Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 19 October 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*		5
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	
B	**True North SA1 - QUALITY AND EFFECTIVENESS**		**09:35**
B1	Maternity Update - Ockenden Report - Perinatal Mortality Dashboard *David Purdue, Chief Nurse*	*Assurance*	10
C	**GOVERNANCE AND ASSURANCE**		**09:45**
C1	Annual Emergency Preparedness, Resilience and Response Core Standards Compliance *Rebecca Joyce, Chief Operating Officer*	*Approval*	5
D	**INFORMATION ITEMS (to be taken as read)**		**09:50**
D1	Progression of Governance Arrangements for the Integrated Care System *Richard Parker OBE, Chief Executive*	*Information*	
E	**OTHER ITEMS**		09:50
E1	Minutes of the meeting held on 21 September 2021 *Suzy Brain England OBE, Chair*	*Approval*	5
E2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	
E3	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10

E4 **Date and time of next meeting:**

Date: Tuesday 16 November 2021

Time: 09:30 *Information*

Venue: StarLeaf Videoconferencing

F	MEETING CLOSE	10:05

*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: Angela O'Mara
Updated: 21 September 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	21 September 2021

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**AR21/05/E 2i**	**Escalation to Board – Job Planning Internal Audit Report** The internal audit report on Job Planning would be escalated to the Board for review.	**TN**	**September 2021**	**Update 21.9.2021** – development of policy and procedures was ongoing. Action plan in place. Update to be provided to Audit & Risk Committee on 12.10.2021
2.	**QEC21/06/ D2ii**	**Inpatient Survey Action Plan** An update to be included as part of the Chief Nurse Report to Board.	**DP**	**September 2021**	**Update 21.9.2021** - received and **action to be closed**
3.	**P21/07/D2i**	**Diagnostic Framework Self-Assessment – Board Leadership** Action would be taken to determine the information provided to arrive at the outcome of the Diagnostic Framework Self-Assessment for Board Leadership and what steps would be required to make improvements.	**KB**	~~**September 2021**~~ **January 2022**	In order to move this assessment to overall green there will be explicit inclusion of the importance and specific priority areas for health and wellbeing within the refreshed People Strategy together with an explicit funding stream. **Update 21.9.2021** – refreshed People Strategy due by 31.12.2021 - action to be carried forward to **January 2022**

Action notes prepared by: Angela O'Mara
Updated: 21 September 2021

No.	Minute No.	Action	Lead	Target Date	Update
4.	**P21/07/D2i**	**COVID-19 Positive Colleagues** The Director of People and Organisational Development would identify of the number of staff that had tested positive for COVID-19, how many received the COVID-19 vaccination.	**KB**	**September 2021**	Included in Our People Update – the data indicates that the majority of staff testing positive for Covid have been double vaccinated **Update 21.9.2021** – action to be closed
5.	**QEC21/08/ B1**	**Mental Health Support** The Chief Nurse would include an update at the next Board meeting on the challenges surrounding increased mental health needs, recruitment to RDaSH posts and the number of mental health beds.	**DP**	**September 2021**	**Update – 21.9.2021** - included within the Chief Nurse's Update paper. Action closed
6.	**QEC21/08/ D3i**	**NHS Food Strategy Update** This would be included in the Chief Nurse Report to Board in September 2021.	**DP**	**September 2021**	**Update – 21.9.2021** - included within the Chief Nurse's Update paper. **Action closed**.
7.	**QEC21/08/ C4i**	**Safeguarding Information to Board** Following a discussion regarding the lack of safeguarding information received at Board, a decision would be made on whether a presentation update be provided to Board, or if regular information would be provided as part of the Chief Nurse report.	**DP**	**November 2021**	Not yet due
8.	**P21/09/C2**	**Civility Training** September's Chief Nurse report highlighted that 50% of complaints in respect of staff values and behaviours related to medical staff. An update to be incorporated in the next Board report with regards to the provision of civility training.	**DP**	**November 2021**	Not yet due
9.	**P21/09/C2**	**Nursing Budgets and Establishments** To incorporate an update on nursing budgets and establishments in November's Chief Nurse paper.	**DP**	**November 2021**	Not yet due

Action notes prepared by: Angela O'Mara
Updated: 21 September 2021

No.	Minute No.	Action	Lead	Target Date	Update
10.	**P21/09/G1**	To establish a task and finish group in respect of risks rated 15+ on Corporate Risk Register.	**FD**	**October 2021**	Discussed at Trust Executive Group on 11/10/2021 and presentation to Audit & Risk Committee on 12/10/2021 - way forward agreed. **BoD action to be closed** and progress to be monitored via Trust Executive Group.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	*Board of Directors*				
Meeting Date:	*19th October 2021*	**Agenda Reference:**	B1		
Report Title:	**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 key metrics to provide safe maternity care* *To provide assurance against the outcome measures for Maternity Services* *To provide assurance against safe staffing numbers for midwifery with mitigation taken to address shortfalls*				
Summary of key issues/positive highlights:	• Good progress is being made in relation to objectives. • Current performance against Maternity Dashboard • Learning areas from reports and incidents				
Recommendation:	To note and take assurance				
Action Require:	~~Approve~~	Information	~~Discussion~~	Assurance	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	***Everybody knows their role in achieving the vision***	*Feedback from staff and learners is in the top 10% in the UK*	*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, Quality and Effectiveness Committee*				
Date:	October 2021	**Decision:**	*Regular updates required to QEC*		
Next Steps:	*Update progress to QEC*				
Previously circulated reports to supplement this paper:	None				

Monthly Board Report

Aug 2021

Please read this report in conjunction with the Board Surveillance Powerpoint Presentation

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

Quarter 1 – 1st Apr to 30th June 2021

Gestation	Antenatal /Intrapartum	Perinatal Mortality Review Tool (PMRT) and investigation /review outcome
23+6	AN	Grading of care A,A however still awaiting response from Yorkshire Ambulance Service.
36+3	AN	Grading of care to be discussed at next PMRT
34+1	AN	To be discussed and investigation completed

Action Plan for Quarter 4

Issue	Action	Implementation Plan
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

2. Findings of review all cases eligible for referral to HSIB.

Cases to date	
Total referrals	17
referrals / cases rejected	4
Total investigations to date	13
Total investigations completed	10
Current active cases	2
Exception reporting	0

2.1 Reports Received since last report

None

2.2 Current investigations

HSIB **Update** • Comments from Trust have been reviewed and amendments made to the draft report • Draft report shared with the family on 1/9/2021
Update • Draft report shared with the Trust on 31 August 2021 • Feedback due 14 September 2021

REJECTED case

Recommendations

1. The Trust to ensure that the staffing model enables the labour ward coordinator to remain supernumery at all times
2. The Trust to ensure that junior staff and newly qualified clinicians have a personalised support plan in place to consolidate their sills and confidence
3. The Trust to ensure that there is escalation to the obstetric team when there are concerns regarding a CTG. An obstetric review with a clear management plan, agreed with the mother should be documented, ensuring that there is oversight of the full clinical picture
4. The Trust to ensure that the staff are supported to categorise CTG, real time and in line with current guidance. The local policy and training programmes should reflect these changes
5. The Trust to ensure that staff are supported to make clinical assessments in real time, and that these assessments are documented contemporaneously
6. The Trust to ensure essential equipment that may be required during birth is immediately available in the labour rooms
7. The trust to ensure a; members of the clinical working team in maternity understand the risks of expectation bias and the key principles of maintain situation awareness to ensure safe management of complex clinical situations.

This action plan is being developed currently

2.4 Identified Key Learning Themes

Senior review / oversight of care
Helicopter view of complex situations
Confirmation bias in decision making
CTG interpretation / escalation

Plans are in place to address these areas:

- Training on PROMPT
- External training being sourced

3. 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	17	17	**100%**
SPRs + SHOs	22	19	**86.3% ↓**
Midwives	175	152	**86.8% ↑**
Anaesthetists	32	24	**75% ↑**
Maternity Theatre ODPs	58	10	
HCAs/MSWs	65	32	**49.2% ↑**
DIVISIONAL	**311**	**244**	**78.4% ↑**

CTG Compliance

MDT Role	Number of staff available to train	Number of staff undertaken Intrapartum CTG training	Compliance %
Consultants & Staff Grades	17	13	**76.4% ↑**
SPRs + SHOs	20	14	**70% ↔**
Midwives	175	135	**77.1% ↑**
DIVISIONAL	**212**	**158**	**74.5% ↑**

Concerns & Actions:

CNST

- Revised standards released in March – 90% threshold has now been removed. MIS contacted to clarify if new minimum threshold in place. No minimum but we need to provide a statement in regards to any shortfall of 90%.

PROMPT

- **Consultant attendance 100% - thank you to all for their ongoing commitment**
- Anaesthetic staff now being rostered on to attend. Compliance increasing.
- All PROMPT training will be delivered via MS Teams until further notice. This gives us scope to have up to 40 attendees per session.
- MSW numbers very low – all managers given dates and asked to allocate staff to attend.
- New PROMPT material coming July 2021

CTG

- Escalation of non-compliance currently being discussed with SLT

SET

- Until further risk assessment has been completed SET numbers in classroom are to remain reduced

4. Service User Voice feedback

No further meetings since last report

5. HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust

None

6. Coroner Reg 28 made directly to Trust

Letter awaited from case concluded on 8th Sept 2020
PFDR re: staff awareness about conformation bias
Training already in place on a rolling programme on PROMPT study day (annual for all staff)
Information about confirmation bias shared on June 2021 Newsletter which is emailed to all maternity staff

Further information to assist sought from:

- HSIB (where the recommendation came from)
- Tracey Cooper regional chief midwife who is escalating to national team
- RCM
- LMNS

7. Progress in achievement of CNST 10

Submission was completed on 20th July 2021 declaring full compliance

Year 4 Incentive Scheme standards were released on Monday 8th August for submission on 22nd June 2022

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: August 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 (%)
July	1:26.8	16%	89%
Aug	1:26.8	16%	89%
Sept			

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate July	Doncaster Rate August	Doncaster Rate Sept
Caesarean Section rate	Elective	<10.4 %	12.8%	15.1%	
	Emergency	<15.2 %	25.6%	25.6%	
Preterm birth rate	≤26+6 weeks	0	2	1	
	≤36+6 weeks	<6%	27	30	
Massive Obstetric Haemorrhage	≥1.5l	<3.5%	1.46%	3.17%	
Term admissions to NICU			4.48%	4.2%	
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	3.7%	2.4%	
	Instrumental (assisted)	<6.05 %	20.8%	0%	
Right place of birth		95%	94%	98%	
Smoking at time of delivery		<11%	13.1%	6.8%	
Percentage of women placed on CoC pathway			2.74%	2.75	
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME		0%	0%	
	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)	
2021/2022	July	2	0	0		0	1	1	0	0	1	0	0	1	0	0
	Aug	11	3	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sept															
	Qu1 T															

BR + Maternity Red Flags (NICE 2015)

		J	A	S
1	Delay in commencing/continuing IOL process	0	3	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	1	3	
4	Missed/delayed care for > 60 minutes	0	2	
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: August 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 (%)
Jun	1;24	16%	95%
Jul	1:24	16%	95%
Aug			

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)	Measurement / Target		Bassetlaw Rate July	Aug	Sept
Caesarean Section rate	Elective	<13.2 %	9.8%	12.9%	
	Emergency	<16.9 %	18.7%	22.7%	
Preterm birth rate	≤26+6 weeks	<6%	0	0	
	≤36+6 weeks		2.47%	2.64%	
Massive Obstetric Haemorrhage	≥1.5l	<3%	7.32%	6.69%	
Term admissions to NICU			98%	98%	
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	3.9%	2.7%	
	Instrumental (assisted)	<6.06 %	0%	10%	
Right place of birth		95%	100%	100%	
Smoking at time of delivery		<11%	12.3%	9.3%	
Percentage of women placed on CoC pathway		35%	0%	0%	
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	
	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	July	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Aug	0	1	0	1	0	1	0	0	0	1	0	0	1	0	0
	Sept															
	Qu1 T															

BR+ Maternity Red Flags (NICE 2015)

		J	A	S
1	Delay in commencing/continuing IOL process	0	1	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	1	1	
4	Missed/delayed care for > 60 minutes	1	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	79%	76%	
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

		J	A	S
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)

	July	August	September
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	July	August	September
Freedom to speak up / Whistle blowing themes	None	None	None
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Unexpected weight below the 10th centile Shoulder dystocia Unexpected readmission PPH Midwifery staffing	Unexpected weight below the 10th centile Shoulder dystocia Unexpected readmission PPH Midwifery staffing	
Themes from Maternity Serious Incidents (Sis)	Medicine administration error IUFD following normal USS no CTG performed	• No SI in July	
Themes arising from Perinatal Mortality Review Tool	No themes	• No themes	
Themes / main areas from complaints	Staff attitude / communication Delays in appointments and reviews Information given / provided	Staff attitude / communication Delays in appointments and reviews Information given / provided	
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP meetings	Reaching out engagement session at Frenchgate shopping centre MVP meetings	
Evidence of co-production			
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Q & A sessions Email updates Increase in incentive for NHSP shifts Reiki sessions offered Continuity of care paused due to staffing levels	SMT increased visibility in clinical areas Managers, Specialist midwives & Matrons working clinically 1:1's increased to support individual issues / sickness Community on call protected for homebirth	
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	Changes to guidelines Newsletter governance Printing of report for staff to review with signature sheet	Changes to guidelines Newsletter governance Printing of report for staff to review with signature sheet	

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% / <13.2% / <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%	<3.5%	>=3.5%	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%	<11%		>11%	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						

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Programme Key Milestone Status			
Milestones	**Milestone deadline**	**Confidence of meeting deadline (RAG RATING)**	**Expected date of completion**
Continuity of Carer – Team bases/recruitment	On going		Paused completely until Dec 2021
Electronic Prescribing	August 2021		Digital Lead Midwife recruited revised plan of projects needed - Dec 2021
Safety Huddles	August 2021		Current emphasis on consultant led ward rounds and establishing correct model for Ockenden. Once established then additional safety huddle can be reviewed and adopted.
Consultant Ward Round	March 2021		MS completing new SOP/Ockenden
Improved escalation processes	April 2021		SOP's and Escalation Policy under review
Refurbishment of CDS	May 2021		Commence April 2022
Bereavement Suite	May 2021		To be reviewed in light of damage to area following flood
Maternal Enhanced and Critical Care	On going		
CNST compliance submission date	21.7.21		COMPLETED
Ockenden Evidence submitted on Portal by 30 June 2021	June 2021		Evidence submitted – awaiting feedback reference compliance/actions
Maternity Quality Strategy under development			Delayed with staffing position. Meeting set up with key individuals to progress
Maternity Escalation plan under review within in DBTH & LMNS	October 2021		Consultant Led review (MS) LMNS looking at SYB strategy – work commenced

Key Decisions That need to be escalated to Children's & families Board		
Description	**Recommended Decision**	**RAG Status**
Increased staffing pressures on maternity services	Support with creating an ICS Escalation process to support maternity services	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	19 October 2021	**Agenda Reference:**	C1
Report Title:	Annual EPRR Core Standards Compliance		
Sponsor:	Rebecca Joyce – Chief Operating Officer		
Author:	Jeannette Reay – Emergency Planning Officer Jane Tombleson – Interim Deputy Chief Operating Officer (Non-Elective) Rebecca Joyce – Chief Operating Officer		
Appendices:	Appendices A and B (Included in Report)		
Report Summary			
Purpose of report:	• To provide the Board with information on the Trust's self-assessment for 2021/22: - Self-Assessment Process - Performance Against the Business Continuity Standards* - Performance Against the Core Standards* - Performance Against the Deep Dive (Oxygen Supply) Standards* - Actions and Progress from the 2020/21 Standards - Declaration of Compliance - Submission - Next Steps - Statement of Compliance * *Assessment detail and action plans (appendices)* • To allow the Board to approve the Statement of Compliance at Appendix A. • To allow the Board to approve the Improvement Plan at Appendix B for submission to NHS England.		
Summary of key issues/positive highlights:	• The declaration for 2021-22 will be of partial compliance as the Trust is 80% compliant with the Core Standards that it is expected to achieve.		

Recommendations:	As recommended by the Trust's Audit and Risk Committee (12 October 2021): • To note the self-assessment process undertaken for 2021-22. • To approve the statement of compliance at Appendix A for submission to NHS England (Yorkshire and the Humber). • To approve the Improvement Plan at Appendix B for submission to NHS England (Yorkshire and the Humber).				
Action Required:	Approval	~~Information~~	~~Discussion~~	Assurance	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	~~*Everybody knows their role in achieving the vision*~~	~~*Feedback from staff and learners is in the top 10% in the UK*~~	~~*The Trust is in recurrent surplus to invest in improving patient care*~~

Implications	
Board assurance framework:	No changes made to BAF for this report
Corporate risk register:	Report regards Risks ID F&P6 on the Risk Register • Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards Report outlines actions plan to make progress, no change to risks on CRR
Regulation:	Compliance with NHS England and Improvement Emergency Preparedness, Resilience and Response (EPRR) Framework – annual statutory requirement for self-assessment.
Legal:	The Civil Contingencies Act (CCA) 2004 places statutory duties on Category One Responders, and the Core Standards assess the Trust's preparedness and response capabilities to those duties and also to other statutory and regulatory requirements.
Resources:	*None*

Assurance Route			
Previously considered by:		Trust Executive Group Audit and Risk Committee	
Date:	11 / 12 October 2021	**Decision:**	The Audit and Risk Committee will make a recommendation to the Board on its approval of the declaration and action plan.
Next Steps:		• The Statement of Compliance will be submitted to NHS England (Yorkshire and the Humber) by 30 October 2021. • By 31 December 2021, LHRP and regional confirm and challenge processes will have taken place and, by 28 February	

	2022, national EPRR confirm and challenge processes will be completed. • By 31 March 2022 the National Health Services' submission will be submitted to the NHS England Board. • The Trust's confirmed level of compliance will be included in its Annual Report and Accounts for 2018-19.
Previously circulated reports to supplement this paper:	None.

BOARD OF DIRECTORS

ANNUAL STATEMENT OF COMPLIANCE

AGAINST

NHS ENGLAND AND IMPROVEMENT CORE STANDARDS FOR EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

2021-22

Jeannette Reay - Emergency Planning Officer
Jane Tombleson – Interim Deputy Chief Operating Officer (Non-Elective)
Rebecca Joyce – Chief Operating Officer

1. Introduction

As part of NHS England and Improvement Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show that they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England and Improvement has an annual statutory requirement to formally assure its own, and the NHS in England's, EPRR readiness. To do this NHS England and Improvement asks providers of NHS funded care to complete an annual assurance process. The first step in this process is organisational self-assessment.

The NHS England and Improvement Core Standards for (EPRR) are the minimum requirements commissioners and providers of NHS funded services must meet. The number of standards for organisations is dependent on function and statutory requirements. For acute Trusts the number of reportable Core Standards to NHS England and Improvement in 2021-22 is 46.

Declaration is via a self-assessment of fully compliant, partially compliant or not compliant against each Core Standard. An overall assurance rating is then assigned to the organisation on the percentage of reportable Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with (see section 3 below).

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 'deep dive' area of focus for 2021-22 is on Oxygen Supply. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating and is reported separately to NHS England and Improvement (see section 7 below).

2. Statutes and Guidance Underpinning EPRR

The Civil Contingencies Act (CCA) 2004 places statutory duties on Category One Responders, and the Core Standards assess the Trust's preparedness and response capabilities to those duties and also to other statutory and regulatory requirements.

The key requirements for compliance are with:

- Civil Contingencies Act 2004;
- NHS Act 2006 (as amended by Health and Social Care Act 2012);
- NHS England and Improvement Emergency Preparedness Framework 2015;
- National Standard Contract SC30;
- NHS Improvement;
- Care Quality Commission.

3. Self-Assessment Process – Compliance and Assurance Ratings

Process

The process for self-assessment was a review of the standards by the Trust's Emergency Planning Officer, the Interim Deputy Chief Operating Officer (Non-Elective) and the Chief Operating Officer. The details of each standard and examples of evidence were considered in detail and the assessment of particular domains was supported by:

- Business Continuity – The Business Resilience Steering Group (see Section 5 below);
- CBRNe – The Trust's CBRNe Lead;
- Deep Dive on Oxygen Supply – The Trust's Estates Team and Head of Medical Technical Services/ Medical Devices Safety Officer (see Section 7 below).

Compliance Ratings

Organisations rate their compliance for each reportable standard as:

Compliance Level	Definition
Fully compliant	Fully compliant with the Core Standard.
Partially compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the Core Standard. In line with the organisation's EPRR work programme, compliance will not be reached in the next 12 months.

Assurance Ratings

An overall assurance rating is assigned to the organisation on the percentage of reportable Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with. The possible overall assurance ratings are:

Compliance Level	Evaluation and Testing Conclusion
Fully	The organisation is 100% complaint with all standards it is expected to achieve. The organisation's Board has agreed with this position statement.

Substantial	The organisation is 89-99% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the Core Standards the organisation is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

4. Performance Against the Core Standards for 2021-22

The 46 Core Standards reportable by Acute Trusts are based on the duties of Category One Responders under the Civil Contingencies Act (CCA) 2004. They are split into ten domains (seen in the table below).

Performance Statement on reportable Core Standards (All)

Domain	No of Standards	Fully Compliant	Partially Compliant	Not Compliant
Governance	5	5	0	0
Duty to Assess Risk	2	2	0	0
Duty to Maintain Plans	9	6	3	0
Command and Control	1	0	1	0
Training and Exercising	0	0	0	0
Response	5	3	2	0
Warning and Informing	3	3	0	0
Co-operation	2	2	0	0
Business Continuity	7	5	2	0
CBRNe	12	11	1	0
Total	46	37	9	0

In total the Trust has assessed itself as fully compliant with 37 of the reportable Core Standards.

In total there are nine standards which have been assessed as Partial Compliance (amber).

This equates to 80% compliance.

5. Performance Against the Business Continuity Standards for 2021-22

The assessment of the Business Continuity Standards has led to improvement plans in prior years, the progress of which has been adversely affected by pressures on the Trust's EPRR resource including EU Exit and support for the Covid-19 response.

Focus has therefore been placed on the Business Continuity Standards for 2021-22.

The seven standards for Business Continuity were considered by the Trust's Business Resilience Steering Group (BRSG) at its meeting on 16 September 2021.

The detail of the seven standards for Business Continuity, and the Trust's self-assessment can be seen on the working paper at Appendix C.

The BRSG:

- **Supported a self-assessment of fully compliant with five of the seven Business Continuity Standards;**
- **Supported a self-assessment of two Business Continuity standards as amber;**
- Supported the action plan relating to the Business Continuity Standards;
- Accepted that, whilst the Trust's Emergency Planning Officer is stated as lead for the implementation of improvement actions, members of the Business Resilience Steering Group were required to take ownership of required actions for their own areas of work.

The details relating to non-compliance and actions for improvement are included on the working paper at Appendix C, and in the Improvement Plan at Appendix B.

6. Performance Against the Domains within the Core Standards for 2021-22

The detail of the remaining 41 reportable Core Standards (Governance, Duty to Assess Risk, Duty to Maintain Plans, Command and Control, Training and Exercising, Response, Warning and Informing, Co-operation and CBRNe), and the Trust's self-assessment can be seen on the working paper at Appendix D.

The Trust has assessed itself as fully compliant with 30 of the reportable Core Standards (outside of Business Continuity).

There are seven standards in total which have been assessed as amber (outside of Business Continuity).

The non-compliances and actions for improvement are included on the working paper at Appendix D, and in the Improvement Plan at Appendix B.

7. Performance Against the Deep Dive Standards for 2021-22

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 'deep dive' area of focus for 2021-22 is on Oxygen Supply. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating and is reported separately to NHS England and Improvement.

Performance Statement on Oxygen Supply Standards

The Trust has assessed itself as fully compliant with four of the seven Oxygen Supply standards.

There are three deep dive standards which have been assessed as Partial Compliance (amber).

The details relating to non-compliance and actions for improvement are included on the working paper at Appendix D.

8. Actions and Progress from the 2020-21 Assessment

There was a simplified process and submission requirement for 2020-21 - in recognition that the events of 2020 had tested organisational plans to a degree above that routinely achievable through exercises or assurance processes.

The amended processes for 2020-21 required the Trust to:

- Confirm that the Trust's EPRR assurance action plan submitted in response to the 2019-20 Core Standards process had been reviewed;
- Report on the Trust's process for capturing and embedding the learning from the first wave of the Covid-19 pandemic;
- Confirm the inclusion of progress and learning in winter planning preparations.

The Trust confirmed all of the above in its return for 2020-21. There were no actions to implement, and therefore no actions to follow up in the current year review.

9. Declaration of Compliance

The Accountable Emergency Officer is required to declare, on behalf of the Trust, the overall level of compliance against NHS England and Improvement's Evaluation and Testing Conclusion (Appendix A).

The declaration for 2021-22 will be of partial compliance as the Trust is 80% compliant with the reportable Core Standards that it is expected to achieve.

The Board of Directors is required to approve the declaration.

A report outlining the process and self-assessment will be provided to the Trust's Audit and Risk Committee at its meeting on 12 October 2021.

The Audit and Risk Committee will be asked to recommend that to the Board of Directors at its meeting on 19 October 202:

The Board of Directors will be requested to approve the statement and improvement plan at its meeting on 19 October 2021. Appendix A.

The statement and improvement plan will be submitted to NHS England and Improvement following the approval by the Board of Directors (no later than the deadline of 28 October 2021). Appendix B

10. Next Steps

- By 31 December 2021, LHRP and regional confirm and challenge processes which will have taken place, and by 28 February 2022, national EPRR confirm and challenge processes will be completed.

- By 31 March 2022 the National Health Services' assessment will be submitted to the NHS England and Improvement Board.

- The Trust's confirmed level of compliance will be included in its Annual Report and Accounts for 2021-22.

APPENDIX A

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0.

Where areas require further action, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Insert Signature

_____

Signed by the organisation's Accountable Emergency Officer

19/10/2018

Date signed

TBC	19/10/2018	TBC (2022)
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

APPENDIX B

Yorkshire and the Humber EPRR Core Standards Improvement Plan 2021-22

Organisation: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

ACTIONS ARISING FROM 2021-2022 ASSURANCE PROCESS (CORE STANDARDS)

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
12	Duty to Maintain Plans In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Action from Women and Children's Incident Report.	Update the Major Incident Plan to capture and reflect changes made to response arrangements (with immediate implementation). Implement refreshed cycle of training of staff and testing to support major incident policy framework (by end of financial year).	Jeannette Reay	31 March 2022
20	Duty to Maintain Plans In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Work to progress on Evacuation of whole buildings on DRI site working with regional partners – risks associated with aged Estate.	Evacuation strategies in place across Trust Buildings (Adam Hunt Knowit Solutions). Action point from 2019/20 Core Standards return completed - overarching Evacuation and Shelter Plan now in place (Approved by Health and Safety Committee on 1 October 2020) for each site in conjunction with DMBC rest centres. Whole building and site evacuation plans in progress in conjunction with regional partners. Plans are being	Accountable Emergency Officer	31 March 2022

			developed to plan for the worse case scenarios in light of the updated risk environment.		

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
21	Duty to Maintain Plans In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Improvements on access issues during Critical and/or Major Incidents. Capital works to enable ED lockdown in the event of a Major Incident. Upgrade of Net2 (access control) system. *N.B: Access/egress is covered within the Security Policy and this includes detail with regards to lockdown. The HAZMAT CBRNE Policy also includes more detailed information on lockdown of emergency departments, including a requirement for local lock down plans to be held within ED at DRI/BDGH.* *The actions detailed here refer to the more detailed response to this standard in appendix D below*	Installation of additional lock in ED. Additional Lockdown training to ED Managers. Complete upgrade of Net2 access system.	Head of Compliance – Estates and Facilities	31 January 2022 30 April 2022 28 February 2022
24	Command and Control A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Action from Women and Children's incidents to improve on communication issues and messaging. Improve the protocols / procedures for handling cascade messages related to major incidents.	Options paper on messaging systems to be provided to Executive Team. Agreement of preferred Comms. Implementation.	Chief Information Officer	30 December 2021

30	Response The organisation has Incident Co-ordination Centre (ICC) arrangements.	Action from Women and Children's Incident Report.	Learning from April 2021 Women and Children's Major Incident report to be fully embedded within arrangements for ICR (some actions have immediate implementation). Cycle of updated staff training and testing to be implemented.	Emergency Planning Officer	End of October for immediate actions 31 March 2022 for training
Ref	**Core standard description**	**Improvement required to achieve compliance**	**Actions to deliver improvement**	**Lead**	**Target date**
32	Response In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Update business continuity processes and plans throughout the organisation.	• Conduct Business Continuity plan audit. • Finalise the update of the processes for business continuity plans (BCPs). • Provide training on BCP processes. • Facilitate workshops with divisions and departments to update BCPs. Undertake exercises to test BCPs - locally and Trust wide.	Emergency Planning Officer	30 June 2022
51	Business Continuity The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Update business continuity processes and plans throughout the organisation. Central oversight and sharing of plans. Planned coordinated review in light of updated risk environment.			

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
54	Business Continuity There is a process in place to assess the effectiveness of the Business Continuity Management System (BCMS) and take corrective action to ensure continual improvement to the BCMS.	Requires review once BCMS has been developed and implemented.	Review of processes for BCMS effectiveness and reporting. Review scrutiny process for business continuity plans. All plans to be updated in light of the updated risk environment.	Emergency Planning Officer	31 March 2022
57	CBRNe There are documented organisation specific HAZMAT/ CBRN response arrangements.	CBRNe plan due for update. Include procedure for contaminated bodies in update of policy.	Update and consult on refreshed policy. Approval via December 2021 BRSG and January TEG meetings.	Emergency Planning Officer	31 January 2022

APPENDIX C

Business Continuity Standards – Trust Self-Assessment

DOMAIN – BUSINESS CONTINUITY

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
47	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake Business Continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	The Trust has a Business Continuity Strategy and Policy - CORP/RISK 9. Current Version (6) reviewed by Business Resilience Steering Group (BRSG) on 17 May 2018 and approved by Executive Group on 11 June 2018. The document was reviewed by Emergency Planning Officer in early 2020 and was determined to be fit for purpose. A review of the Strategy and Policy is due (31 December 2021). This will be undertaken with support from the COO and in the refreshed risk context following COVID and incidents through 20/21.	**Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Set out in Business Continuity Strategy and Policy. This will be refreshed in light of the updated risk context.	**Compliant**
50	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	The Trust is DSPT compliant (2020/21 submission) - annual requirement.	**Compliant**
51	**Business Continuity Plans (BCP)**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Plans are Divisional based and require better central coordination. The Trust has an IT business continuity plan. Regular planned outages provide 'controlled' environments in which to practice BC plans. For example, annual electrical maintenance power down. The planned review to take place during 2019/20 assisted by Consultant from YAS did not take place. Not all plans have been subject to annual review in the last two years and this will be an important area of focus particularly in the updated risk environment. **Action:** - **Central oversight and sharing of plans.** - **Planned coordinated review in light of updated risk environment.**	**Partially Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	• EPRR policy document or stand-alone Business continuity policy • Board papers • Audit reports	KPMG internal audit of policies 2018/19 and reported "substantial compliance".	**Compliant**
54	**Business Continuity Management System (BCMS) continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• EPRR policy document or stand-alone Business continuity policy • Board papers • Action plans	Business Continuity on BRSG work plan - reported to all meetings. Whilst this is in place, the process and scrutiny should be refreshed in light of the updated risk environment. The process will be important through 2021/22 as we strengthen the focus on business continuity planning in light of increased and "new" risks to estate. **Action:** - **Review scrutiny process for business continuity plans.** - **All plans to be updated in light of the updated risk environment.**	**Partially Compliant**
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers' business continuity arrangements work with their own.	• EPRR policy document or stand-alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Action from 2019/20 completed. All in place.	**Compliant**

APPENDIX D

Core Standards – Trust Self-Assessment

DOMAIN - GOVERNANCE

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
1	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	• Name and role of appointed individual.	The Accountable Emergency Officer is the Trust's Chief Operating Officer. As an Executive Director of the Board she retains overall responsibility for the Emergency Preparedness, Resilience and Response, and Business Continuity Arrangements. The Trust has an Emergency Planning Officer - EPO (30hrs). This is supported by the Deputy COO for Non-Elective (a change through 2020/21) which provides additional senior support for the role. There is a Non-Executive Director (active Board Member) who formally holds the EPRR portfolio. The NED is briefed on the progress of the EPRR work plan outside of Board meetings by the AEO and EPO.	**Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment. • Access to funds. • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Major Incident Plan section 3 sets out the Trust's intention of meeting the requirements of a Category 1 responder. That will safeguard health and safety of individuals, minimise financial losses, damage to property and the environment and minimise the impact on the reputation of the Trust. Includes role of Board - CEO - AEO EPO etc - reporting structure.	**Compliant**
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	• Public Board meeting minutes. • Evidence of presenting the results of the annual EPRR assurance process to the Public Board.	The reporting route for the Core Standards is via the Trust's Audit and Risk Committee - to a Public Board of Directors' meeting for approval. An annual report of the BRSG meeting is included in the work plan - for reporting to the Trust's Executive Group. The annual report will cover the work of the BRSG - including the reporting of information on training and exercises, major incidents and business continuity incidents and learning. The annual report of BRSG is due for production.	**Compliant**
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board. • Assessment of role / resources. • Role description of EPRR Staff. • Organisation structure chart. • Internal Governance process chart including EPRR group.	The Major Incident Plan sets out the roles and responsibilities of AEO and EPO. Review of EPRR resource and structure, in light of backlog and known current future pressures in the current context to be undertaken. Known risks from aged Estate – multiple incidents for reporting. Organisation to look at additional resources.	**Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR policy statement.	Debriefs after events. Staff have completed the PHE structured debrief course. Action plans to address any learning. Debriefing structures outlined in Plans.	**Compliant**

DOMAIN – DUTY TO ASSESS RISK

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded. • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register.	The LRF Community Risk Assessment is used to develop the agenda for the BRSG and is referenced in the Trust's Business Continuity Plan. The Emergency Planning Officer attends HRSG meetings to provide input to support the completion of system wide capability and risk assessments. The Major Incident Plan and Business Continuity Plan reference the relevant risks to the organisation. EPRR Work Plan in place - reported to BRSG. Associate Director of Assurance / Company Secretary attends BRSG meetings to report on Corporate Risk Register and to ensure that EPRR risks are captured.	**Compliant**
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	• EPRR risks are considered in the organisation's risk management policy. • Reference to EPRR risk management in the organisation's EPRR policy document.	EPRR risks captured, escalated for reporting and monitored in line with Trust's risk management policy and system. Deputy Director of Corporate Governance / Company Secretary attends BRSG meetings to report on Corporate Risk Register and to ensure that EPRR risks are captured.	**Compliant**

DOMAIN – DUTY TO MAINTAIN PLANS

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Arrangements should be: • current. • in line with current national guidance. • in line with risk assessment. • tested regularly. • signed off by the appropriate mechanism. • shared appropriately with those required to use them. • outline any equipment requirements. • outline any staff training required.	Detailed within Major Incident Plan and specific guidance contained in Major Incident - ICR - Guidance folder for ICR. (B Drive) Director on call - senior manager on call to respond when required.	**Compliant**
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).		The Trust has in place: - Major Incident Plan; - HAZMAT / CBRN plan; - Business Continuity Plan; Incident Reporting Policy; - Out of Hours Operational Policy; - Fire Safety Policy; - Bomb Threat Policy; - Deployment of Firearms Officers to the Trust; - Abduction of a Child/Baby Policy - IM&T Disaster Contingency Policy; - Switchboard System Failure; - Bleep System Failure Policy; - Heatwave Policy; - Severe Weather Contingency Plan; - Pandemic Influenza Operational Contingency Plan; - Communicable Disease Control Policy. Whilst all policies are in place, due to the pressures of ongoing management of the COVID incident and other estates related incident, not all policies have been recently tested and staff trained. Therefore this will be an area of focus. Action from Women and Children's incidents – update the Major Incident Plan with changes made to response arrangements. **Action:** - **Refreshed cycle of training of staff and testing to support major incident policy framework.**	**Partially Compliant**

Ref	Standard	Detail		Trust Response / Comment / Evidence	Self Assessment Rating
13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.		Severe Weather Plan - (2020) linked to SYLRF Plan - tested June 2019 - Multi-agency exercise Prolatio2. Heatwave protocols within Medical teams - Estates teams.	**Compliant**
14	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.		Severe Weather Plan (2020) as above including 4x4 plan.	**Compliant**
18	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).		Major Incident Plan - Yorkshire & Humber patient dispersal plan.	**Compliant**
19	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.		Major Incident Plan - Section 8.	**Compliant**
20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.		Evacuation strategies in place across Trust Buildings (Adam Hunt Knowit Solutions). Action point from 2019/20 Core Standards return completed - overarching Evacuation and Shelter Plan now in place (Approved by Health and Safety Committee on 1 October 2020) for each site in conjunction with DMBC rest centres. **Action:** - **Work to progress on Evacuation of whole buildings on DRI site – risks associated with aged Estate.** - **Region wide plan to be developed to plan for worse case scenarios in light of the updated risk environment**	**Partially Compliant**

21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.		Security Policy including Bomb Threat in place - includes Lockdown. Action from Women and Children's incidents to improve on access issues. Changes to Departmental upgrades - there is an element of capital works outstanding to enable the ED departments to complete a full lockdown in the event of a Major Incident. This is currently under review with input from capital, security and fire safety management teams with a target date of completion for January 2022. On completion the LSMS will plan training with ED Managers. This will then become the Managers responsibility to cascade to all staff. <u>Net 2</u> As part of the Digital Transformation project to upgrade the servers for the Paxton NET2 door access system (Risk Register entry E&F 2342), an action to undertake a Trust wide review of the system was agreed with Paxton. Following the review, Paxton has reported that a number of NET2 units (hardware) no longer have the ability to receive updates for the system software with the risk of failure increased due to the IT windows 10 upgrade which is not compatible with the older NET2 units identified. Quotations for work to be undertaken to upgrade the system and provide compliance assurance against access control and staff/patient safety are currently in progress, with a completion date of February 2022. **Action:** - **Lockdown action as described.**	**Partially Compliant**

Ref	Standard	Detail		Trust Response / Comment / Evidence	Self Assessment Rating
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage. 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.		Carbon Steeple arrangements in place. Most recent visit to area was on 10 September 2020 (Bassetlaw). Staff confirm readiness to respond.	**Compliant**

DOMAIN – COMMAND AND CONTROL

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
24	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement. • On call Standards and expectations are set out. • Include 24 hour arrangements for alerting managers and other key staff.	On Call Executive - and Senior Manager in place - System for receiving Major Incident calls from YAS/EMAS in place. Action from Women and Children's incidents to improve on communication issues and messaging. **Action:** - **Improve the protocols / procedures for handling cascade messages related to major incidents.**	**Partially Compliant**

DOMAIN – RESPONSE

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
30	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements.	• Documented processes for establishing an ICC. • Maps and diagrams. • A testing schedule. • A training schedule. • Pre identified roles and responsibilities, with action cards. • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards.	ICR in place with resources. Used in Covid-19 response. Learning from April 2021 Women and Children's Major Incident report to be fully embedded within arrangements for ICR, including cycle of staff training and testing. **Action:** - **All practical improvements and learning to be fully implemented following experience of 21/22 incidents, building on current arrangements** - **Refreshed testing and training cycle to be implemented**	**Partially Compliant**
32	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans.	Business continuity response plans are held at divisional level. The Trust has identified arrangements can be further built upon following evaluation and learning from incidents. **Action:** - **Implement improvements to the business continuity plans as outlined earlier in the document**	**Partially Compliant**
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps.	Process in place - tested and exercised during EU Exit and Covid-19.	**Compliant**
35	**Access to 'Clinical Guidelines for Major Incidents and Mass**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies.	Yes - Major Incident Clinical lead (JA) - Awareness Training for key Clinicians.	**Compliant**

	Casualty events'				
36	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Guidance is available to appropriate staff either electronically or hard copies.	Yes – (SN) ED Trainer CBRN Lead undertakes training across Division.	**Compliant**

DOMAIN – WARNING AND INFORMING

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place. • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response. • Using lessons identified from previous major incidents to inform the development of future incident response communications. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	Major Incident Plan section 12.	**Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
38	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Comms Team - Policy Corp/Comms 27 v1 - LRF Warning Informing - SYH Area Team.	**Compliant**
39	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy F72	Media and Public relations Media and Public Relations Policy CORP/COMM 27 v1- Major Incident Plan section 12 - ICR Action Card MI 7.	**Compliant**

DOMAIN – COOPERATION

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests. • Signed mutual aid agreements where appropriate.	Divert Policy. CC Mutual aid during Covid-19. Recent use of Maternity and Paeds diverts – working closely with partners during time of DBTH and system capacity issues.	**Compliant**
46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	• Documented and signed information sharing protocol. • Evidence relevant guidance has been considered, e.g., Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Resilience Direct - Doncaster Health Partnership - SYLRF Business Continuity Group, Doncaster MBC Microsoft Teams Emergency Planning portal.	**Compliant**

DOMAIN – CBRNe

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
56	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements.	YES CBRN Plan - assessed as fully compliant in annual audits by YAS - Neil Kelly.	**Compliant**
57	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures. • procedures for activating staff and equipment. • pre-determined decontamination locations and access to facilities. • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance. • interoperability with other relevant agencies. • plan to maintain a cordon / access control. • arrangements for staff contamination. • plans for the management of hazardous waste. • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes. • contact details of key personnel and relevant partner agencies.	YES CBRN Plan. Requires procedure for contaminated bodies in update of policy.	**Partially Compliant**
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies. • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities.	Yes.	**Compliant**
59	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7.	Yes.	**Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist. • Initial Operating Response (IOR) DVD and other material.	Completed equipment inventories; including completion date.	Yes.	**Compliant**
62	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits. • Decontamination structures. • Disrobe and rerobe structures. • Shower tray pump. • RAM GENE (radiation monitor). • Other decontamination equipment. There is a named individual responsible for completing these checks.	Record of equipment checks, including date completed and by whom. Report of any missing data.	Yes.	**Compliant**
63	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits. • Decontamination structures. • Disrobe and rerobe structures. • Shower tray pump. • RAM GENE (radiation monitor). • Other equipment.	Completed PPM, including date completed, and by whom. There is an aged decontamination unit (tent) at Bassetlaw Hospital. EMAS audit (29 October 2021) to include a review of the facility and advice on alternatives.	Yes.	**Compliant**
64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Organisational policy	Yes.	**Compliant**
65	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training.	Maintenance of CPD records	Yes.	**Compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
67	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Maintenance of CPD records	Yes.	**Compliant**
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance. • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/. • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf. • A range of staff roles are trained in decontamination technique.	Yes.	**Compliant**
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		Yes.	**Compliant**

APPENDIX E

Deep Dive – Oxygen Supply Standards – Trust Self-Assessment

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
DD1	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum. • Committee has signed off terms of reference • Minutes of Committee meetings are maintained. • Actions from the Committee are managed effectively. • Committee reports progress and any issues to the Chief Executive. • Committee develops and maintains organisational policies and procedures. • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs). • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate. • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board.	- Committee in place. Meets at least twice per annum. - Terms of Reference in place. - Minutes of committee meetings are in place - Medical Gas Systems Policy approved via Medical Gas Committee and Trust Health & Safety Committee. - Contingency plans in place for loss of O2 / low pressure faults - Various risks relating to medical gas systems on the Estates risk register and where applicable the corporate risk register / Board Assurance Framework (risk score dependent). - Authorising Engineer's audit completed annually and an action plan is in place to address issues identified.	**Fully compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
DD2	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases.	• The organisation has reviewed and updated the plans and are they available for view. • The organisation has assessed its maximum anticipated flow rate using the national toolkit. • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site. • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available). • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices.	- Action cards in place for a loss of O2 / low pressure conditions, reviewed in 2020. - Regular assessment of capacity and demand carried out using a combination of manual assessment using spreadsheets/assessment tools and meter reading data from newly installed O2 flow meters. This includes a daily assessment when covid patient numbers warrants this action. - Medical Gas Pipeline System drawings have been updated at all Trust sites - Maximum O2 supply capacity calculated for key areas. - Trust has plans in place to manage oxygen cylinders during surge activity, including consideration of suppliers capacity to maintain adequate deliveries - Medical Technical Services department have staff trained who can who can deliver ward level training as required, programme of training is underway and progress is managed via the Trust medical gas committee	**Fully compliant**

Ref	Standard	Detail	Examples of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
DD3	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries. • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms. • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes. • Organisation has utilised the checklist retrospectively as part of an assurance or audit process.	- Cryogenic oxygen supplies assessed at all Trust sites. - Project completed to install a second vacuum insulated evaporator (VIE) at DRI completed. - Trust remains in contact with suppliers to ensure an adequate delivery frequency is maintained. -Supplier monitors consumption on all sites via telemetry and adjust deliveries accordingly. - Flow meters reporting to a web portal installed at DRI to assist monitoring of consumption, demand at other sites assessed using manual calculation via spreadsheet and reviews of historic data using supplier telemetry. - Medical Gas Pipeline System improved at DRI to create an O2 ring to improve delivery capacity and resilience.	**Fully compliant**

Ref	Standard	Detail	Example of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
DD4	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role. • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements. • Medical gas training forms part of the induction package for all staff.	- Trust has x 4 appointed MGPS AP's - All AP's trained and appointed after assessment by AE only - MGPS AE Appointed in writing - Trust employs an external Quality Controller, with contacts for others if needed - Trust employs x 2 MGPS service contractor providing 24/7 support to ensure availability - Availability of AP's considered during approval of annual leave to ensure cover is maintained - Work underway to determine additional training requirements for designated nursing officers, progress managed via Medical Gas Committee	**Partially compliant**
DD5	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds. • Staff are informed and aware of the requirements for increasing de-icing of vaporisers. • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO.	- Daily O2 consumption assessment in place during periods of surge activity – assessment requested when required via enhanced ops meeting. - O2 data shared with multi-disciplinary team daily to assist planning. - VIE inspected daily as a minimum and vaporisers de-iced when necessary, inspections increased during periods of surge. - CCTV in place to monitor condition of vaporisers remotely if necessary at DRI.	**Fully compliant**
DD6	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report.	- All files reviewed and updated with supplier in 2020, available for each site.	**Fully compliant**

Ref	Standard	Detail	Example of Evidence	Trust Response / Comment / Evidence	Self Assessment Rating
DD7	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6.	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01. • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review).	Various risks identified on the risk register informed planning for O2 improvement works. This includes the installation of an additional VIE and O2 ring main at DRI in FY20/21 and a project that is currently underway to install an additional O2 cylinder manifold at Bassetlaw Hospital in FY21/22. Capital programmes are also developed taking a risk based approach, which includes reference to the Trust risk register. Work is also in progress to develop an overarching risk assessment document that will be reviewed annually as advised in HTM02-01 part A section 6.6.	**Partially compliant**

Deep Dive – Oxygen Supply Standards – Action Plan for Improvements

Ref	Deep Dive standard description	Action to be taken	Lead	Timescale	Comments
DD4	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	Review medical gas training provision during Trust induction Review medical gas training provision for clinical designated nursing/medical officers	DBTH Medical Gas Committee	12 months	Medical gas training provision for inductions & designated nursing/medical officers is under review via the Trust Medical Gas Committee
DD7	The organisation has undertaken a risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6.	Develop an overarching risk assessment for O2 supply systems at each of the Trust's sites.	Head of Estates	3 months (Dec 2021)	Oxygen supply systems throughout the Trust have been reviewed adopting a risk based approach, leading to the installation of a second oxygen VIE plant and improved oxygen distribution pipelines at DRI and enhanced security measures at all sites. Work is also currently underway to install an additional oxygen cylinder manifold at BDGH to improve resilience. Work is also in progress to develop an overarching risk assessment document for oxygen supplies throughout the Trust to facilitate the ongoing annual review of oxygen systems as recommended within the guidance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	19 October 2021	**Agenda Reference:**	D1
Report Title:	**Progression of Governance Arrangements for the Integrated Care System**		
Sponsor:	Richard Parker OBE, Chief Executive		
Author:	Will Cleary-Gray – Chief Operating Officer, South Yorkshire and Bassetlaw Integrated Care System		
Appendices:	None		

Report Summary	
Purpose of report:	This report provides an update on progress made in developing the governance arrangements in readiness for the establishment of statutory Integrated Care Systems (ICSs) on 1 April 2022. It summarises progress, key guidance and the indicative timetable for next steps. This includes engaging on key components of the Integrated Care Board (ICB) in developing governance arrangements in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022.
Summary of key issues/positive highlights:	• The South Yorkshire and Bassetlaw Health and Care Partnership agreed a set of arrangements to take the partnership forward. A key group of the partnership is the ICS Development Steering Group, whose membership is drawn from across all system partners and key ICS building blocks • The ICS Development Steering Group and the Health Executive Group have been considering the published guidance and policy including the development of partnership governance arrangements at its monthly meetings and most recently at its meetings on 14 September 2021 • National guidance to support establishment of statutory ICS was published over August and September, including on the functions and governance of the Integrated Care Board (ICB) and Model Constitution of the ICB • ICS leaders and designate ICB leaders are asked to proceed with preparations to implement ICB governance and leadership arrangements • The chair designate is now in post and appointment to the chief executive designate is underway • Engagement with appropriate partners on key components of the Constitution are expected by 30 November 2021

Recommendations:	The Board of Directors is asked to: • Note the progress and summary of the position • Note and consider the key activities and timetable, Annex, A • Consider the published guidance on the functions and governance of an ICS and key elements of the Bill, Annexes B- G • Note the requirement to engage with partners on the ICB Constitution • Note the step to engage with partners on specific issues relating to the constitution later in October • Note the priority to recruit to the first two designate non-executive directors of the ICB • Note boundary changes and name change of the Health and Care Partnership from 1 April 2022				
Action Required:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	~~*To provide outstanding care for our patients*~~	~~*Everybody knows their role in achieving the vision*~~	~~*Feedback from staff and learners is in the top 10% in the UK*~~	~~*The Trust is in recurrent surplus to invest in improving patient care*~~

Implications	
Board assurance framework:	N/A
Corporate risk register:	N/A
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:		SY&B ICS Health Executive Group	
Date:	12 October 2021	**Decision:**	To share with Trust Boards for information

Next Steps:	
Previously circulated reports to supplement this paper:	None

South Yorkshire and Bassetlaw
Health Executive Group

Date: 12 October 2021

Subject: Progressing ICS governance

Report of: Will Cleary-Gray, Chief Operating Officer, SYB Health and Care Partnership

Sponsor: Pearse Butler, Chair SYB Health and Care Partnership, Chair Designate South Yorkshire Integrated Care Board

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SUMMARY OF THE REPORT

This report provides an update on progress made developing the governance arrangements in readiness for the establishment of statutory Integrated Care Systems (ICSs) on April 1 2022.

KEY MESSAGES

SYB Health and Care Partnership agreed a set of arrangements to take the partnership forward. A key group being the ICS Development Steering Group, whose membership is drawn from across all system partners and key ICS building blocks.

Guidance to support establishment of statutory ICS was published over August and September, including on the functions and governance of the Integrated Care Board (ICB) and Model Constitution of the ICB.

ICS leaders and designate ICB leaders are asked to proceed with preparations to implement ICB governance and leadership arrangements.

The chair designate is now in post and appointment to the chief executive designate is underway.

Initial discussions on the ICB guidance and arrangements took place at the 14 September ICS Development Steering Group.

Engagement with appropriate partners on key components of the Constitution are expected by 30 November 2021

PURPOSE OF THE REPORT

This report summarises progress, key guidance and indicative timetable for next steps. This includes engaging on key components of the ICB in developing governance arrangements, in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022

The Health and Care Bill: Developing our governance arrangements

Purpose

1. This report summarises progress and indicative timetable for next steps in developing our governance arrangements in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022.

Background and context

2. South Yorkshire and Bassetlaw agreed a set of arrangements to respond to NHS England and Improvement next steps to Integrating Care, and the White Paper ***"Integration and Innovation: Working together to improve integration and innovation for all"*** This included the establishment of an ICS Development Steering group involving all partners across the ICS including Local Authorities, VCSE, Providers, including Primary Care, Mental Health and Children's Services, Commissioners and reflecting the key building blocks of our ICS including all five Places, Partnerships and Collaboratives.

3. Subsequently, the Health and Care Bill was put before Parliament on 6 July 2021 and further guidance on the governance arrangements of ICSs have been published during August and September. This includes **guidance on the functions and governance of the Integrated Care Board and model constitution for the ICB.**

4. ICS leaders, and designate ICB leaders as they are appointed, are asked to proceed with preparations to design and implement ICB governance and leadership arrangements before April 2022 that fulfil the requirements set out in this interim guidance. CCGs are legally responsible for proposing the ICB Constitution to NHS England and Improvement and engaging with relevant partners. The four CCGs have agreed a collective approach through the JCCCG. Key components of the Constitution including the size and composition of the Board and the process for the ICB nomination and selection of partner members, will now be taken forward by the designate chair and designate CEO, once appointed. The next step to take this forward is to engage with partners on these specific issues to get their input to shape proposals - this is anticipated in the next couple of weeks and further details on this will follow.

   A summary of the timeline and key activities is attached at Annex, A

5. South Yorkshire and Bassetlaw partnership now has its Chair Designate for the Integrated Care Board and recruitment for the designate Chief Executive is underway with interviews taking place on 11 October 2021.

6. The ICS Development Steering Group and the Health Executive Group have been considering the published guidance and policy including the development of partnership governance arrangements at its monthly meetings and most recently at its meetings on 14 September 2021.

7. The transition approach with five key steps was set out and discussed at the September HEG, to enable a smooth transition to statutory ICS. Both the framework to work on functional design and undertake due diligence is underway.

Key elements of the Bill and guidance on establishing ICBs

8. A statutory ICS will be made up of a statutory NHS body – the Integrated Care Board (ICB) and a statutory joint committee - the Integrated Care Partnership (ICP) - bringing together the NHS, Local Government and partners.

A summary of the core components of ICB governance are attached in Annex B

9. The ICB will be directly accountable for NHS spend, commissioning and performance within the system. ICBs will bring partner organisations together in a new collaborative way with a common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. Statutory functions, including those currently exercised by CCGs, will be conferred on ICBs from 1 April 2022, along with the transfer of all CCG staff, assets and liabilities (including commissioning responsibilities and contracts). In addition, NHSEI direct commissioning functions will be transferred or delegated starting April 2022 for Primary Medical Services with further delegation of other directly commissioned services from 2023 onwards.

A summary of the statutory functions of the ICB are attached at Annex C.

10. The core governance of the ICB will be an NHS unitary board and its membership, as a minimum, must include a chair and two further non-executives, the ICB chief executive and clinical and professional executive leaders, and partner members drawn from NHS trusts, primary care and local authorities within the ICS geography. Partner members are to be nominated and selected, as set out in the ICB Constitution, to ensure the board benefits from these important perspectives and the experiences these members will bring to enrich the leadership and decision-making of the Board. Partner members are not delegates or representatives of organisations. Other members may be determined locally.
A summary of the minimum membership of the ICB is attached at Annex D.

11. The Integrated Care Partnership is likely to be a wider group than the ICB and will develop an integrated care strategy to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to local areas to decide as they form this joint committee. SYB has made significant progress co-producing its draft Health and Care Compact and a draft Terms of Reference for the refresh Health and Care Partnership, both of which have been consulted on with partners across the system and provide a good basis to build on now we have guidance from DHSC.

A summary of arrangements for ICPs are attached at Annex, E

12. A **duty to co-operate will** be introduced to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the '**Triple Aim**' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources. SYB spent some time co-producing a Compact between health and care partners which set out the share commitment to our **quadruple aim** for the people of South Yorkshire.

A summary of our commitment to the quadruple aim are attached at Annex Ei.

13. **ICBs will be able to delegate** significantly to place level and to provider collaboratives. Delegation can be internal or external and will require due diligence and delegation agreements or contracts where appropriate to give clarity and confidence of any delegation or delivery agreement.

14. **Guidance to support thriving places was published in September 2021.** Place-based arrangements between local authorities, the NHS and providers of health and care will be left to local areas to arrange. The statutory ICB will work to support places to integrate services and improve outcomes. Health and Wellbeing Boards will continue to have an important role in local places. NHS provider organisations will remain

separate statutory bodies and retain their current structures and governance but will be expected to work collaboratively with partners.

Governance options for Place-based Partnerships are attached at Annex, F.

15. **Working together as scale: guidance on provider collaboratives was published in August 2021.** Provider Collaboratives are expected to be in place by April 22 for all trust providing acute and mental health services. They are expected to agree specific objectives with one or more ICBs. ICBs and Provide collaborative must also define their working relationships for how they will contribute to the delivery of the ICB strategic objectives.

Governance options for Provider Collaboratives are attached at Annex, G.

Key governance issues

16. **Inclusivity, values and behaviours** – strong and effective governance is as much about living our values as they are about formal arrangements and structures. Critical to our success will be that our new arrangements reflect, build on and strengthen our principles and behaviours and support the culture that we have strived to established as a partnership over the last 5 years. In particular, we will ensure that the arrangements reflect that which we know, our people are what make us successful and our focus is the people we serve. We continue to make real our commitment to equality, diversity and inclusive cultures. We are keen to continue to make progress in ensuring that our leadership and involvement in decision-making reflects the diversity of our communities and are exploring how we can take this forward. Equality impact assessments will play an important role in our new arrangements.

17. **Consistency of governance standards** – our principles of subsidiarity mean that places are developing arrangements that meet their local circumstances, within a common framework of good governance. The ICS Development Steering Group considered governance standards at its meeting in 14 September 2021 which it is proposed would apply across our system. The standards cover outcomes, values, transparency, citizen involvement, diversity, independent challenge and probity and can **be seen in Annex, H.**

18. **Subsidiarity and delegation** – under statutory arrangements, the vast majority of ICS capacity and resources will remain in our place teams. Places and are developing arrangements to fit local circumstances, within the context of our core governance standards and our place development matrix, the overall operating model of the ICS and governance of the ICB. This will bring to life the concept of one organisation, one workforce working in four place teams and support delegation.

19. **Considerations in each place arrangement are:**

- Health and Wellbeing boards continuing to play a key role in bringing partners together and setting strategy.
- Building on existing strong place arrangements and relationships to enable effective collaborative decision making
- The importance of clinical and profession leadership in decision-making
- Involving statutory and non-statutory partners and ensuring that the citizen voice is heard
- Ensuring that providers working across footprints are effectively represented without duplication and overlap.

20. **Our four places** have well established arrangements involving all partners. These are being reviewed in light of the published guidance and as part of the steps to establish

statutory ICSs and the ICB. Key next steps are: i) to agree priorities and the arrangements needed to work together to deliver these priorities and ii) the relationship and arrangements needed between these and the ICB to ensure we have thriving Places within a strong and vibrant ICS.

21. **Our system provider collaboratives**: Mental Health Alliance, Acute Federation and Primary Care Collaborative and Children and Young Peoples Alliance have established arrangements. These are being reviewed in light of the published guidance and the steps to establish statutory ICSs and ICB. Key next steps are: i) to agree priorities and the arrangements needed to work together to deliver these priorities and ii) the relationship and arrangements needed between these and the ICB to ensure we have strong and vibrant collaboratives within a strong and vibrant ICS.

22. **System arrangements** – the **Integrated Care Partnership** will be a statutory joint committee between partners. The ICS Development Steering Group put forward revised arrangements for our ICP together with a Health and Care Comact of our commitment to working together, to our Trust Boards, Governing Bodies and Councils earlier this year with a view to this new arrangement being in place for the 3rd Quarter 2021. Further consideration will be given to this at the ICS Development steering group on 12th October 2021 in light of guidance on the future ICP. The Partnership Board gave oversight to the development of our five-year plan, setting out our strategic direction and how we will work together as partners to improve health and wellbeing and reduce health inequalities. The Partnership Board focuses on the wider connections between health and wider issues including socio-economic development, housing, employment and environment. It takes a collective approach to decision-making and supports mutual accountability across our system. Our current arrangements mean that we are well placed to transition to a statutory joint committee and we will be reviewing the membership and terms of reference of the Partnership Board in line with the **national guidance on Integrated Care Partnerships, now published.**

23. Our Integrated Care Partnership will set the overall strategy for our ICS, it will be built from the four place-based strategies which in turn will have been signed off by Health and Wellbeing Boards and delivered through place-based partnership arrangements. This will ensure that the specific needs of all our populations will be met at the same time as having the benefit of working as a whole system where those needs can't be met in anyone place or where to achieve equality of access, outcome, standards and quality a system approach is required.

Integrated Care Board in South Yorkshire.

24. At the ICS Development Steering Group on 14 September key components of the national guidance on governance and functions of the ICB, including its minimum membership, were presented and discussed to inform initial work on the membership and working arrangements for the ICB board in South Yorkshire. We want our board to look, feel and function in the way that make sense for our system; one which aligns with the legislation, but not completely driven by it. Our system has developed significantly over the past 5 years with Places working in partnership and collaborations and providers being a central partner. The board will be built on principles of inclusivity, independent challenge and effectiveness and will reflect the scale and complexity of a diverse system which serves a population of 1.3 million and the core functions of an ICB. It will be part of a complex, decision-making framework, focused on delivery of our shared outcomes and with independent challenge built in at all levels and strong and consistent clinical and professional leadership. The executive portfolio will be developed to ensure that the CEO accountabilities are

appropriately delegated. The proposed roles will be part of the engagement of the whole board composition, to ensure it is effective and balanced. The ICB will be a statutory core member of the ICP Joint Committee. South Yorkshire will look to discharge the ICBs statutory duties in a way that aligns much more with our approach through Places and Collaboratives and will focus its operating model and one workforce, integrating in four places and across the system to achieve this for April 2022. This reflects, recognises and respects the importance and value in giving time for the new ICB to established as a legal entity on the April 1, 2022.

25. **Committees of the ICB**. The ICB will be required to establish two statutory committees – **audit** and **remuneration**. We will also need to establish other committees to focus on oversight and assurance and provide the IC board with assurance on the delivery of key functions, including how the four key purposes of an ICS, equality of access and outcomes, quality and finance. The Partnership already has a number of effective collaborative forums such as the Health Oversight Board, the Integrated Assurance Committee, the Health Executive Group, Quality Surveillance Group, Clinical Forum and Finance Forum and People Board. Development work is focusing on how the role, membership and ways of working of these groups may need to be adapted in line with new statutory arrangements or need to end as statutory arrangements take shape.

26. **Designate non-executive members of the ICB.** ICBs are required to have, as a minimum, two non-executive members. Recruitment of the two designate non-executive members of the ICB is a priority for South Yorkshire and the final composition of the board may include more non-executives than the minimum and this will be part of the engagement of the full composition of the ICB. It is anticipated that the national process to enable local recruitment to progress will be up and running week commencing 11 October 2021. South Yorkshire plans to progress its non-executive recruitment as soon as possible after that date.

Boundary changes and ICB naming convention

27. As part of the changes, we are proposing a name change for our ICS from April 2022 to South Yorkshire Health and Care Partnership. In addition, the naming convention approach for ICBs is anticipated. It's important to note that whilst Bassetlaw place will be part of the Nottingham and Nottinghamshire Health and Care Partnership (ICS), our work with Bassetlaw will continue both in terms of the strategic partnership with the Nottinghamshire and Nottingham ICS, Doncaster and Bassetlaw NHS Teaching Hospital Foundation Trust (and the work of the Acute Federation of Hospitals) and wider clinical and professional networks. Existing patient flows will be unaffected by this change to the boundary and this joint working is critical for the population of Bassetlaw.

Simplifying arrangements

28. Our **ICS Development Steering Group** has served as the working group for our work on Governance to date and this is chaired by our ICS lead. It has representation from across our places, providers and sectors including NHS commissioners, provider collaboratives, local authorities, voluntary, community social enterprise (VCSE). This group has enabled sharing across each of our places and system, advising on where consistency is helpful and on the linkages between place, ICB and ICP arrangement. It has also steered the co-production of key products including, the Health and Care Compact, revised terms of reference for the Health and Care Partnership and a development matrix for place-partnership development We want to simplify our arrangements as we move into the final six months to implementation of statutory

ICSs, to make it even easier for all key partners to engage in this important work. Two changes are proposed at this stage: i) Regular briefing to inform discussions into the weekly **Health and Care Management meetings**. ii) Amending the terms of reference of the **Health Executive Group** to reflect a renewed focus on ICS development and invite any regular remaining members from the Steering Group to join this group which has to date, taken place on the same day. It is proposed that this change takes place from November and therefore October will be the last meeting of ICS steering group as a separate meeting.

Recommendations:

The Health Executive Group is asked to:

- Note the progress and summary of the position
- Note and consider the key activities and timetable, Annex, A
- Consider the published guidance on the functions and governance of an ICS and key elements of the Bill, Annexes B- G
- Note the requirement to engage with partners on the ICB Constitution
- Note the step to engage with partners on specific issues relating to the constitution later in October
- Note the priority to recruit to the first two designate non-executive directors of the ICB
- Note boundary changes and name change of the Health and Care Partnership from 1 April 22
- Agree changes to simplify arrangements from November 2021

ANNEXES

Annex, A

Table 1: Areas, activities and timescales

Area	Activity	Timescales
Constitution	• Start the development of the ICB constitution, subject to discussions with the regional team. • The Bill sets out that CCGs will propose the constitution for the first ICBs[4] to NHS England and NHS Improvement, which will require confirmation that designate board members are supportive of its terms. • NHS England and NHS Improvement has developed a draft model constitution which system leaders and CCGs should use to guide the development of and consultation on their local version.	• Development of the constitution to take place throughout the year. • Board size and composition **by 17/11/21** • All other aspects including the nomination and selection process for partner members **by 30/11/21** • A final version approved **before the end of Q4** by NHS England and NHS Improvement.
Board recruitment	• Plan how the board of the ICB will be populated.	• Designate chief executive identified by the end of November • Designate finance director, medical director, director of nursing and other executive roles in the ICB, **before the end of Q4** • Designate partner members and any other designate ICB senior roles **before the end of Q4.**
Commissioning functions	• Confirm plans to ensure that commissioning functions are organised across the ICS footprint including apportioning between the ICB (system) level and 'place' level.	• Discussions with partners and decisions on commissioning arrangements at system and place to be finalised **by the end of Q3.**
Functions and decision map	• Develop a 'functions and decision map' showing the arrangements with ICS partners to support good governance and dialogue with internal and external stakeholders.	• Discussions and decisions on a functions and governance map to take place throughout the year. • A final 'functions and decision map' due **before the end of Q4** to be completed alongside the model constitution.

[4] CCGs will be legally responsible for the development of ICB constitutions, but we expect this process to be led by the designate ICS chair and CEO. System partners must be engaged in the development of the constitution.

Extract from Interim guidance on the functions and governance of the integrated care board

Annex, B

Table 2: Core components of ICB governance arrangements and expectations

Core component	Expectation
Integrated care partnership (ICP) ***statutory***	• Each ICS area will have an ICP (a committee, not a body) at system level established by the ICB and relevant local authorities as equal partners and bringing together organisations and representatives concerned with improving the care, health and wellbeing of the population. • The ICP to have a specific responsibility to develop an integrated care strategy. • Each ICB will need to align its constitution and governance with the ICP.
Integrated care board ***statutory***	• ICBs will be established as new statutory organisations, to lead integration within the NHS. • The ICB will have a unitary board, responsible for ensuring the body plays its role in achieving the four purposes • Minimum requirements for board membership will be set in legislation. We have set further minimum expectations for board membership. • Each board will be required to establish an audit committee and remuneration committee • All ICBs will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for other committees and groups to advise and feed into the board, and to exercise functions delegated by the board.
Place-based partnerships	• ICBs will be able to arrange for functions to be exercised and decisions to be made, by or with place-based partnerships, through a range of different arrangements. The ICB will remain accountable for NHS resources deployed at place-level. • Each ICB should set out the role of place-based leaders within its governance arrangements.
Provider (may be at sub system, system or supra-system level)	• Provider collaboratives will agree specific objectives with one or more ICB, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved. • The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any other local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.

Annex, C

The Integrated Care Board

ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

Table 3: Functions of the integrated care board

1	Developing a plan to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.
2	Allocating resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.
3	Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
4	Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.
5	Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including: a) putting contracts and agreements in place to secure delivery of its plan by providers b) convening and supporting providers (working both at scale and at place) to lead[6] major service transformation programmes to achieve agreed outcomes c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships,

[6] It is expected that the ICB will be able to delegate functions to statutory providers to enable this.

	including through investment in PCN management support, data and digital capabilities, workforce development and estates d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.
6	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.
7	Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
8	Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.
9	Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.
10	Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.
11	Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
12	Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services.

Statutory CCG functions to be conferred on ICBs

Statutory functions, like those currently exercised by CCGs, will be conferred on ICBs from 1 April 2022, along with the transfer of all CCG staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant duties of CCGs include those regarding health inequalities, quality, safeguarding, children in care and children and young people with special educational needs and (SEN) or disability.[7].

The full expected list of CCG functions to be conferred will be made available to NHS organisations via the NHS England and NHS Improvement ICS implementation hub.

Delegating direct commissioning functions to ICBs

It is the intention to delegate some of the direct commissioning functions of NHS England and NHS Improvement to ICBs as soon as operationally feasible from April 2022.

Our expectation is that from April 2022 ICBs will:

- assume delegated responsibility for Primary Medical Services (currently delegated to all CCGs, and continuing to exclude Section 7A Public Health functions)
- be able to take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and dispensing appliance contractors)
- establish mechanisms to strengthen joint working between NHS England and NHS Improvement and ICSs, including through joint committees, across all areas of direct commissioning (in systems where they are not already delegated).

By April 2023, all ICBs will have:

- taken on delegated responsibility for dental (primary, secondary and community), general ophthalmic services, and pharmaceutical services
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level
- worked collaboratively with our organisation to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse

Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

Commissioning healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services will remain with NHS England and Improvement.

[7] Further guidance will be developed to support the transition of functions to ensure ICSs deliver for babies, children and young people.

Extract from Interim guidance on the functions and governance of the integrated care board

Annex, D

Membership of the ICB board

We will expect every ICB to establish board roles as required to carry out its functions effectively, building on the minimum membership set out below in Table 4.

Table 4: Minimum membership of the unitary board of the ICB.

Type	Role	Appointment and expectations
Independent non-executive members	Chair	• appointed by NHS England and NHS Improvement (with Secretary of State approval). The chair must be independent and cannot hold a role in another health and care organisation within the ICB area.
	A minimum of two other independent non-executive members	appointed by the ICB and are subject to the approval of the chair • these members will normally not hold positions or offices in other health and care organisations within the ICS footprint
Executive roles	Chief Executive	• Must be employed by / seconded to the ICB
	Chief Finance Officer	• Must be employed by / seconded to the ICB
	Director of Nursing	• Must be employed by/seconded to the ICB
	Medical Director	• Must be employed by/seconded to the ICB
Partner members (a minimum of three)	At least one member drawn from NHS trusts and foundation trusts that provide services within the ICS's area	• We expect the partner member(s) from NHS trusts/foundation trusts will often be the chief executive of their organisation.

	At least one member drawn from the primary medical services (general practice) providers within the ICB area	• We expect the member drawn from primary medical services providers to engage and bring perspectives from all primary care providers, including primary care networks
	At least one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICB.	• We expect this partner member will often be the chief executive of their organisation or in a relevant executive- level local authority role
*All members of the ICB *ICBs will be able to supplement the minimum board positions*	As listed above and additional members.	Each member of the ICB must: • By law be subject to the approval of the Chair (excluding the CEO, who is approved by NHS England and NHS Improvement). • Comply with the criteria of the "fit and proper person test[9] • Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles). • Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification. • Meet the eligibility criteria set out in the constitution of the ICB

The constitution of the ICB must set out board roles, the process of appointing the partner members and eligibility criteria that must be fulfilled. The constitution must be submitted to and approved by NHS England and NHS Improvement.

[9] We anticipate that regulations regarding the "fit and proper person test" will apply to ICBs when established. We expect that designate board member appointments will comply with these principles. These includes agreement that evidence of compliance will be shared with the relevant authority and a commitment to regular review of continued compliance.

Extract from Interim guidance on the functions and governance of the integrated care board

Annex, E

The ICP and the ICB

ICP guidance will be issued by the Department of Health and Social Care (DHSC). It will be jointly developed between DHSC, NHS England and NHS Improvement and the Local Government Association (LGA). The proposed legislation and ICS Design Framework set out that:

- The ICP will be established locally and jointly by the relevant local authorities and the ICB, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration.
- Members must include local authorities (that are responsible for social care services in the ICS area) and the local NHS (represented at least by the ICB).
- The ICP will have a specific responsibility to develop an 'integrated care strategy'[5] for its whole population (covering all ages) using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.
- The strategy must set out how the needs assessed in the Joint Strategic Needs Assessment(s) for the ICB area are to be met by the exercise of NHS and local authority functions. This will be complemented by the Joint Health and Wellbeing Strategy prepared by each Health and Wellbeing Board in the geographical area of the ICS.
- Each ICP should champion inclusion and transparency and challenge all partners
- to demonstrate progress in reducing inequalities and improving outcomes. It should support place-and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it covers.

Key considerations to support system leaders as they develop local arrangements between the ICB and ICP including the development and delivery of the integrated care strategy can be found in section A, Annex 1.

[5] We expect the inaugural ICP strategy will be developed in 2022/2023

Extract from the Integrated Care Partnership: engagement document, September 21

Representatives and organisations for ICP membership and engagement

We expect the ICP to have a broad membership and engagement with the organisations and communities it serves. However, this membership should be managed appropriately to ensure that the operations of the ICP remain efficient and effective. This illustrative list for ICP membership and engagement should not be viewed as a box-ticking exercise but as a genuine way of ensuring the partnerships include people able to represent and connect with communities and the voluntary sector. We welcome perspectives on whether there are any other voices who should form part of this list. For example:

- voices for children & young people
- patients, service users, & public voices
- voluntary, charity and social enterprise sector
- voices from the Children's Board
- led by and for women's organisations
- Black and minoritised voices
- Healthwatch
- social care providers and workforce
- unpaid carers voices
- disability voices
- mental health providers and service users
- primary care (GPs, dental, eye care, pharmacy)
- NHS Trusts and Foundation Trusts (acute, mental health, community, ambulance)
- community care
- public health voices (e.g., Directors of Public Health)
- local Authority Officers (e.g., Director of Children's Services, Director of Adult Services)
- Acute Care
- housing voices
- Criminal Justice System agencies, including probation services
- offenders health and care voices
- alcohol and addiction services
- homeless services
- social prescribing services
- learning disabilities and autism providers and service users
- businesses
- Local Enterprise Partnerships
- armed forces
- police and crime commissioners
- employment support services (e.g., Jobcentre Plus)

Extract from the draft Health and Care Compact co-produced with all partner members of the ICS development steering group

Annex, Ei

Values and Principles for the ICS Partnership

The partners recognise that achieving the Shared Purpose will depend on their ability to effectively co-ordinate themselves in order to deliver an integrated approach to the provision of services across the ICS. This may include (if partners choose) combining expertise, workforce and resources and also a review of how the Health and Wellbeing Boards in each of the five Places can play a key role in the development and structure of the Partnership.

The partners also wish to support each other in the development of successful place based systems within the ICS for Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield, which will each work as an effective part of the wider system and key building block. Members will also deploy appropriate resource to support the Partnership (each member retains ownership of its resources and is solely responsible for decisions about how those resources are used).

The members will embrace the following values:

- The **'quadruple aim'** of 'better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the people alongside the reduction of health inequalities
- Recognising the critical importance of the workforce, to work closely together to develop and support the wider workforce of the members operating across the system
- To play their part in social and economic development and environmental sustainability of the SYB region
- Committing to making decisions
- Always keeping citizens at the centre of everything the partners do
- Ensuring that the children's, young people and families agenda is a key element of this work
- Supporting each other and working collaboratively to take decisions at the most local level as close as possible to the communities that they affect whether that be system, place or neighbourhood (subsidiarity) and not to simply replicate what is at place in the ICS
- Developing collaborative leadership to deliver the Shared Purpose, and a culture and values to support transformation. All partners are respected and valued. They understand their own contribution and support the contributions of other partners to the Shared Purpose
- Strengthen the links between Place and ICS as well as other local representative structures such as Health and Wellbeing Boards and demonstrate inclusivity and shared ownership
- Making time and other resources available to develop the Partnership and deepen working relationships between partners at all levels
- Being transparent with each other and the people of SYB around decisions and appointments
- Using the best available data to inform priorities and decision-making
- Looking for simplicity and effectiveness in any Partnership structures and governance and follow the rule of form following function

- Acting with honesty and integrity and trusting that each other will do the same; This includes each member being open about the interesss of their organisation and *any* disagreement *they* have with a proposal or analysis. Partners will assume that each acts with good intentions: and
- Working to understand the perspective and impacts of their decisions on other parts of the health and social care system
- Decisions should be taken together at the right level to deliver the Shared Purpose and benefit the population of SYS. Decisions around resource at place should be made with the relevant partners at the place level and when decisions are taken together across the SYS system *they* should not adversely affect the outcomes or equity for populations within SYBICS

...together these are the 'Values'.

The ways in which the members will put the Values into practice include:

- Promoting and striving to adhere to the Nolan Principles of public life (selflessness. integrity. objectivity, accountability. openness, honesty and leadeship) including:
- Specifically being accountable to each other for performance of respective roles and responsibilities for the Partnership and the ICS, in particular where there is an interface with other members; and
- Communicating openly about major concerns. issues or opportunities relating to this Compact and adopting transparency as a core value, including through open book reporting and accounting. subject always to appropriate treatment of commercially sensitive information if applicable
- Having conversations about supporting the wider health and care system. not just furthering their own organisations' interests
- Undertaking more aligned decision-making across the partners and trying to commission and deliver services in an integrated way wherever reasonably possible
- Routinely using insights from data to inform dec ion making
- Positive engagement with other partners in other geographies in pursuit of the quadruple aim and effective planning and delivery including Clinical and Professional Networks
- Ensure that problems are resolved where possible rather than being moved around the system
- Acting promptly. Recognising the importance of integrated working and the Partnership and responding to requests for support from other partners
- Seeking to ensure that our organisations reflect the diversity of the population and that this is reflected in the governance and dec ion making groups for the system

...together these are the 'Principles'.

Extract from Interim guidance on the functions and governance of the integrated care board

Annex, F

Place-based partnerships and the ICB

The governance arrangements of place-based partnerships (PBPs) and their relationship to the board of the ICB should be agreed by the board of the ICB with place leaders. They will depend on the agreed functions and responsibilities that sit with PBPs, local relationships as well as existing structures.

Table 5 summarises the broad types of governance arrangements that could be established to support PBPs to make decisions between the appropriate partners to support the aims of the partnership, if the Bill is passed in its current form. Further consideration will need to be given to the decision-making arrangements of committees and agreed with statutory bodies where they relate to the delegation of statutory functions. For example, agreeing the approaches to managing disagreement in their terms of reference and whether a lead member of a committee is required.

Table 5: Governance options for place-based partnerships[11]

Consultative forum Helpful for engaging the widest range of partners to discuss and agree shared strategic direction together.	A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.
Individual executives or staff Helpful for engaging partners in the decision-making of statutory bodies, while retaining a single SRO for decisions.	Statutory bodies may agree individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership which includes representatives from other organisations. In this instance, the individual could become the SRO for the place in their body, enabling budgets to be defined for the committee and managed through their internal management and reporting arrangements. The individual director could be a joint appointment, between the ICB and local authority, or statutory NHS provider, and could have delegated authority from those bodies.

[11] The governance options are not mutually exclusive; places may draw upon multiple versions of the options for different sets of business and decision -making as appropriate and could use a single forum for multiple purposes. It may be possible to use and amend existing forums to support decision-making.

Committee of the ICB Helpful for making decisions of the ICB based on a range of views	A committee provided with delegated authority to make decisions about the use of NHS resources, including the agreement of contracts for relevant services. This committee could include members from outside the organisation. However, the decisions reached are the decisions of the ICB, in line with the organisation's scheme of delegation. The terms of references and scope are set by the ICB and agreed to by the committee members. A delegated budget can be set by the ICS NHS body to describe the level of NHS resources available to cover the remit of the committee.
Joint committee Helpful for making joint decisions between relevant partners	A committee established between partner organisations, such as the ICB, local authorities, statutory NHS providers or NHS England and NHS Improvement. The committee may appoint representatives of non-statutory providers to participate in the committee or attend meetings to take part in discussions without being members, but only where the convening statutory bodies consider it appropriate. The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit.
Lead provider Helpful for giving provider leaders greater ownership and direction around the delivery and coordination of services.	A lead provider manages resources and delivery at place-level, as part of a provider partnership, under a contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services. The lead provider would sub-contract other providers within the scope of the place-based delivery partnership. They can agree how NHS resources are spent within the payment envelope agreed with the ICB, complying with the terms of the contract, and establish governance with partnering providers to support delivery.

Where place-based partnerships agree with statutory bodies (for example the ICB, NHS providers or local government) to take on delegated statutory functions for the place, the relevant bodies will retain accountability for these functions and must be satisfied the place-based partnership is able to manage the functions appropriately.

Extract from Interim guidance on the functions and governance of the integrated care board

Annex, G

Providers and provider collaboratives

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (e.g. community interest companies, social care providers) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.

Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.

We expect:

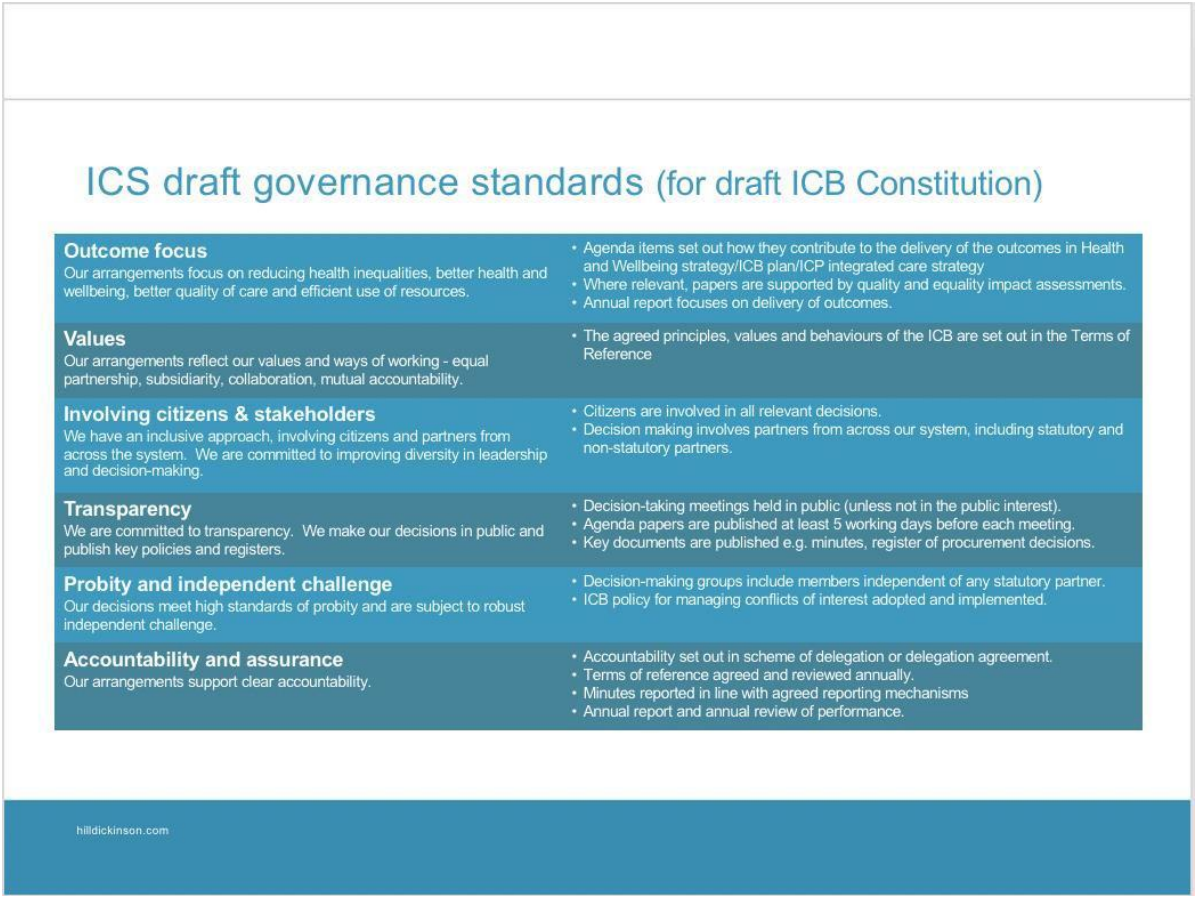
- The ICB could arrange for its commissioning functions to be delegated to one or more NHS trusts and/or foundation trusts, including when working as provider collaboratives (this would require a lead provider arrangement or for the delegation to be to all the trusts involved). ICBs will continue to be held to account for the way in which the function has been discharged. An ICB would have to continue to monitor how the delegation was operating and whether it remained appropriate.
- Another option would be for the ICB to arrange for its commissioning functions to be delegated to a joint committee of itself and another/other NHS trust(s) and/or foundation trust(s).

Further information on provider collaboratives can be found on the NHS England and NHS Improvement website

Annex, H

DRAFT ICS Governance standards

(Applicable to the ICP and ICB, joint committees, committees and sub committees with delegated authority from the ICB.)



DRAFT

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 21 September 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 Tim Noble – Executive Medical Director Richard Parker OBE – Chief Executive David Purdue – Deputy Chief Executive and Chief Nurse Marie Purdue – Director of Strategy & Improvement Neil Rhodes – Non-Executive Director and Deputy Chair 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 Angela O'Mara – PA to Chair & Chief Executive (Minutes)	
Public in attendance:	Peter Abell - Public Governor Bassetlaw Dennis Atkin – Public Governor Doncaster Hazel Brand – Public Governor Bassetlaw Gina Holmes – Staffside Chair Steve Marsh – Public Governor Bassetlaw Vivek Panikkar – Staff Governor Debbie Pook – Member of the Public Pauline Riley – Public Governor Doncaster Clive Tattley – Partner Governor Mandy Tyrell – Staff Governor	
Apologies:	None	**ACTION**
P21/09/A1	**Welcome, apologies for absence and declaration of interest (Verbal)**	
	The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and the member of public in attendance via the audience functionality. No apologies for absence were received. As Senior Responsible Officer for the South Yorkshire & Bassetlaw (SY&B) Pathology Transformation Programme the Chief Executive declared an interest in respect of agenda item F1 (SY&B Pathology Transformation Outline Business Case). Should those in attendance be required to vote on this matter the Chief Executive would be unable to cast his vote. The Director of Strategy & Improvement would present the paper relating to the agenda item.	

	No further declarations of interest were declared, pursuant to Section 30 of the Standing Orders.	
P21/09/ A2	**Actions from Previous Meetings (Enclosure A2)**	
	Action 1 – Escalation to Board – Job Planning Internal Audit Report – an update would be provided as part of today's agenda by the Executive Medical Director. Action 2 – Inpatient Survey Action Plan – an update would be provided as part of today's agenda by the Chief Nurse, to include wider engagement of the public Action 3 – Escalation to the Finance & Performance Committee – the action was closed Action 4 - Diagnostic Framework Self-assessment Board Leadership - explicit inclusion in the People Strategy, due by the end of 2021. To be carried forward as an action. Action 5 – Covid-19 Positive Colleagues - included in the Director of People & OD's update Action 6 - Mental Health Support – included in the Chief Nurse's update Action 7 - NHS Food Strategy Update - included in the Chief Nurse's update Action 8 - Safeguarding Information to Board - not due until November 2021	
	The Board: - ***Noted the updates and agreed which actions would be closed.***	
P21/09/ C1	**Board Assurance Framework – SA1 (Enclosure C1)**	
	The Board received an updated Board Assurance Framework in respect of risks to the achievement of the Trust's Strategic Aim 1 – To provide outstanding care and improve patient experience. The following suggestions were made: • **Controls / assurance (mitigation & evidence of making an impact)** – to add further work required on patient CQC action plans, details of which would be shared at the Quality & Effectiveness Committee. • **Comments** – in response to a question from Pat Drake, the Chief Nurse confirmed the consolidation of maternity should remain on the list due to continuing staffing challenges and the suspension of continuity of care. • **Measures** – Pat Drake suggested the inclusion of Perfect Ward. The Chief Nurse agreed that this would be updated on the next iteration for Inpatient Quality Assessment Tool (IQAT) and Department Quality Assessment Tool (DQAT)	

P21/09/ C2	**Chief Nurse Update (Enclosure C2)**	
	The Chief Nurse presented a comprehensive report, which provided supporting information and assurance on the following items: • key deliverables for patient safety and experience • outcome measures for Maternity Services • safe staffing numbers for nursing and midwifery In preparation for the introduction of the Patient Safety Incident Response Framework (PSIRF) next year, and in response to guidance issued by the national patient safety team, the Chief Nurse reported that the previous three year's data for patient safety incidents, serious incidents, moderate harms, complaints and inquests had been analysed and triangulated at a recent Trust workshop. During August 2021 the following were reported: • Clostridium difficile – six cases, one Hospital Onset, Hospital Acquired (HOHA) and the remaining five Community Onset, Hospital Acquired (COHA). In view of the numbers reported work had been undertaken to consider geographical locations and establish any trends; no lapses in care had been identified and patients had been appropriately prescribed antibiotics. • e-Coli Bacteraemia – five cases • MRSA colonisations – two • Nosocomial Covid – one ward area had reported an outbreak, which affected two patients. A Post Infection Review had been completed and no issues had been identified; rates continued to be closely monitored. In response to a question from Kath Smart, the Chief Nurse confirmed appropriate reporting of nosocomial covid through the Clinical Governance and Quality and Effectiveness Committees. In all of the above cases no lapses in care had been identified, Post Infection Reviews had been completed and all appropriate infection, prevention and control measures were in place. Where necessary, additional deep cleans had been commissioned. In accordance with national guidance the Chief Nurse advised that the Trust had issued duty of candour letters to the relatives of 90 inpatients who had died of Covid-19 during the first wave of the pandemic. To date only three responses had been received to clarify issues. Following a trust-wide learning needs analysis and linked to the recently published framework for involving patients in patient safety, e-learning modules would be made available in the Autumn via ESR, for completion by all trust staff, with a specific module for the Board of Directors. An overview of patient experience was provided, including analysis of complaint/concern themes and compliance with internal timeframes. In response to a question from Sheena McDonnell, the Chief Nurse acknowledged there was a correlation between incidents of violence and aggression and complaints, which would be reported to the Quality & Effectiveness Committee.	

	A significant amount of negative feedback had been received from visitors and patients who had experienced difficulties navigating the site, due to the relocation of clinics/services and associated temporary signage. Following a site walk around a phased approach to address the concerns had been proposed, phase 1 would commence in September 2021 and once the site had stabilised, the final stage was expected to be completed in Spring 2022 , which included a review of site maps. Sheena McDonnell welcomed the review of signage and suggested an opportunity to engage with the public and secure a digital solution would be favoured. The Chief Nurse drew the Board's attention to the maternity update and the key learning and themes from the referrals to the Healthcare Safety Investigation Branch (HSIB). Sheena McDonnell asked for some context to be provided on the number of referrals, which the Chief Nurse advised did not cause concern when compared to the total number of births, the key factors for consideration by the Board should be the identification of themes and that appropriate actions had been taken. The Royal College of Obstetricians and Gynaecologists (RCOG) had recently released a workforce report on the roles and responsibilities of the consultant, the recommendations from which had been reviewed, a gap analysis completed and an action plan developed. As Chair of the Quality & Effectiveness Committee Pat Drake requested these actions be reported into this committee. It was reported that staffing in maternity had been particularly challenging during July and August and with the support of the Local Maternity and Neonatal System (LMNS) a decision to pause continuity of care until December 2021 had been taken, to allow staff to be hospital based. This decision was in line with other organisations and at a time when seasonally high birth rates were being seen. The Nursing and Midwifery staffing report identified the planned vs actual staffing across July and August. New registrants were awaited, and discussions had taken place with the University to establish flexibility on proposed start dates. The impact of the incident in the Women's & Children's Hospital continued to affect all services, along with the need for staff to take annual leave, sickness absence and vacancy factors. Work on rotas to review effectiveness by a confirm and challenge process was being undertaken, overseen by the Director of Nursing and the Chief Nurse. Pat Drake thanked the Chief Nurse for his report and for bringing Organ Donation Week to the attention of the Board, noting that the Regional Chair was due to visit the Trust shortly. A request was made for a glossary of acronyms to be included in the maternity paper. Pat also took the opportunity to feedback positively on the Trust's Sharing How We Care Conference which took place on 16 September. However, she did express concern at the category 4 hospital acquired pressure ulcer which had been reported in July, which would require investigation. In respect of the complaint theme "values and behaviours" (staff), it was noted that 50% of complaints related to the attitude of medical staff and assurance was sought that civility training was provided and that feedback be provided on this at the next Board. The Director of People & Organisation Development advised that civility and respect training was part of the Emergency Department Organisational Development Programme and consideration would be given as to how best to cascade this across the organisation. In respect of nurse staffing for the current level of patient acuity, the question was asked if there was a need to look at skill mix, staffing levels and budget, rather than making temporary fixes, as 30% of inpatients required enhanced care. A review of nurse establishments and	DP/TN DP TN/DP

	discussions with the Director and Deputy Director of Finance had taken place and it was agreed that work on the Safer Nursing Care Tool would be completed and budgets and establishments would be included in a future board report. The Chief Executive acknowledged the challenges, and with the support of appropriate measures, and tools the Trust would ensure that necessary plans were in place, although as we approached winter it was acknowledged that this would be a bigger piece of work than previously seen. There was a need to support annual leave due to the pressures colleagues had faced over an extended period, although it was recognised this would in turn create additional pressures. The Chief Executive extended a huge thank you to staff for all their efforts, in what had been the most challenging period he had experienced. The Chair of the Board noted that the Trust could not expect the same approach to Winter as in previous years, the Trust had lost beds due to Covid, as well as the impact of the incident in the Women's & Children's Hospital and we now needed to move forward with strength. In response to a question from Pat Drake the Chief Nurse advised that arrangements for the Board Maternity Safety had been received from Professor Jacqueline Dunkley-Bent's office, an initial date of 12 November 2021 had been proposed. In respect of enforcing visitor restrictions Kath Smart enquired of the level of difficulty and frequency of decision making. The Chief Nurse confirmed the primary aim of any decision was to protect staff and vulnerable patients, appropriately linked to guidance and to ensure system-wide consistency. The importance of appropriate communication to support changes in visiting was reinforced. The renewed focus on food was welcomed by Kath Smart and in response to a question relating to pre-Covid food audits the Chief Nurse confirmed that delivery of the Trust Food and Drink Strategy would be monitored by the Nutritional Steering Committee as a sub-committee of the Clinical Governance Committee. All place assessments would be informed by national guidance.	DP
	The Board: - ***Noted and took assurance from the Chief Nurse Update.***	
P21/09/ C3	**<u>Executive Medical Director Update (Enclosure C3)</u>**	
	The Board received the Executive Medical Director's report which provided the following updates: • continued progress of risk stratification of the admitted referral to treatment active waiting list, which stood at 94% as of 8 September 2021. • a Trust 12 month rolling Hospital Standardised Mortality Ratio of 105, which had stabilised after a period of reduction • 100% scrutiny of all adult in-patient deaths, with continued work to include the scrutiny of paediatric and non-coronial deaths in the community by the Medical Examiner's office • a summary of July and August 2021's Caldicott Guardian activity • progress update on the clinical governance review, to be presented at October's meeting of the Quality & Effectiveness Committee	

	• finalised structure and appointment to the Executive Medical Director's Office. The following appointments were confirmed, with the Medical Directors to work alongside Deputy Medical Director, Ray Cuschieri in a phased handover - Dr Nick Mallaband, Medical Director Workforce & Speciality Development - Dr Joseph John, Medical Director of Stability and Optimisation - Dr Sudipto Gosh, Associate Medical Director - Revalidation & Professional Standards (12 month fixed term) - Dr Juan Ballesteros, Associate Medical Director - Clinical Safety (12 month fixed term) - Julie Butler, Senior Manager (secondment) In response to a question from Pat Drake, the Executive Medical Director confirmed the newly appointed colleagues would be assigned to board sub-committees. The Executive Medical Director confirmed that development of policy and procedures in respect of job planning was ongoing, an action plan was in place and KPMG were assured in line with NHSE expectations. Pat Drake shared her appreciation of the work undertaken as part of the clinical governance review and requested that all assurance routes were sighted on the outcomes. She also sought assurance that the Medical Examiner's team would meet the deadline of scrutiny of all deaths by April 2022; the Executive Medical Director acknowledged the excellent work undertaken by the Medical Examiner team to date and shared positive feedback received but noted the deadline was a challenging one. He assured the Board that progress towards the deadline would be reported through the Quality and Effective Committee. Kath Smart acknowledged the strong appointments made to the Medical Examiner roles and stressed the importance of the interface between primary and secondary care. Neil Rhodes congratulated the Executive Medical Director on the recruitment to his team, and looked forward to the realisation of business benefits, the Executive Medical Director's expectation was a proactive approach to ensure all specialities and disciplines were equipped to fully deliver services. All appointed Medical and Associate Medical Directors would be exposed to the board, with support and buddying arrangements in place. Ahead of the Executive Medical Director's attendance at October's Audit and Risk Committee Kath Smart reinforced the need for a briefing on progress in respect of job planning, including any challenges and anticipated revisions to the timeframe.	
	The Board: - ***Noted and took assurance from the Executive Medical Director Update.***	
P21/07/ D1	**<u>Board Assurance Framework – SA2 & 3 (Enclosure D1)</u>**	
	The Board received an updated Board Assurance Framework, which included 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.	

	Minor amendments had been incorporated but following discussions at this month's meeting of the People Committee it had been agreed that the Board Assurance Framework would be updated further to include the outcome of the internal audit reports.	
P21/09/ D2	**<u>Our People Update (Enclosure D2)</u>**	
	The Director of People & Organisational Development's report provided an extensive update across the following topics: • Widening participation, including school's engagement, apprenticeships, work experience and partnership working. During Q1 an encouraging number of apprentices have commenced in post, the highest seen since the introduction of the apprenticeship levy • Statutory and essential training – as of 31 July 2021 the trusts compliance stood at 85% • Staff survey – the quarterly Pulse survey (previously known as the Staff Friends and Family test) had only achieved a 19% response rate. Plans to actively promote the full survey were in place, with a go live date of 4 October 2021 • Freedom to Speak Up activity, performance against the strategy, and learning and development • RACE Code – the Trust has been awarded the Race Equality Code quality mark and significant progress against the RACE action plan had been reported via the People Committee • Covid absence and staff testing data • Covid and Flu vaccination programme The Director of People & Organisational Development advised the refresh of the workforce strategy was ongoing, with discussions planned for October's Workforce Planning Meeting and November's People Committee. As Chair of the People Committee Sheena McDonnell reported the positive progress of the widening participation agenda and excellent work in support of equality, diversity, and inclusion. In respect of an area of improvement a focused effort was required to increase the fire safety compliance level. Neil Rhodes enquired what a reasonable expectation for level of completion would be for the quarterly survey and if it would be possible for the Trust to calibrate their response to that of other trusts. As this was the first Pulse survey the Director of People & Organisational Development was not yet sighted on how the benchmarking data would be received but acknowledged that when colleague's satisfaction was at a reasonable level this could result in a low completion rate. Thought would be given as to how completion rates could be increased and a reduction in neutral responses achieved. The efforts in securing the RACE code quality mark were acknowledged by Pat Drake, however, it was recognised that much of the work to date had focused on staff and consideration should now be given from a patient's perspective. The Director of People & Organisational Development recognised further work was required in this area and would consider how Stacey Nutt, Deputy Director of Nursing – Patient Experience could link into the Equality Diversity and Inclusion Forum.	

	The flu vaccination programme would commence this week, with mobile vaccinators working across the site, the Covid booster was expected to be in place by mid-October but would be provided from a fixed location, due to the nature of the vaccine. It was noted that the level of Covid positive staff continued to increase, with 56 colleagues currently testing positive and a further 14 displaying symptoms.	
	The Board: - ***Noted and took assurance from the Our People Update.***	
P21/09/ D3	**Report from Guardian for Safe Working (Enclosure D3)**	
	The Board received the first quarterly report, prepared by Dr Anna Pryce, Guardian of Safe Working. In summary the report identified a low level of exception reporting in the last quarter, with no specific areas of concern identified. The absence of educational exception reporting suggested good education opportunities for trainees. Where exception reports had been received in respect of working additional hours these were due to work pressures arising from colleague's absence rather than rota gaps. Previous reports relating to the lack of rest facilities had now been addressed by the provision of a junior doctor's mess room. As Dr Pryce had been unable to attend today the Chair of the Board asked the Director of People and Organisational Development to convey the Board's appreciation for her report.	KB
	The Board: - ***Noted and took assurance from the Guardian for Safe Working Report***	
P21/09/ D4	**Workforce Race Equality Standard / Workforce Disability Equality Standard & Gender Pay Gap Report (Enclosure D4)**	
	The Board received the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and gender pay gap report, the data from which is submitted nationally against a set of key indicators. The Director of People & Organisation Development brought to the Board's attention the continued work required to address the disability disclosure rate and the recruitment of Black, Asian and Minority Ethic (BAME) and disabled applicants. In respect of BAME disciplinary or capability matters it was noted the Trust performed well. Due to a lack of BAME representation at Trust Board level the placement of an Associate Non-Executive Director had taken place to strengthen the BAME voice at Board level. Pat Drake raised the matter of the international nurse recruits who were initially employed at Band 3 until the point at which they registered and queried if this should be reflected in the report. Sheena McDonnell shared her view that the refresh of the Equality, Diversity and Inclusion strategy should include the Trust's ambition, rather than a pure focus on numbers.	
	The Board: ***Noted and took assurance from the Workforce Race Equality Standard / Workforce Disability Equality Standard Report/Gender Pay Gap Report***	

P21/09/ E1	**Board Assurance Framework – SA4 (Enclosure E1)**	
	The Board received an updated Board Assurance Framework which identified risks to the achievement of the Trust's strategic aim 4 – in recurrent surplus to invest in improving patient care.	
P21/09/ E2	**Finance Update (Enclosure E2)**	
	The Director of Finance brought the Board's attention to the following points: • The increased pay spend, particularly nursing had impacted the Trust's financial position, discussions with the Chief Nurse had taken place in respect of H2 budgets and an increase was anticipated due to bank and agency spend. Grip and control meetings to review rotas and leave rates would be implemented by the Director of Nursing • The £12.4m capital pressure arising from the Women's & Children's incident was expected to be taken as a system wide cost pressure. Each Director of Finance within SY&B ICS had agreed to support a £3m capital underspend and this would be discussed at the meeting of SY&B ICS Health & Care Management Team on 28 September. Proposals for the Trust's £3m contribution were likely to be supported by underspends in IT, Medical Equipment and Estates and would be considered at the Finance & Performance Committee on 24 September 2021, • As yet financial arrangements for H2 were unknown, although guidance was expected by the end of next week and at this stage no significant change to the regime was anticipated. Under normal circumstances it was noted that the Trust would be expecting to receive information relating to next year's plans. • A targeted investment fund to support restoration of elective pathways was expected and the Trust would bid against this for the modular theatre and additional ward. • Whilst the Trust remained in surplus, it should be noted that for the second month running an in-month deficit position had been reported. In response to a question from Neil Rhodes with regards to the public's perception of the challenges faced by Trusts working without an identified H2 budget the Director of Finance confirmed our approach was to continue to deliver services, making the best use of public money, building a strong skill base for delivery and caring for our staff. The Chief Executive recognised alongside the public's perception it was also important to consider that of our staff, reinforcing the need to ensure good housekeeping, doing the right things for the right reason and to achieve the right outcome, primarily for the benefit of the patient. The Director of Finance provided assurance that the Trust was setting budgets on cost, the difference being at this point we didn't know the income. Whilst an increase in costs had been seen this would need to be well managed to ensure the Trust continued to maintain its CQC good rating for use of resources. Kath Smart reinforced the importance of good systems, processes, and internal controls in managing the risks.	

	Neil Rhodes complimented the way in which the Women's & Children's issues had been handled both operationally and for the extensive work that had taken place behind the scenes.	
	The Board: - ***Noted and took assurance from the Finance Update.***	
P21/09/ E3	**<u>Operational Update – Looking Forward</u>**	
	The Chief Operating Officer shared with the Board the following operational update: A steady rise had been seen in Covid-19 infection rates, particularly in the over 60 age group, despite the rates of infection the number of inpatients remained steady around 45-50. Similar pressures were noted across South Yorkshire & Bassetlaw, with the rate of infection remaining higher than the Yorkshire & Humber average. Covid bed occupancy stood at 8.2%, with active cases representing 6.7% of the bed base, the Trust currently had 10 Covid patients on critical care and surge capacity was being utilised. Critical Care remained under pressure with significant workforce challenges and support from the network had been sought. Attendances in the Emergency Department remained high, particularly for minors and paediatrics and non-elective admissions exceeded pre-Covid levels and were anticipated to remain high into winter. These levels were being used to inform winter planning. The significant impact from the Women's & Children's incident continued to be felt, with a loss of 19 surgical adult beds and 23 paediatric beds. Mutual aid continued to be required. Going into winter, pressures were expected to increase significantly with the potential for a doubling of Covid-19 and critical care requirements. Flu season was also expected to have a greater impact and with an earlier onset. In paediatrics a surge of 25-50% of Respiratory Syncytial Virus (RSV) was anticipated, with the peak expected in November. This would be challenging in view of reduced bed capacity, as the modular paediatric wards were not expected to arrive until early December 2021. A significant amount of time had been devoted to winter planning, to include different models of delivery, change in flow and improvements to processes and systems. Partnership plans were being worked up alongside internal discussions and redeployment of colleagues was expected. Bed capacity and staffing challenges had impacted upon elective delivery and although the Trust's performance benchmarked well with others it had achieved 85% and 82% in July and August respectively against the target of 95% of 2019/2020 value. The focus had been on Emergency, P2, long waiters and cancer patients, with ongoing insourcing work undertaken in ophthalmology, oral and endoscopy. The 52 week wait position had improved but progress was noted to be slowing due to pressures, and further work was required on the diagnostic position, with a specific focus required on radiology waits.	

	Good progress continued to be reported with cancer performance, with a reduction in <62 day waiters, continued improvements in 2 week waits and an improving position in the faster diagnosis standard. In response to a question from the Chair of the Board the Chief Operating Officer confirmed the Trust continued to work closely with Park Hill, where an average of 30 cases a week were undertaken. Having considered the Chief Operating Officer's update and in recognition of the Board's interest in colleagues' health and well-being Neil Rhodes enquired of the impact on staff morale and resilience. The Executive Team were well sighted on colleague's fatigue levels; the Chief Executive acknowledged that often the impact on front line colleagues was more obvious but the impact on those working behind the scenes should not go unrecognised. On behalf of the Board thanks were shared with all colleagues who continued to support delivery of all services. The challenges this winter were expected to have a significant impact on our partners and at both place and system level their involvement would be critical to success. In response to a question from Pat Drake the importance of partnership working with social care and community providers could not be underestimated, to ensure appropriate support for admission avoidance and effective discharge. Proactive in-reach support from RDaSH would be stepped up to a higher level for winter and dialogue with Doncaster MBC would support clear and active solutions. The recently appointed joint post of Director of Allied Health Professionals would support a range of initiatives including red to green and Home First. The priority during this time would be to ensure existing practices worked well, rather than looking to reinvent the wheel. The biggest challenge for diagnostics continued to be non-obstetric ultrasound and although investment had been made in providing additional capacity backlogs had built up throughout the pandemic due to staffing challenges. The Chief Operating Officer advised Pat Drake that further work was required to understand capacity and demand for the diagnostic modalities. The Chief Executive acknowledged that the Trust was likely to exit winter with significant workforce challenges, with a need to understand capacity and demand and appropriate workforce solutions. Kath Smart recognised the enormously challenging position, which was not underestimated. Whilst there was noise in the system about Primary Care it appeared that the number of attendances were increasing in general practice, which would hopefully support a reduction in ED attendances, with more work required on 111 streaming routes and the creation of hot primary care centres. At an introductory meeting with Gill Marsden, Deputy Chief Operating Officer – Elective plans were shared for the medium and long term and Kath Smart enquired about short term solutions. The Chief Operating Officer confirmed the focus would be on P1, P2 and cancer, with winter plans focused on day cases and mutual aid to provide additional capacity.	
	The Board: - ***Noted and took assurance from the Operational Update – Looking Forward***	

P21/09/ E4	**Performance Update (Enclosure E4)**	
	The Board received the Chief Operating Officer's Integrated Quality and Performance Report (IQPR) which provided assurance that appropriate actions were being taken to support operational performance across the Trust in terms of recovery and a return to business as usual. The IQPR provided: • at a glance charts, showing performance against a set of key indicators • performance exception report • speciality level activity against % value of 2019/2020, in line with Elective Recovery Fund requirements For elective and cancer performance the next key steps of the restoration strategy were to improve access to radiology and other key enablers to the elective pathways. From an emergency perspective to develop bed and capacity plans and ensure effective internal systems and processes, alongside strong partnership plans.	
	The Board: - ***Noted and took assurance from the Performance Update.***	
P21/09/ F1	**SY&B Pathology Transformation Outline Business Case (Enclosure F1)**	
	The Board received the detailed Outline Business Case (OBC) prepared by the SY&B Pathology Transformation Team, through consultation with SY&B ICS providers and led by Richard Parker, as Senior Responsible Officer. In view of the Chief Executive's previously declared interest the paper was presented by the Director of Strategy & Improvement. The OBC described the recommendations to transform pathology services across South Yorkshire and Bassetlaw and approval was sought from the Board to proceed and develop a Full Business Case (FBC) that would further assess and finalise proposals for the configuration of pathology services. A decision from the Trust Boards of Barnsley, Rotherham, Sheffield Teaching and Sheffield Children's Hospitals would also be sought. The recommendations noted were that: • the formation of the pathology network was configured as described in the economic case as the recommended Target Operating Model. • the SY&B Pathology Service was established between the five partner Trusts as a Hosted Network, operating as a single service, with Sheffield Teaching Hospitals FT as the Host Organisation • a Pathology Partnership Board and Operational Team should be appointed to lead delivery of the substantial reconfiguration of services as described in the recommended target operating model of this OBC. In response to a question from the Chair of the Board the location of services was not felt to impact on delivery and as the Trust had been identified as the base for the mini-CSL (Central Service Laboratory) this offered a degree of resilience.	

	Kath Smart confirmed she was pleased to see that no redundancies were planned as part of the service transformation and enquired how colleagues had been engaged in the process to date. In answer to a direct question about the programme the Chief Executive advised that communications across the Trusts had been ongoing for some time and would continue for some time to come. The Director of Strategy and Improvement confirmed that key personnel, including colleagues from DBTH also attended the Pathology Programme Operational Board. The fact that the Trust had been chosen as the site for the mini-CSL was a positive reassurance, although it was recognised that there would be an impact on the histopathologist over the coming years with their future base being Sheffield. The Board were informed that three network posts would be going out to competitive recruitment, and if successful appointments could not be made would be advertised externally. It had also been determined that the Chair of the Network Board would not be from the host organisation. Neil Rhodes offered his support to progress, as did Mark Bailey who recognised the significant amount of work involved to progress the programme to this point, noting the financial benefits and the need for innovation. The Chief Executive acknowledged the need to embrace the benefits of the network for our patients and population and develop a culture to support this.	
	The Board - ***Approved the Pathology Transformation OBC and agreed to proceed to the FBC.***	
P21/09/ F2	**<u>Collaborative Working with RDaSH (Enclosure F2)</u>**	
	The Director of Strategy and Improvement shared with the Board a short briefing paper on discussions to further develop collaborative working with Rotherham Doncaster and South Humber NHS FT (RDaSH). Allowing both Trusts the opportunity to consider efficiencies for underutilised or duplicated services. Following previous Board approval to proceed with exploring opportunities a Design Group had been established with representation from both organisations including Chairs, Chief Executives, Non-Executive Directors and Directors of Strategy. The next step would involve scoping of opportunities and an external partner would be engaged to carry out this work. No questions were raised, and it was agreed that a periodic update would be received.	
	The Board - ***Noted the Collaborative Working with RDaSH Update***	
P21/09/ F3	**<u>Teaching Hospital Board Update (Enclosure F3)</u>**	
	The Board received a brief update on the focus of the newly formed Teaching Hospital Board. In his capacity as Chair of the Board Mark Bailey acknowledged the positive start and active engagement of place-based partners, schools, higher education institutes and Public Health.	
	The Board	

	- ***Noted and took assurance from the Teaching Hospital Board Update***	
P21/09/ G1	**<u>Corporate Risk Register (Enclosure G1)</u>**	
	No new corporate risks had been added or escalated from the Trust Executive Group. Sheena McDonnell enquired of the progress with those risks rated 15+ on the Corporate Risk Register. The Deputy Director of Governance/Company Secretary confirmed they continued to be monitored via the Trust Executive Group, where Divisional Directors were in attendance and at the Executive Team meetings. The rating of risks had also been considered at the Clinical Governance Committee. Kath Smart reinforced the need to ensure that the challenges faced were appropriately recorded on the Corporate Risk Register. It was suggested that a task and finish group to consider the issue be set up to include Kath Smart, Sheena McDonnell and the Deputy Director of Corporate Governance/Company Secretary. Identified areas for review included PE01, PE02, feedback from the Granger Report and the findings from KPMG's internal audit. The Chief Executive acknowledged the positive change in the reporting of the Board Assurance but recognised that the Trust needed to return to good housekeeping standards on the administration and management of the risk register. It was acknowledged that the issue was wider than clinical governance matters.	**FD**
	The Board: - ***Noted the Corporate Risk Register.***	
P21/09/ G2	**<u>Trust Board Annual Declaration of Interests (Enclosure G2)</u>**	
	The annual report offered assurance on the Board's statutory and regulatory requirements in respect of Director interests.	
	The Board: - ***Noted and approved the Trust Board Annual Declaration of Interests.***	
P21/09/ G3	**<u>Use of Trust Seal (Enclosure G3)</u>**	
	The Board noted and approved the use of the Trust Seal (Number 125) - WH Smith Hospital Limited, WH Smith Hospitals Holding Limited and Doncaster and Bassetlaw Teaching Hospitals renewal lease by reference to an existing lease. Sealed on 8 September 2021 by Richard Parker OBE, Chief Executive and Jon Sargeant, Director of Finance.	
	The Board: - ***Approved the use of the Trust Seal***	
P21/09/ G4	**<u>Internal Audit Report Status: Job Planning (Enclosure G4)</u>**	
	The update relating to this agenda item was provided in agenda item C3 – Executive Medical Director Update.	

P21/09/ H1-	**Information Items (Enclosure H1 – H9)**	
	The Board noted: - ***H1 Chair and NEDs Report*** - ***H2 Chief Executives Report*** - ***H3 ICS Update*** - ***H4 Performance Update Appendices*** - ***H5 Minutes of the Finance and Performance Committee 17 June 2021*** - ***H6 Minutes of the Quality and Effectiveness Committee 14 June 2021*** - ***H7 Minutes of the People Committee 6 July 2021*** - ***H8 Minutes of the Trust Executive Group 12 July 2021 and 9 August 2021*** - ***H9 Minutes of the Teaching Hospital Board 11 June***	
P21/09/ I1	**Minutes of the meeting held on 20 July 2021 (Enclosure I1)**	
	The Board: - ***Approved the minutes of the meeting held on 20 July 2021.***	
P21/09/ I2	**Any other business (to be agreed with the Chair prior to the meeting)**	
	There were no items of any other business.	
P21/07/ I3	**Governor Questions regarding the business of the meeting (10 minutes) ***	
	On behalf of the Council of Governors Hazel Brand echoed the Chief Executive's words of appreciation for the continued efforts of staff in these challenging times and hoped that those able to attend the thank event at the Yorkshire Wildlife Park on Saturday enjoyed their day. Hazel Brand, Lead Governor asked the following questions on behalf of the Council of Governors: In respect of Hospital Acquired Pressure Ulcers (HAPU) the governors shared their appreciation of the excellent briefing and development session recently delivered by the Skin Integrity Team, but shared their disappointment of the reporting of a Category 4 HAPU and would welcome a better understating of the categories Staffing – with reference to being under staffed and under pressure, a likely result would be an increase in staff absence, it would be good to hear of the mitigating actions put in place. The use of plain English would be welcomed in reports, acronyms should be written in full, or supported by a glossary. Page 200 of today's meeting papers references the implications of the boundary changes could this be shared with governors please. The Chair thanked Governors for their attendance at the Board and for their vigilance in reviewing the papers.	

	The Board: - ***Noted the comments raised, and information would be provided in response.***	
P21/09/I4	**<u>Date and time of next meeting (Verbal)</u>** **Date:** Tuesday 16 November 2021. **Time:** 09:30am **Venue:** StarLeaf Videoconferencing	
P21/09/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.***	
P21/09/J	**<u>Close of meeting (Verbal)</u>**	
	The meeting closed at 13:00	