blowing themes	None	None	
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	CDS: • Unexpected weight below the 10th centile • BBA • Shoulder dystocia LW: • Unexpected weight below the 10th centile • 3rd/4th degree tear • COC escalation	CDS: • Unexpected weight below the 10th centile • PPH • Midwives LW • Unexpected weight below the 10th centile • Unexpected admission to the neonatal unit • PPH	
Themes from Maternity Serious Incidents (Sis)	CTG classification	• CTG Classification	
Themes arising from Perinatal Mortality Review Tool	Domestic violence risk assessment	• Partogram for 16-22 week gestation	
Themes / main areas from complaints	Poor communication Attitude of staff	Lack of feeding support Medical staff attitude	
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	Facebook pages Complaints – proactive phone calls for resolution of issues MVP meetings	Facebook pages Complaints – proactive phone calls for resolution of issues MVP meetings	
Evidence of co-production			
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Virtual Safety Champion session as planned Board Level Safety Champion session with Matrons & DHOM	NED Safety Champion Visit at DRI Virtual Safety Champion session as planned Board Level Safety Champion visit to all areas on IDM Board Level Safety Champion session with Consultants	
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT Emails to all staff Change to guidelines New face to face fetal monitoring study day	WHATS HOT Emails to all staff	

KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency	29% EL 13% / EM 17%	<30% <13% / <17%	NA	> 33% > 15% / > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks	<6%	< 6% achieved in 12 months	N/A	> 6 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	NA	>2.9%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU	<6%	<6%	NA	>6%	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	< 3.5%	NA	>5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre	95%	>90%	80% – 90%	<80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery	6%	4% – 6%	6% - 8%	>8%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation	35%	25% - 35%	15%-25%	<15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway** (denominator as above)	% BAME women placed on continuity of carer pathway at 29 weeks gestation	75%	65% - 75%	55% - 65%	<55%	Trust / MSDSv2
	Red Flags						

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	Yes
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	NHS Digital will issue a monthly scorecard to data submitters (Trusts). Was this presented to your Trust Board?	Yes
2	Were your Trust compliant with all 13 criteria in either the December 2020 or the January 2021's submission?	Yes
3	Has the Trust Board confirmed to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT?	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note standard a), b) and c) of safety action 3 have now been removed.		
Standard D) Commissioner returns on request for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		
1	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	Yes
Standard E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.		
2	Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding	Yes
An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.		

3	Do you have evidence of the following An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	• Yes
Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.		
4	Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	Yes
5	Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion ?	Yes
6	Has the progress on Covid-19 related requirements been monitored monthly by the board safety champions from January 2021?	Yes

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note that the standards related to the obstetric workforce have been removed.		
1	**Anaesthetic medical workforce** Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	
2	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	
3	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	Yes
4	If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	
5	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	Yes
6	If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	Yes
2	Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	Yes
3	Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	Yes
4	Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	Yes
5	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **supernumerary labour ward co-ordinator** status in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
6	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the **labour ward coordinator** which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
7	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **1:1 care in labour** in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
8	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with **1:1 care in labour** has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
9	Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	Yes

10	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	Yes

Safety action No. 6
Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by the Clinical Network.	Yes
3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted this?	Yes
ELEMENT 1 - Reducing smoking in pregnancy		
Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
4	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
5	If the process metric scores are less than 95% for Element 1 **standard A**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.		
6	Has **standard b)** been successfully implemented (80% compliance or more)?	Yes
7	If the process metric scores are less than 95% for element 1 **standard b)**, has an action plan for achieving >95% been completed?	N/A
Standard c) Percentage of women where CO measurement at 36 weeks is recorded.		

8	Has **standard c)** been successfully implemented (80% compliance or more)?	Yes
9	If the process metric scores are less than 95% for element 1 **standard c)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		
Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.		
10	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
11	If the process metric scores are less than 95% for element 2 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation:		
12	1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	Yes
13	2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation	Yes
14	3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Yes
15	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	N/A
16	If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
17	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	N/A

18	If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
ELEMENT 3 Raising awareness of reduced fetal movement		
Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.		
19	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
20	If the process metric scores are less than 95% for element 3 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women who attend with RFM who have a computerised CTG		
21	has **standard b)** been successfully implemented (80% compliance or more)?	Yes
22	If the process metric scores are less than 95% for element 3 **standard b)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 4 Effective fetal monitoring during labour		
Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		
23	Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted?	Yes
24	If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shorfall in reaching the 90% and commit to addressing those?	Yes
Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment.		
25	Have training resources been made available to the multi-professional team members?	Yes
26	If the process metric scores are less than 90% for **Element 4 standard b)**, has the trust board identify shorfall in reaching the 90% and commit to addressing those when this is permitted?	Yes

ELEMENT 5 Reducing preterm births		
Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth		
27	Has **standard a)** been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes
28	If the process metric scores are less than 85% for Element 5 **standard a)**, has an action plan for achieving >85% been completed?	N/A
Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
29	Has **standard b)** been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes
30	If the process metric scores are less than 85% for Element 5 **standard b)**, has an action plan for achieving >85% been completed?	N/A
Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
31	Has **standard c)** been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	Yes
32	If the process metric scores are less than 85% for Element 5 **standard c)**, has an action plan for achieving >85% been completed?	
33	Do you have evidence that the Trust Board has specifically confirmed that: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	Yes

Safety action No. 7

Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes
2	Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Yes
3	Do you have evidence of service developments resulting from coproduction with service users?	Yes
4	Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?	No
5	Do you have evidence that the MVP is prioritising the voice of woman from Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?	Yes

Safety action No. 8

Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, including Covid-19 specific training, including maternal critical care training and mental health & safeguarding concerns training In the current year we have removed the threshold of 90% for this year. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.		
Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:		
1	Obstetric consultants	Yes
2	All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	Yes
3	Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes
4	Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Yes
5	Obstetric anaesthetic consultants	Yes
6	All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota	Yes
7	Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Yes
8	Can you evidence that 90% of all staff groups in line 1-7 above have attended the the multi-professional training outlined in the technical guidance?	No
9	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	Yes

NEONATAL RESUSCITATION TRAINING

Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019:

10	Neonatal Consultants or Paediatric consultants covering neonatal units	Yes
11	Neonatal junior doctors (who attend any deliveries)	Yes
12	Neonatal nurses (Band 5 and above)	Yes
13	Advanced Neonatal Nurse Practitioner (ANNP)	Yes
14	Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes
15	Can you evidence that 90% of all staff groups in line 10-14 above have attended the the neonatal resuscitation training as outlined in the technical guidance?	No
16	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	Yes

Safety action No. 9

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	Yes
2	Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	Yes
3	Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	Yes
4	Are Board level safety champions undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback?	Yes
5	Was a monthly feedback sessions for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	Yes
6	Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	Yes
7	Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	Yes
8	Is the progress with actioning named concerns from staff workarounds visible from no later than 31 December 2020?	Yes
9	Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	Yes
10	Has the Board level safety champion reviewed the continuity of carer action plan in the light of Covid-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	Yes

11	Do you have evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan?	No
Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed		
12	I) Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020?	Yes
13	II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	Yes
14	III) The MBRRACE-UK SARS-COVID19 report	Yes
15	IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	Yes
16	Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	Yes
Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas:		
17	• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems	Yes
18	• utilise SCORE safety culture survey results to inform the Trust quality improvement plan	Yes
19	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	Yes

Safety action No. 10

Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	Yes
2	Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	Yes
3	For cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes
4	Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	Yes

NHS Resolution

Section A : Maternity safety actions - Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	No
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	No
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	Yes
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	No
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes

Section B : Action plan details for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name	**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
Trust code	**T581**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	No		-	You have not entered an action plan for this unmet safety action, please check
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	No		-	You have not entered an action plan for this unmet safety action, please check
Q7 Patient feedback	No		-	You have not entered an action plan for this unmet safety action, please check
Q8 In-house training	Yes		-	
Q9 Safety Champions	No		-	You have not entered an action plan for this unmet safety action, please check
Q10 EN scheme	Yes		-	
Total safety actions	**6**	**-**		**You have validations on 4 safety actions. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.**
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature

For and on behalf of the board of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the

Name:
Position:
Date:

Missing Evidence Expected before submission

Safety Action	Evidence waiting for to be compliant
1	None
2	None
3	None
4	Confirmation compliant with ACSA standards Anaesthetic rotas
5	None
6	Excel sheet submission for SBL
7	Letters from the CCG's to confirm remuneration available for the chair and out of pocket expenses MVP action plan sent with this needs recording in minutes for oversight and plan
8	None
9	C of C plan sent this with submission needs recorded in minutes for oversight
10	None

The service will be compliant as soon as all the above is in the evidence files.

Submission date 15th Jul 2021 using the attached excel sheet

Lois Mellor

Director of Midwifery

10th June 2021

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Doncaster & Bassetlaw Teaching Hospitals Foundation Trust

Maternity Voices Partnership Action Plan

	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
1.1	To move from interim MVP chairs to permanent chairs	Current MVP chairs & Pat Drake	December 2021		JD in place and agreed Ongoing recruitment planned
1.2	DBTH Non Exec Director to work with the MVP about improving maternity services and attend meetings as invited		September 2021		Contact made by the NED with the MVP chairs Will attend meetings as required
1.3	Continue to engage women that have recently used the service and encourage them to be part of the MVP's	Matrons and Ward Managers	Ongoing		
1.4	Organise a date for a 15 step challenge review on both sites once face to face meetings are possible	Sarah Ayre & MVP chair	September 2021		

	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
1.5	Ensure engagement with the MVP members and the relevant DBTH staff continues and use any form of feedback to shape services	Sarah Ayre	Ongoing		
1.6	Engage with local mother and toddler groups to support the MVP	MVP chairs & Sarah Ayre	Ongoing		
1.7	Continue to promoting the MVP groups and their work via social media	MVP chairs & Jacqui Yeates	Ongoing		
1.8	Reinvigorate the Teddy bears picnic / Carousel meeting once large groups can meet face to face	MVP chairs	As soon as Covid restrictions allow		

DBTH Draft Plans for achieving 51% Continuity of Carer

Working to achieve 51 % 2022

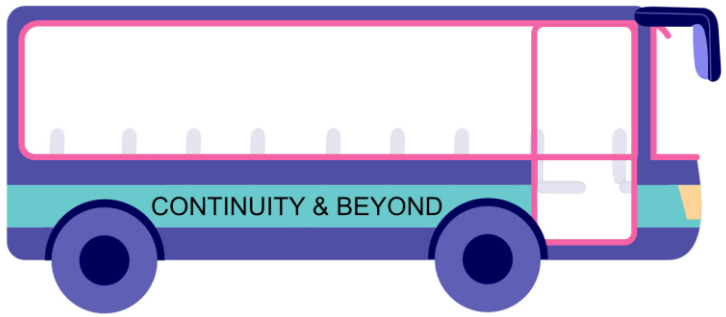
- **May 2021-** 4 Teams Clumber, Rufford, Welbeck and Lotus team. Achieved %

- **June 2021-** 3 Teams (1 team paused due to staffing deficit, 1 Team not providing Intrapartum care due to temporary team vacancy)
- 2 Bassetlaw teams targeted for families from Black and other minority ethnic groups and areas of social deprivation.

- **Jan 2022-** Whole scale Bassetlaw (Back to 3 teams) and lotus team **= 25%**

- **April 2022-** 2 Further teams in Central area- targeted to areas of high levels of social deprivation and families who's ethnicity is black or other minority ethnic groups. Teams geography/patch is in central town centre. **= 38%**

- **July 2022-** 2 Further teams in North area (8 Teams in total) **= 59%**



DRAFT

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 18 May 2021 at 09:30 via Star Leaf Video Conferencing

Present:	Suzy Brain England OBE - Chair of the Board (In the Chair) Mark Bailey – Non-Executive Director Karen Barnard - Director of People and Organisational Development Pat Drake - Non-Executive Director Rebecca Joyce – Chief Operating Officer Sheena McDonnell – Non-Executive Director Dr T J Noble – Executive Medical Director Neil Rhodes – Non-Executive Director and Deputy Chair Richard Parker OBE – Chief Executive David Purdue – Deputy Chief Executive and Chief Nurse Marie Purdue – Director of Strategy and Transformation Jon Sargeant – Director of Finance Kath Smart – Non-Executive Director	
In attendance:	Fiona Dunn – Deputy Director Corporate Governance/Company Secretary Emma Shaheen – Head of Communications and Engagement Katie Shepherd – Corporate Governance Officer (Minutes)	
Public in attendance:	Peter Abell – Public Governor Dennis Atkin – Public Governor Mark Bright – Public Governor (from item P21/05/C2) Jayant Dugar – Guardian for Safe Working (Item P21/04/C3 to P21/05/D3) Gina Holmes – Staff Side Chair Lynne Logan – Public Governor Steve Marsh – Public Governor Bianca Mohammed – NHS Professionals Dave Northwood – Public Governor Anna Pryce – Consultant in Sexual Health (Item P21/05/D3) Pauline Riley – Public Governor (until item P21/04/F1) Lynne Schuller – Public Governor (until item P21/04/E4)	
Apologies:	None	**ACTION**
P21/05/A1	**Welcome, apologies for absence and declaration of interest (Verbal)**	
	The Chair of the Board welcomed all in attendance at the virtual Board of Directors and extended the welcome to the Governors and members of the public in attendance via the audience functionality. There were no apologies for absence. No declarations of interest were declared, pursuant to Section 30 of the Standing Orders.	
P21/05/A2	**Actions from Previous Meetings (Enclosure A3)**	

	Action 1 – Committee Structures – The Medical Director advised that a further meeting would take place to finalise the Clinical Governance meeting structure, and it would be presented visually for an easier display. Action 2 – Service Changes – This was not completed; however, it was proposed that this be delegated to the Finance and Performance Committee for receipt. The Board agreed. The action was closed. Action 4 – Glossary of Acronyms – The Lead Governor advised that there continued to be many acronyms used in Board papers and asked that the first time an acronym was used, that it was written in full first.	
	Action: The Head of Communications and Engagement would provide guidance to team on house style for reports.	**ES**
	The Board: - ***Noted the updates and agreed which actions would be closed.***	
True North SA1 - QUALITY AND EFFECTIVENESS		
P21/05/ C1	**Board Assurance Framework**	
	The Board received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 1 – to provide outstanding care and improve patient experience. There were no further updates, however, it would be updated in readiness for the next meeting.	
P21/05/ C2	**Chief Nurse Update (Enclosure C2)**	
	There was one serious incident in April 2021. This related to a patient undergoing spinal surgery who unexpectedly deteriorated. There were no serious incidents in maternity. There were 113 inpatient falls in April. Of these, two resulted in severe harm (both on the Frailty Assessment Unit, and one resulted in moderate harm. The Falls Policy had been updated in March 2021. The quality improvement projects had commenced within Ward 16 and 17. A falls therapy assessment and treatment intervention would be undertaken for high risk/complex falls patients. Work had commenced on falls prevention and management within the Emergency Department at Doncaster. Mobility Champion Training had commenced on Ward 17 at DRI. Preceptorship, Foundations of Care and Therapy induction training had recommenced. Improvement work was underway to reduce the numbers of hospital acquired pressure ulcers (HAPU) and included a review of the investigation process and a review of the Pressure Ulcer Policy. It was noted that there would be a change to how HAPU was reported from number of patients to number of ulcers. For April 2021, there were 75 category 2 and two category 3 HAPUs reported. The Skin Integrity Team had commenced work to review and confirm category two pressure ulcers. There would be a relaunch of all skin integrity training. There were five cases of Clostridium difficile in April. Four cases were Hospital onset Hospital Acquired (HOHA). One case was Community onset, Hospital Acquired. No lapses in care had been identified as yet, with patients appropriately being prescribed antibiotics.	

	An update was provided on the Digital Transformation Programme deployment to date, and it was advised that the Digital Transformation Team were progressing well with the development of a nurse assessment core risk bundle with a target date of June 2021. Following an incident within the Women and Children's Hospital that led to an electrical fire in the Women and Children's Hospital on 27th April 2021, a formal meeting had taken place with the CQC to review the evacuation of patients undertaken, who were fully assured that no patient had come to any harm and that the areas the patients were relocated to were suitable for their requirements, both in the short and medium term. A survey monkey would be sent to patients involved, to identify how they felt during the evacuation. Feedback would be provided to the Patient Experience Committee. The Perinatal Maternity Dashboard which outlined the findings of the review of all cases eligible for referral to HSIB (Healthcare Safety Investigation Branch), which outlined that the Trust had received one completed HSIB report back with three recommendations identified for the Trust to complete. An action plan would be developed to achieve this. Anaesthetic staff had been rostered on to attend PROMPT training, and it was reported that training compliance had increased in-month. An ongoing escalation policy was in place for non-compliance with CTG (Cardiotocography). The current midwifery workforce position held 18.08WTE vacancy against the current workforce model. Ongoing recruitment continued locally. The service was progressing international recruitment for European midwives within NHS Professionals. The DATIX system had been restructured to ensure that the right person would complete the right task. The timeframe of 90-working days had been reduced to 60-working days and any request for renegotiation was to be taken to the complaints panel for discussion and agreement. There had been a 37% reduction in the number of open complaints. Volunteers had been welcomed back into the organisation. A number of areas had reduced to under 10% with their planned versus actual staffing data. Mitigations were in place to ensure that all departments were safe. Software would be introduced to provide assurance from bedside to Board, to be implemented by the end of Q2 2021/22. Pat Drake noted the improvements in place for falls, and advised that a presentation from the Holistic Care Team had been well received by the Council of Governors. Pat Drake noted that it was good to see the benefits that the use of digitalisation had on patient safety and intervention. Pat Drake advised the Board that the Finance and Performance Committee had received a comprehensive presentation from the Cancer Services Team, where it was highlighted that there had been recruitment challenges for senior posts. The Chief Nurse advised that current senior roles out to advert had received a good level of interest. Pat Drake noted that the vacancies within Maternity Services would need to be closely monitored as it could affect skill mix. The Chief Nurse advised that prior to the introduction of Birthrate plus the Trust had 156WTE in post in Maternity, but with the introduction of specialist roles, the establishment had increased to 189 WTE, so whilst there were 18.08WTR vacancies, the unit was significantly better staffed than previously.	

	The Chief Nurse advised the Board that the first cohort of international nurses from Kerala in India were due to commence in July 2021, however due to the challenges that the country had experienced with COVID-19, the national work was on hold. It would be reviewed at the end of May 2021. In response to a question from Kath Smart regarding previously identified issues with accommodation, it was advised that the Estates and Facilities Team had sourced suitable accommodation local to the area for the international nurses. Kath Smart advised that the Audit and Risk Committee had received and considered the internal audit report undertaken on Complaints, and asked how contact with families was balanced with staffing pressures. The Chief Nurse advised that the lack of visiting during the COVID-19 had been a significant issue, however procedure had been reviewed throughout the pandemic, and compassionate visiting had recommenced during the second wave of COVID-19. The Chief Nurse advised that there had been three complaints, where, upon review, compassionate visiting should have been allowed. The identified learning had been discussed with the ward staff involved. Following a question from Mark Bailey about post implementation reviews of e-Observations, it was advised that a number of reviews had taken place throughout the launch at Bassetlaw Hospital. Reviews would be undertaken for implementation at Doncaster to identify the effectiveness of the roll out and impact it had on patient safety. This would be reported to the Quality and Effectiveness Committee. In response to a question from Mark Bailey regarding the implementation of the Safer Care software, it was advised that the date for implementation was yet to be identified. Sheena McDonnell noted the good progress seen within the report relating to volunteers and complaints. In response to a request from Sheena McDonnell, it was agreed that that Quality and Effectiveness Committee would review the challenges seen with the completion of the Friends and Family Test (FFT). Following a request from Sheena McDonnell on the preparations that were in place prior to the incident within the Women and Children's Hospital on 27th April 2021, it was advised that as fire works had been taking place within the Women and Children's Hospital at the time of the incident, the evacuation routes were well marked. Horizontal evacuation was undertaken first, followed by vertical evacuation and all protocols were followed. Invaluable support have been received from key stakeholders to assist with the evacuation. The Chief Operating Officer advised that business continuity meetings were held monthly where divisional and speciality level plans were considered and approved. Fire and evacuation principles were included as part of induction and there was training available for specific major incidents. Following a further debrief there would be an incident action plan which would capture the learning points. The Chief Executive advised that a review was underway on the processes in place to triangulate lessons learned, how they have been adopted and adapted within the Trust and how they were embedded through an IT solution that would host the four main sources of learning: incidents, claims, concerns and complaints, and national learning. It had been agreed that a briefing would be provided at the Finance and Performance Committee once the root cause analysis had been undertaken. It was noted by Sheena McDonnell that it was good to see the learning had been picked up, however, asked what steps were taken following a 'never event' to relaunch the standard operating procedures. The Chief Nurse advised that staff involved in incidents receive training on human factors to reflect and learn.	

	***Action**: The review undertaken on the implementation of e-Observations would be reported to the Quality and Effectiveness Committee.*	**DP**
	***Action**: It was agreed that that Quality and Effectiveness Committee would review the challenges seen with the completion of the Friends and Family Test (FFT).*	**DP**
	The Board: - ***Noted and took assurance from the Chief Nurse update.***	
P21/05/ C3	**Medical Director Update (Enclosure C3)**	
	The risk stratification of patients on the admitted RTT active waiting list continued. The Trust was awaiting further information on data inclusion of the risk stratification process. It was noted that only 29% of patients had been risk stratified within Cardiology as there were very few patients waiting at any length of time and therefore didn't seem necessary to risk stratify them. As of 4th April 2021, there were 6262 priority 2 patient waiting for surgery. These include those patient who had been re-reviewed and been upgraded from a category 3 or 4 to a category 2. The patient communication plan commenced on 8th March 2021 which saw 6k+ letters sent to patients to acknowledge the delay and provide assurance, and to ask if they wish to remain on the waiting list for treatment. Only small numbers expressed wished to no longer receive care from the Trust. Crude mortality had reduced, and it was anticipated that overall mortality would return to pre-COVID-19 levels by early 2022. Whilst elective deaths appeared high, assurance was provided that all deaths had been analysed. The Medical Advisory Committee continued to meet and had received many presentations of a broader interest. All were well received. A plan was in place to develop a survey to identify further broad topics for discussion. An advert was out for a co-chair who would chair every second meeting and as required when the chair was unavailable. Whilst the annual audit of medical appraisal for 2020/21 was cancelled due to the COVID-19 pandemic, the Trust had undertaken 68% of medical appraisal, ahead of peer benchmarking. Medical appraisal training continued. The Trust reported 99% compliance against standards of business conduct on 31 March 2021. The process would be reviewed to make it as easy as possible. The Medical Director reported that two posts for Medical Directors were out to national advert, open to Consultants and SAS doctors to apply. The General Manager post was to be finalised prior to national advertising. Neil Rhodes noted the high number of priority-two patients waiting which had been discussed at length and the Finance and Performance Committee, however asked that as the Trust moves back to normal levels of service delivery, what assessment had been undertaken on the energy and capacity of key people to undertake the required activity that was high. The Medical Director advised that colleagues were tired from the response to the COVID-19 pandemic, however noted that capacity levels would be balanced with this, and a discussion took place regarding the use of the independent sector. There was a challenge with Theatre staffing. Work was underway within Trauma and Orthopaedics to ensure that patients had been classified correctly in line with other providers. The Chief Executive noted that the impact of staff during	

	the COVID-19 pandemic had been significant and therefore the Trust would work collectively across the ICS to achieve activity targets. The Medical Director would review the National Medical Examiners report, which would include a review of the cases scrutinised by the Medical Examiner, to identify how this could be reported as a key performance indicator in future reports. Following a question from Sheena McDonnell regarding the way in which completions of appraisals was reported, it was advised by the Medical Director that they were reported as percentages as opposed to by numbers to complete, because medical appraisals were undertaken during the year specific to the medic. Following a question from Sheena McDonnell regarding the quality of medical appraisals, it was advised that a system was in place by which the lead appraiser quality assesses a proportion of the completed appraisal form. All appraisers were expected to attend training. Sheena McDonnell noted the progress made with the Medical Advisory Committee, and requested an update on engagement within the medical workforce. The Medical Director advised that the Medical Advisory Committee had improved engagement with the medical workforce, and a good presentation had been received from different departments including the Leadership team, Procurement team and pay services. Following a request from the Chair, it was agreed that future Medical Director reports to Board would include an update on culture and communication with the medical workforce. Pat Drake noted that whilst there was a staffing challenge, due to the COVID-19 pandemic, there would be patients with a higher dependency. Pat Drake noted the good work with the patient letters sent to those on the waiting list for treatment and care, however asked if the implementation of a patient communication strategy would be beneficial, to provide a more modern way of communicating. The Medical Director advised that the system DrDr was used to communicate with patients that have a mobile phone. The DrDr platform would be expanded, but it isn't at maturity stage yet.	
	Action: The Medical Director would review the National Medical Examiners report, which would include a review of the cases scrutinised by the Medical Examiner, to identify how this could be reported as a key performance indicator in future reports.	**TN**
	Action: It was agreed that future Medical Director reports to Board would include an update on culture and communication with the medical workforce.	**TN**
	The Board: - ***Noted and took assurance from the Medical Director Update.***	
P21/05/ C4	**Ockenden Report (Enclosure C4)**	
	This was discussed as part of item P21/05/C2.	
	The Board: - ***Noted and took assurance from Ockenden Report Action Plan.***	
True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT		

P21/05/ D1	**Board Assurance Framework**	
	The Board received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 2 – everybody knows their role in achieving the vision and strategic aim 3 - feedback from staff and learning in top 10% in UK. The measures had been updated to reflect the updated breakthrough objectives for 2021/22. The ongoing impact of the restoration of services post-COVID-19 was highlighted as a risk to the achievement of the measures.	
P21/05/ D2	**Our People Update (Enclosure C2)**	
	There continued to be regular updates to the People Committee on the Emergency Department Organisational Development programme. The programme was underpinned by six pillars developed through engagement with colleagues to form 30, 60- and 90-day action plans. Weekly team huddles continued to engage with colleagues that were not directly involved in the development of the six pillars. The reciprocal mentoring programme had commenced with pairs identified following the first workshop which was held. The next workshop would take place in June 2021. The mentoring relationship would last one-year, and a steering group would be commenced to monitor progress. Regular updates would be provided to the People Committee. The Equality, Diversity and Inclusion Forum terms of reference had been updated to reflect the adoption of the RACE Equality Code. An update would be provided at the People Committee. The Trust had established networks in relation to BAME and LGBTQ+ colleagues and a new network with focus on dyslexia and long-term conditions was to commence at the end of May with good interest coming forward. Future networks planned were Women's and Men's Wellbeing. The Trust had agreed to host an Associate Non-Executive Director through Gatenby Sanderson's Insight programme for two six-month periods, commencing in June 2021. The Trust continued to explore a programme run by NHSE/I which was being considering with the ICS. The new Leadership Prospectus had been launched with a continued focus on the Develop Belong Thrive Here model, with an addition of 'Everyone Counts'. Colleagues continued to undertake twice-weekly lateral flow testing, with 0.31% returning a positive test. The report included the number of positive COVID-19 tests by staff group, demonstrating that the Nursing and Midwifery workforce saw the highest positive tests results. The COVID-19 vaccination programme had concluded, however colleagues that had not yet had the vaccine could do so through the mass vaccination programme and their GPs. The Chair noted that there were regular updates regarding the Emergency Department Organisational Development programme in BUZZ, on the Trust's website and staff Facebook page, however asked for assurance that all colleagues within the Emergency Department were aware of the programme, the work being undertaken, and how they could contribute. The Director of People and Organisational Development advised that there were various other routes that colleagues could get involved which included a specific Emergency Department Facebook page and website page. The six pillars had been launched within the Emergency	

	Department and a further survey would be circulated to receive further detail from colleagues. Sheena McDonnell advised that she and Kath Smart had met with the Emergency Department General Manager to receive additional assurance. In response to a question from Pat Drake regarding whether objectives regarding leadership behaviours could be incorporated into the appraisal process, it was advised that the True North and Breakthrough Objectives form part of the appraisal process and objectives were set based on these for achievement that year. The Chief Executive advised that the True North and Breakthrough objectives were underpinned by the values of the organisation, which were the expected behaviours of all colleagues. Following a request from Pat Drake regarding the expected numbers of COVID-19 absence that would lead to long-term absence, it was agreed that a report would be provided to the People Committee of the number of colleagues on long-term sickness absence specifically related to COVID-19 related absence. Following a request from Kath Smart, it was agreed that assurance was to be provided on the tangible differences and benefits which have been created throughout the Emergency Department Organisational Development Programme. In response to a question by Kath Smart regarding the uptake of the COVID-19 vaccination by colleagues and the risk for the organisation and how the Trust benchmarked, it was advised that as there were many ways that colleagues could now receive the vaccination, it was difficult to report a final figure, due to the different recording systems in place. It had been estimated based on the data the Trust had and what colleagues had advised the Trust of, that 90% of colleagues had received the vaccination. The Trust benchmarked well in relation to other providers in the ICS. The Chair advised that the Board was supportive of members receiving the COVID-19 vaccination if able to do so. Assurance to be provided to the People Committee that colleagues who were unable to access the COVID-19 vaccination as part of the Trust's vaccination programme were aware of how to access the COVID-19 vaccination should they wish to have it. The Director of People and Organisational Development advised that a thank you had been posted in the Buzz magazine to all colleagues involved in the vaccination programme and to those that had received their vaccination.	
	Action: The number of colleagues on long-term sickness absence would be reviewed at the People Committee with a consideration of those with COVID-19 related absence.	**KB**
	Action: Assurance was to be provided to the People Committee on the tangible differences and benefits which have been created throughout the Emergency Department Organisational Development Programme.	**KB**
	Action: Assurance to be provided to the People Committee that colleagues who were unable to access the COVID-19 vaccination as part of the Trust's vaccination programme were aware of how to access the COVID-19 vaccination should they wish to have it.	**KB**
	The Board: - ***Noted and took assurance from the 'our people' update.***	
P21/05/ D3	**Annual Report from the Guardian for Safe Working (Enclosure C3)**	

	The Board welcomed Mr Dugar, the current Guardian for Safe Working and Anna Pryce, who would take over Mr Dugar in the role as Guardian for Safe Working within the next month. The Board wished to thank Mr Dugar for his years of service in the role. Mr Dugar thanked the Board and the Junior Doctors who had put in their service to the Trust during the previous year. Mr Dugar also thanked the Director of People and Organisational Development for her support. The total numbers of exception reports were lower than the previous year due to the change in work schedule this year, due to the COVID-19 pandemic. It was reported that the number of exception reports in the Medicine Division were higher than other areas, however, the Medicine Division was significantly affected during the COVID-19 pandemic and therefore this was expected. There had been strong interaction with junior doctors, with over two-hundred junior doctor forums took place between December and April with successful attendance. At a recent Junior Doctor Forum it was brought to notice that doctors were being asked not to exception report in the Emergency Department, however, this leads to under reporting of shift overruns, therefore a suggestion of logging the overrun with an exception report and claiming hours on existing basis had been put forward at JDF. There had been some concern raised by junior doctors regarding rest/working space which was shared by a large number of colleagues. This had been deemed an urgent problem. There would be some further improvement with the new doctor's mess room. There had also been concern regarding the poor quality of on call rooms, however money had been allocated to rectify the issues. The works to renovate the Silks restaurant into a junior doctor's mess was complete. The importance there being a rest facility for junior doctors in the main tower block at DRI was noted. The Director of People and Organisational Developed advised that open sessions were held so that trainees could influence what would be included in the new junior doctor's mess room. £290k had been utilised to make improvements to accommodation the previous year, with a further £125k identified for further improvements to be made this year. The Director of Estates and Facilities would provide an update at the People Committee in July 2021. In response to a request for assurance from Sheena McDonnell on the concerns raised in the report, it was advised that this would be included in the report to the People Committee in July 2021. The Medical Director wished to thank Mr Dugar for his contributions whilst in the role of the Guardian for Safe Working and welcomed Anna Pryce into the role.	
	The Board: - ***Noted and took assurance from the Annual Report from the Guardian for Safe Working.***	
True North SA4 - FINANCE AND PERFORMANCE		
P21/05/ E1	**Board Assurance Framework**	
	The Board received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 4 – in recurrent surplus to invest in improving patient care. Two new risks had been added:	

	- Significant theatre staffing issues were not foreseen by the Division within the workforce plan, leading to expensive agency spend and presents a risk to the delivery of activity plans. - Impact of major incident at Women and Children's Hospital on delivery of 21/22 capital and revenue plan. Agency staff would be contracted for a period of 6-months to ensure that the Trust could maintain its services. The major incident in the Women and Children's Hospital would have a significant financial impact, and work was underway to identify what repair work would be required. A modular building would be used as an interim solution.	
P21/05/ E2	**<u>Covid19 Update / Recovery of Elective Work – Looking Forward (Presentation)</u>**	
	The vaccination programme had progressed well in Doncaster and Bassetlaw. The link between the number of community cases and hospital admissions had further distanced. The total COVID-19 occupancy was reported as 0.9%, and the active case occupancy was 0.3% demonstrating a significant reduction. There were no COVID-19 patients within the intensive care unit. There was national modelling work underway in line with the Delta variant of COVID-19 which was a significant area of concern. There was continued high attendance at the Emergency Departments, mostly minor demand and paediatrics. There were ongoing discussions with the primary care networks and CCGs regarding this high attendance following feedback from patients regarding accessibility to GPs. The Theatre step up planned had commenced, with 68% of pre COVID sessions stepped up by 19th April 2021 and 100% on 1st May 2021 at Doncaster and Bassetlaw. It was expected that theatre activity would reach 100% at Montagu by 1st June 2021. The independent sector continued to provide support and would undertake 30 cases per-month (at Parkhill) from 1st May 2021 for six-months. The Trust was reported as best in the region in terms of elective restoration for day case procedures, and average for outpatient's activity. The 52-week position had continued to improve over an 8-week period, however, modelling for this was yet to be finalised and the trajectories for the year were unclear. The PTL (patient tracking list) continued to grow with over 35k patients waiting. The Trust had seen an improved position on priority 2 patients dated within 28-days, however further work was required. The key risks were outlined and included theatre staffing challenges which were a risk to both activity and finance. An options paper was in development to review the bed plan. There was a risk to patients due to the backlog and unknown clinical risk. Efforts would continue to ensure that oversight and governance arrangements were robust. Next steps included further work to increase throughput within outpatients. Further escalation meetings would take place to resolve the theatre staffing pressures. The 52-week trajectories were to be finalised and 'confirm and challenge' meetings with Divisions on the annual plan would commence at the end of May 2021. An update was provided on the water leak incident that took place within the Women and Children's Hospital at DRI on 27th April 2021. There had been a need to stand down routine elective operating which saw a loss of seven half-day lists within the April position. There had been a loss of routine outpatients in gynaecology for six days, however this had recommenced on 6th May 2021. In addition to this there had been a loss of some paediatric emergency work and routine paediatric surgery. A divert was in place for maternity from 28th April to 31st April	

	2021. Obstetric emergencies had moved to the main theatres at DRI, however had since returned to the restored Women's Theatre since 1st May 2021. Additional workforce plans were in place to support the changes. The incident had affected capacity and the neonatal unit were down to 11 cots from 18. The temporary paediatric ward had 13 beds and there were some issues with the environment, a reduction from 18 pre-incident, and 30 pre-fire works. There were no capacity changes within maternity. A number of children had been transferred to partners and a standard operating procedure was in place for transfer and divert. Further capacity was required and the interim bed plan for H1 was under discussion. There was a concern regarding the anticipated level of paediatric respiratory admissions looking forward to autumn and winter. A hot debrief had taken place, with an in depth debrief would take place and include the refinement of emergency planning. The Chair noted the comprehensive presentation. Neil Rhodes noted the comprehensive planning that had been undertaken under challenging circumstances. Pat Drake echoed the comments and asked for clarification on the confidence that the diagnostic service would be able to deliver and support the outlined trajectories. The Chief Operating Officer advised that there were some challenges in some modalities, however this had been a key area of focus and a plan would be created on how diagnostics would support the plan. Following a question from Pat Drake regarding the bed plan, it was agreed that this would be reported to the Finance and Performance Committee. Kath Smart informed the Board that the KPMG had undertaken an audit on capacity and demand, the report had been concluded. There were some helpful recommendations in the report relating to the standardisation of the annual cycle of capacity modelling and being consistent in the training of staff. The report would be received at the Audit and Risk Committee in due course. In response to a question from Mark Bailey regarding pathway management to use collective capacity better, it was advised by the Chief Executive that historically, if patients declined two reasonable offers of care, they would be moved to the bottom of the waiting list for treatment, however this process would need to managed effectively to ensure that patients understand the reasons why they would receive their care and treatment from another provider. Neil Rhodes advised that the Finance and Performance Committee received a comprehensive presentation from the Cancer Services Team, who raised concerns regarding late presentation of patients with cancer due to the COVID-19 pandemic. Assurance was provided on the plans in place to action this, however asked for assurance from the Chief Operating Officer on the Trust's ability to deliver. The Chief Operating Officer advised that the Cancer Services Team had a good grip on their plans, and whilst this was a challenging position, the trajectories had been thoroughly thought out for the different tumour groups.	
	<u>Action</u>: The bed plan would be presented at the Finance and Performance Committee.	**RJ**
	The Board: - ***Noted and took assurance from the information provided in the Covid19 Update/ Recovery of Elective Work – Looking Forward presentation***	

P21/05/ E3	**<u>Performance Update (Verbal)</u>**	
	The April Integrated Performance Report was not ready in time for the meeting due to the early Boad meeting date; therefore, the Chief Operating Officer provided a verbal update on performance for March 2021. There were 1,864 patients waiting over 52-weeks, which was a reduction on the previous month. Further focused work was required within diagnostics as the Trust was not performing well against peer benchmarking.	
	The Board: - ***Noted and took assurance from the performance report for February 2021.***	
P21/05/ E4	**<u>Finance Update (Enclosure E4)</u>**	
	The Trust's surplus for month 1 (April 2021) was £366k, which was c. £116k favourable to budget. Capital expenditure in month 1 was £0.8m, which was in line with the plan. There were no significant variances to report. However, it should be noted that the incident at the Women's and Children's block that occurred on the 27th April was a risk to the delivery of the capital plan (and revenue) if additional funding and capital allocation was not provided. The cash balance at the end of April was £44m (March 2021: £51.7m). Cash had reduced by c. £7.7m as a result of the Trust paying capital invoices totalling £8m in month. These were within capital creditors at year-end. There remained no guidance for the second half of the year with regards to financial arrangements. Thereby there remains the significant risk that the potential that system top up funding received under current arrangements was removed causing a potential significant deficit in the second half of the year. The annual accounts for 20/21 were due within the next month for signing, post review by external audit. Therefore, it was requested in line with previous years that the Board approves delegated authority for the Audit and Risk Committee to sign off the accounts, the annual governance statement and the annual report for 20/21. The Director of Finance wished to thank the Finance Team for the production of the final accounts aligned to pre-COVID-10 timetables, whilst producing the month-1 accounts and the budget planning. The clinical income position reported at month-1 was aligned to the national block arrangements for H1 (month-1-6). In month the Trust had a favourable income variance of £86k relating to specialist excluded drugs which were not part of block arrangements. The clinical income position included income related to the Elective Recovery Fund (ERF). In month 1 the estimated ERF position was £985k, which was £360k favourable to plan. Neil Rhodes noted the report and endorsed the comments discussed at the Finance and Performance Committee regarding the work that the Finance Team had undertaken to meet deadlines. In response to a question from Kath Smart regarding the Committee at which the Quality Accounts would be sighted on, it was confirmed that the Quality and Effectiveness Committee would receive them.	
	<u>Action</u>: The Quality and Effectiveness Committee would receive the Quality Accounts.	**FD**
	The Board:	

	- ***Noted and took assurance from the finance report*** - ***Approved the delegated authority request for the Audit and Risk Committee to sign off the accounts, the annual governance statement and the annual report for 2020/21.***	
P21/05/ F1	**<u>Strategy and Improvement Update (Enclosure F1)</u>**	
	The Director of Strategy and Improvement provided an update on the work undertake to develop the new Trust Strategy, national changes that had impacted the strategic direction and the quality improvement work undertaken to refocus on the restoration of services. The Service Line Review process had progressed according to the planned timeline, however there was a risk that this would slip later in the year due to expected changes to the team structure over the forthcoming months. A concurrent listening exercise was underway to inform the development of the Trust's new strategy. A series of engagement events had taken place with stakeholders and public and staff surveys were due to go live in June 2021. Work on the strategy ran concurrently with strategic developments underway in the SYB ICS and at Doncaster and Bassetlaw place level. Work was underway at Place level to understand the implications of the Health and Social Care Bill 2022. The Quality Improvement Team had been impacted by the COVID-19 pandemic as were required to undertake the vaccination programme and lateral flow testing roll out, however, all staff had been returned to their normal roles and were able to plan for the year ahead. The Chair advised that the Board would attend a workshop the following week on the development of the clinical strategy.	
	The Board: - ***Noted and took assurance from the Strategy and Improvement Update.***	
P21/05/ G1	**<u>Corporate Risk Register (Enclosure G1)</u>**	
	There were no new corporate risks added or escalated from the Trust Executive Group (previously called Management Board). There were 122 risks logged rated 15+ within the Trust, fourteen of which were monitored via the Corporate Risk Register. KPMG had undertaken an internal audit on two areas of the risk management system and the final report would be received in due course.	
	The Board: - ***Considered and noted the information in the Corporate Risk Register.***	
P21/05/ G2	**<u>Quality and Effectiveness Committee Annual Report (Enclosure G2)</u>**	
	The Board: - ***Noted and took assurance from the Quality and Effectiveness Committee Annual Report.***	
P21/05/ G3	**<u>NHS Providers License Self-Assessment/Certification (Enclosure G3)</u>**	

	The Board received and agreed with the submitted NHS Providers License Self-Assessment/Certification.	
	The Board: - ***Noted the NHS Providers License Self-Assessment/Certification***	
P21/05/ G4	**Board of Directors Meeting Dates (Enclosure G4)**	
	The Chief Executive advised the Board that in line with partner organisations in SYB ICS, the frequency of the Board of Directors meeting would change bi-monthly, with a shorter meeting to take place each month in-between to receive items that were required at Board monthly such as the Ockenden Report action plan and the Perinatal Mortality Dashboard. This would allow the Board the time and opportunity to undertake strategic planning and other significant discussions. It was proposed that the June 2021 meeting be the shorter meeting, followed by a full meeting in July 2021. The Board agreed the change to the meeting pattern.	
	The Board: - ***Approved the change to Board of Director meeting dates for the remainder of 2021.***	
P21/05/ H1-H8	**Information Items (Enclosures H1 – H8)**	
	The Board noted: - ***H1 Chair and NEDs Report*** - ***H2 Chief Executives Report*** - ***H3 ICS Update*** - ***H4 Minutes of Finance and Performance Committee – 22 March 2021*** - ***H5 Minutes of the Management Board Meeting – 12 April 2021*** - ***H6 Minutes of the People Committee – 02 March 2021*** - ***H7 – Minutes of the Council of Governors – 28 January 2021*** - ***H8 – Doncaster and Bassetlaw Healthcare Services Annual Performance***	
P21/05/ I1	**Minutes of the Meeting held on 20 April 2021 (Enclosure I1)**	
	The Board: - ***Received and Approved the Minutes of the Public Meeting held on 20 April 2021.***	
P21/05/ I2	**Any Other Business (Verbal)**	
	Major Incident in the Women and Children's Hospital The Director of Finance advised the Board that work was underway to identify how the issue could be rectified as soon as possible. The Director of Estates and Facilities was in liaison with a company that provide modular ward and theatre buildings as part of an interim plan. The total costs of the repair work was unknown. This would have a significant impact on the capital plan and therefore discussions had taken place with NHSEI and the ICS regarding this. The Director of Finance advised that he required approval from the Finance and Performance	

	Committee on 17 May 2021 to proceed with the ground works and enabling works for the modular buildings, and to confirm a slot in the factory to build the modular buildings. The Committee had agreed for the Director of Finance to proceed with the modular buildings. It was noted that the urgency for approval was due to a 5-6 month wait until the modular buildings would be received. Funding discussions had taken place with NHSEI and the SYB ICS, however nothing had yet been confirmed. It was noted that the Trust had an unsuccessful bid to undertake estate work within the Women and Children's Hospital in 2018. The Trust had standard NHS insurance which would not cover the costs of the repair work. The Chief Executive advised that the loss of capacity in the Women and Children's Hospital due to the major incident, would impact the winter plan, and noted that the Trust provided resilience in winter to other Trust's in South Yorkshire and North Lincolnshire. This would be a risk to the ICS and provide uncertainty relating to the financial implications. Neil Rhodes noted that the Finance and Performance Committee had received a comprehensive update on the matter.	
P21/05/I3	**<u>Governor Questions Regarding the Business of the Meeting (Verbal)</u>**	
P21/05/I3 (i)	The Lead Governor asked questions on the behalf the Council of Governors: <u>In reference to the Chief Nurse Report and digital transformation, the Council of Governors received a briefing on the roll out of e-observations in January 2021, therefore a further update would be welcomed early 2022. How does e-observations and Nerve Centre work together and how does it flag up if any e-observations have not been completed?</u> The Chief Nurse advised that the system, Nerve Centre was the system that e-observations were conducted on, and this flags up if there were any e-observations that have not been completed in time. There were key performance indicators in place to manage this, and each Ward had an 'at a glance' board which the use of Nerve Centre feeds into. The Chair noted that public Governor, Peter Abell had advised the NHS Providers Governor Advisory Committee of the Trust's successful use of the Nerve Centre system. It was suggested and agreed that the digital transformation team would be invited to showcase the implementation and use of Nerve Centre at a national committee such as the Governor Advisory Committee. <u>Could you advise further on vacancies as it was referred to a lot in the reports?</u> The Chair advised that through the COVID-19 pandemic, the NHS had proved to be a stable working environment and noted that the Trust had jobs to offer. The Trust worked hard at school level to encourage young people into careers in the NHS and international recruitment programmes continued. The Chief Executive advised that the overall vacancy rate wasn't higher that it had been in previous years, however noted the different circumstances including an increased sickness absence rate and that the demand on staff was different due to the increased number of patient pathways and the visiting restrictions that had been in place. It was noted that the wellbeing of the workforce was a focus. The Chief Nurse provided assurance that the Trust had a comprehensive workforce plan for the nursing, midwifery and allied health professional's workforce. New registrants would commence in September 2021, overseas recruitment would continue and a consideration of how the local population can gain access to training were included as part of the workforce	

	plan. The Director of People and Organisational Development advised that this would be discussed in detail at the People Committee in July 2021.	
	<u>Action</u>: The digital transformation team would be invited to showcase the implementation and use of Nerve Centre at a national committee such as the Governor Advisory Committee.	**FD**
	The Board: - ***Noted the comments raised, and information provided in response.***	
P21/04/I4	**<u>Date and Time of Next meeting (Verbal)</u>** **Date:** Tuesday 15th June 2021 **Time:** 09:30am **Venue:** Star Leaf Videoconferencing	
	The Board: - ***Noted the date of the next meeting.***	
P21/04/I5	**<u>Withdrawal of Press and Public (Verbal)</u>**	
	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.***	
P21/04/J	**<u>Close of meeting (Verbal)</u>**	
	The meeting closed at 13.00.	