Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 21 December 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 - Perinatal Mortality Dashboard - Ockenden Update - Continuity of Carer - Maternity Self Assessment *David Purdue, Chief Nurse*	*Assurance*	15
C	**True North SA4 - PERFORMANCE**		**09:50**
C1	Ambulance Handovers *Rebecca Joyce, Chief Operating Officer*	*Assurance*	10
D	**PRESENTATION**		**10:00**
D1	Green Plan *Dr Kirsty Edmondson-Jones, Strategic Director of Estate & Facilities* *Simon Chiva, Senior Solutions Engineer, Inenco*	*Approval*	20
E	**OTHER ITEMS**		**10:20**
E1	Minutes of the meeting held on 16 November 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 25 January 2022 **Time:** 09:30 **Venue:** StarLeaf Videoconferencing	*Information*	

F	**MEETING CLOSE**	**10:35**

***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: 16 November 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	16 November 2021

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**P21/07/D2i**	**<u>Diagnostic Framework Self-Assessment – Board Leadership</u>** 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: 16 November 2021

No.	Minute No.	Action	Lead	Target Date	Update
2.	**QEC21/08/ C4i**	**<u>Safeguarding Information to Board</u>** 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**~~ **January 2022**	To be included in the Chief Nurse Update Update 12.11.2021 to be reported in January 2022 report.
5.	**P21/09/C2**	**<u>Civility Training</u>** 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**~~ **KB**	**November 2021**	**Update 16.11.2021** – update included in the Our People Update. **Action to close**
6.	**P21/09/C2**	**<u>Nursing Budgets and Establishments</u>** To incorporate an update on nursing budgets and establishments in November's Chief Nurse paper.	**DP**	**November 2021**	**Update 16.11.2021** – update included in the Chief Nurse Update. **Action to close**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	21 December 2021	**Agenda Reference:**	B1		
Report Title:	**Maternity Update**				
Sponsor:	David Purdue – Chief Nurse and Deputy Chief Executive				
Author:	Lois Mellor, Director of Midwifery David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:	3				
Report Summary					
Purpose of report:	*To provide assurance against the outcome measures for Maternity Services* *To assure the Board against the progress against action plan for the Ockenden report.*				
Summary of key issues/positive highlights:	The report shares with the Board the outcomes from the perinatal mortality review tool over the previous quarter. Highlighting the key issues which have been identified with the actions being undertaken. Sharing learning from Hospital Safety Investigation Branch reports so the Board is assured that changes are made in line with recommendations. To update the Board on the Ockenden action plan, following the review from the LMNS, which aligned with the internal self-assessment. The Board is asked to support the Trust plan to introduce Continuity of Carer. Continuity guidance has been changed to allow the roll out to be delayed until April 2023 as a result of the National Shortage of midwives. Currently our continuity of carer is suspended due to the vacancy rate.				
Recommendation:	To approve				
Action Require:	Approve	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** ***To provide outstanding care for our patients***	**TN SA2:** ***Everybody knows their role in achieving the vision***	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

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

Assurance Route	
Previously considered by:	*Board of Directors, Quality and Effectiveness Committee*

Date:	*December 2021*	**Decision:**	*Regular updates required to QEC*
Next Steps:		*Update progress to QEC*	
Previously circulated reports to supplement this paper:		None	

Monthly Board Report

November 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

1.1 Stillbirths and late fetal loss > 22 weeks

Gestation	Initial review findings	PMRT and investigation /review outcome
34+1	Attended for USS, no FH on scan. Reported change in movements antenatally. SI (report outstanding). PM shows maternal diabetes effects on placenta	Awaiting Grading
28+5	Attended with DFM 1st episode. Severely pathological CTG on admission and fetal demise whilst on CTG. SI (report outstanding) Asymptomatic of covid, detected on admission. Cause of death: Covid changes to placenta severe necrosis.	Grading of care: B & A
34+5	Had DFM 3 days, no FH on home Doppler, no FH on scan. Covid Positive. Cause of death: Covid changes to placenta	Awaiting Grading
22+5	Attended A&E with abdominal pain ?UTI x2. SI (report outstanding) one twin delivered off pathway, second on delivery suite. Cause of death: Covid changes to placenta	Grading of care: A & A
25+3	Type 1 diabetic. Hypertension. referred to FMU Sheffield. Sadly no FH when attended. Cause of death: Severe placental maternal arterial mal-fusion.	Awaiting Grading
?28/40	Un-booked and unknown pregnancy. Attended A&E with abdo pain, and then transferred to triage. No FH. Discharged against advice. Delivered at home. Attended with baby, wants no follow-up or contact to do with baby. No cause of death as investigations declined.	Review cancelled following MBRRACE discussion
22+4	DCDA twin pregnancy. Raised BMI. Attended triage with PV bleed and abdo pain. Admitted to ward. Subsequently laboured overnight and transferred to CDS. SI (report outstanding) sadly both twins born with no signs of life. Investigations pending.	Due for discussion and grading
39+6	Attended triage DFM, with tightenings. Sadly no FH. SI (report outstanding) HSIB referred. Full PM requested, awaiting reports.	Due for discussion and grading

1.2 Neonatal deaths

Gestation /age	Initial review findings care until the birth of the baby	Initial review findings of care of the baby	PMRT and investigation /review outcome
38+5	Severe hypoplastic left heart syndrome, delivered at DRI, transferred to Leeds	Cytogenetics normal, awaiting follow-up joint	Grading A & A

	for postnatal opinion. Supported by Bluebell wood until death at 12 days. Declined bereavement support	review with NNU team and FMU consultant to discuss care	
21+3	MTOP for severe spina bifida, Arnold Chiari malformation and cerebellum banna and severe bilateral ventriculomeglay. Born with signs of life.	HR detected following delivery Referred to coroner and rapid review and child response. Informed open and closed case. Awaiting investigations	PMRT Not applicable due to MTOP

1.3 Action Plan for Quarter 2

Issue	**Action**	**Plan**	**Person responsible & role**	**Target**
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	Serenity suite project to be launched.	Julie Humphries Intrapartum Matron And Bereavement Midwives	11.11.2021

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

Cases to date	
Total referrals	18 ↑ 1 case since Oct
referrals / cases rejected	4
Total investigations to date	14
Total investigations completed	12
Current active cases	2
Exception reporting	0

2.1 Reports Received since last report

None

Sharing of learning and changes made by the services in response to recommendations from HSIB

- PROMPT training days using real life case for training
- Multidisciplinary Obstetric Case review meeting weekly to learn from cases and CTG's
- Twice daily MDT safety huddles to address operational risks (oversight of the whole service)
- Twice daily consultant Lead ward rounds
- Change made to K2 (electronic patient record) to mandate risk assessments and plans of care
- Training about all forms of bias added to the CTG training day in June 2021
- Induction of labour lead to coordinate and audit the IOL service

2.4 Other identified improvements that are ongoing

- Understanding forms of bias and human factors
- Senior medical review with holistic approach

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

Jan 20	Feb 20	March 20	April 20	May 20	Jun 20	July 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
88.66%	89.01%	87.13%	86.43%	83.01%	82.45%	84.51%	84.72%	84.21%	84.07%	84.63%	85.57%
Jan 21	Feb 21	March 21	April 21	May 21	Jun 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
85.23%	83.84%	84.11%	85.45%	86.16%	86.52%	84.01%	83.16%	83.77%	83.68		

PROMPT Compliance

MDT Role	Number of staff available to train	Number of staff that have attended PROMPT	Compliance
Consultants & Staff Grades	17	17	**100%**
SPR's & SHO's	28	7	**24.13%**
Midwives	166	142	**85.5%**
Anaesthetists	32	24	**75%**
Maternity Theatre ODPs	58	16	**27.5%**
HCAs/MSWs	65	32	**49.2%**
DIVISIONAL	**367**	**238**	**64.8%**

CTG compliance

MDT Role	Number of staff available to train	Number of staff undertaken Intrapartum CTG training	Compliance %
Consultants & Staff Grades	17	14	**82.3%**
SPRs + SHOs	19	13	**68.4%**
Midwives	166	129	**77.7%**
DIVISIONAL	**202**	**156**	**77.2%**

SET E Day Compliance

MDT Role	Number of staff available to train	Number of staff SET Training	Compliance %
Consultants & Staff Grades	17	15	**88.2%**
Midwives	166	130	**75.5%**
HCAs/MSWs	65	47	**72.3%**
DIVISIONAL	**254**	**193**	**75.9%**

Concerns & Actions:

CNST

- Year 4 launched 9th August.
- PROMPT training under review following amended guidance sent out in October.

PROMPT

- Under review due to challenges as a result of a combination of vacancies within education team and difficulty releasing both faculty and staff to attend. November courses cancelled.

CTG

- Escalation of non-compliance currently being discussed with SLT.
- Agreement from SLT that due to current low compliance staff can complete ONLY the assessment tool of K2MS. This will class as compliant for the 12 months. This will be reviewed in April 2022.

SET

- SET numbers in classroom unchanged.
- Difficulty covering NLS training due to vacancies in education team.

13 December 2021
Version 1
Lois Mellor – Director of Midwifery

- Very low attendance on SET Days so cancellation of training being considered until after festive period.

The educator roles are currently vacant,

The education team are developing an interim solution to support the maternity services until a permanent solution can be arranged.

The CD has identified medical staff to support PROMPT training, however the midwifery team can only provide limited support due to the current and ongoing midwifery vacancies. There is also a national deficit in neonatal life support training (NLS), the service is looking to utilise in house training.

This is an ongoing risk for the service and has been added to the risk register.

4. Service User Voice feedback

The Bassetlaw and Doncaster MVP have merged to ensure sustainability of co production of services. The MVP group is working together to identify areas to formulate a work plan for 2022.

The Matrons and Deputy HOM speak to any users who wish to complain about the maternity service to identify areas of improvements. These users are also asked if they wish to join the MVP to work with the service on future improvements.

Women and their families use digital formats to leave feedback including Facebook, which are monitored by the senior midwifery team. The team aim to speak to any users with concerns.

The CCG's continue to work with local groups to improve feedback from local families.

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

None since the last report

7. Progress in achievement of CNST 10

Submission was completed on 20th July 2021 declaring full compliance clarification has been requested by the MIS team. Richard Parker CEO, David Purdue as Board Level Safety Champion and Lois Mellor Director of Midwifery are in contact with the MIS team after submission of further evidence of compliance.

A meeting has been arranged on the 20th Dec 2021 for further clarification of the MIS team requirements.

Year 4 standards are in progress.

Risks

Safety Action 5 – Midwifery workforce

Safety Action 7 – MVP's / User Feedback

Safety Action 8 – due the current vacancies in the education team and midwifery vacancies.

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: November 2021

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

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Oct		16%	89.7%
Nov			
Dec			

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate Oct	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	14.1%	14.6%	
	Emergency	<15.2 %	19.7	21.2%	
Preterm birth rate	≤26+6 weeks	0	0	3	
	≤36+6 weeks	<6%	8.5%	4.3%	
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.4%	2.9%	
Term admissions to NICU		<6%	3.8%	2.7%	
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.2%	0.6%	
	Instrumental (assisted)	<6.05 %	13.6%	5.3%	
Right place of birth		95%	100%	98%	
Smoking at time of delivery		<11%	12.4%	12.9%	
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		0 %	0 %	

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	Oct	59	36	0	0	0	0	0	0	0	0	0	0	0	0	0
	Nov	37	9	0	0	0	1	2	0	0	0	0	0	0	0	0
	Dec															
	Q3															

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	59	35	
2	Delay in elective work	0	2	
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

NE&Y Regional Perinatal Quality Oversight Group Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2021

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

Oct		Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Oct		16%	92.9%
Nov			
Dec			

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			Oct	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	8.7%	11.4%	
	Emergency	<16.9 %	28.3%	21.1%	
Preterm birth rate	≤26+6 weeks	<6%	0	0	
	≤36+6 weeks		7%	1.8%	
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	5.5%	7%	
Term admissions to NICU		<6%	3.9%	7.2%	
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.9%	3.1%	
	Instrumental (assisted)	<6.06 %	0%	0%	
Right place of birth		95%	100%	100%	
Smoking at time of delivery		<11%	7.1%	3.6%	
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		0%	0%	
			0 %	0%	

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	Oct	9	13	0	0	0	0	0	0	0	0	0	0	0	0
	Nov	15	5	0	0	0	0	0	0	0	0	0	0	0	0
	Dec														
	Q3														

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	18	14	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	1	0	
4	Missed/delayed care for > 60 minutes	6	1	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	1	0	

Assessed compliance with10 Steps-to-Safety

		Oct	Nov	Dec
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training			
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

		Oct	Nov	Dec
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)

	Oct	Nov	Dec
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	83% no educators in post	
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	October	November	December
Freedom to speak up / Whistle blowing themes	None	None	None
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile Midwifery Staffing Born before arrival PPH 3rd 4th degree tear	Unexpected admission to NNU False fire, smoke or intruder alarm PPH Unexpected birthweight <10th Centile PPH Delay in dispensing or supply process	
Themes from Maternity Serious Incidents (Sis)	No SI this month 2 moderate harm incidents: Uterine inversion and Patient feedback highlighted missed opportunity for earlier diagnosis of PET	No SI this month 2 moderate harm incidents Delay in care from ED perspective Historical care incident from 2020 (came in as a complaint) delay in diagnosis with PET	
Themes arising from Perinatal Mortality Review Tool	October meeting: graded 6 mortality cases all graded B and above No care concerns. Covid related changes to placentas seen in high percentage of PM/placental histology reports. Recurrent NND from MTOP – to review national guidance for feticide <22/40	November meeting graded 2 cases 1, A and A and 1, B and A No care deficits that would have changed the outcome	
Themes / main areas from complaints	Communication / staff attitudes Care pathways Delay in care	Communication / staff attitudes Care pathways Delay in care	
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	DoM listening event – lone working late community visits raised as concern – all midwives have lone worker devices	No attendees at safety champion sessions and poor uptake recently – plan to relaunch	
Evidence of co-production	Grandmother met DoM as concerned about her daughters experience in 2018 7 2019. Seen improvement in 2021 and wants to help with development of services – working with NVP & Deputy HoM	Ongoing work with MVP's - CURRENT RISK due to lack of continuity of families attending MVP meetings. BDGH & DRI groups merged to hopefully improve this	
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Live drills for obstetric emergencies due to the lack of face to face PROMPT study days	Live drills for obstetric emergencies due to the lack of face to face PROMPT study days	
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	MBRRACE reports shared with all staff WHATS HOT – delayed due to work commitments	WHATS HOT shared with HSIB incidents from June and July of this year All SI and moderate harm reports printed and shared with staff in all areas	

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						

Ockenden Action Plan Update

December 2021

IEA Action	Plan	Target date	RAG	Lead	Comments / Progress
1	PMRT reviews with MDT review	In place			
	MSDS submission full compliance	Achieved			
	100% compliance with ENS cases	Achieved			
	Minimum dataset submitted to Trust Board on a monthly basis	In place			
	Quarterly reporting to LMNS of all SI & HSIB cases			CG MW & Obs Lead	Meetings timetabled
	MDT support for peer review of SI's within the LMNS			CG MW & Obs Lead	Meetings timetabled
2	Senior advocate role to be developed	National			
	Further development of MVP's and co-production of maternity services			DHoM & NED	MVP's combined to assist with work plan
	Exec Director and NED in place as safety champions	Completed			David Purdue – Board Level safety Champion Pat Drake – NED Posters in all areas
	NED has monthly meetings with MVP's			NED	PD made contact with MVP's to arrange meetings
	NED to attend Children & Families Board			DoM	PD now invited to C & Families Board
	Actions logs in place for safety Champion meetings	In place		DoM	
3	PROMPT training in place			TBC	Education team now has vacancies Jobs out to advert Interim solution needs to be put in place Training been cancelled in Nov & Dec 2021
	Skills drills in place			TBC	
	Twice daily Consultant Led MDT ward rounds			CD/ DD	
	Ward Rounds audited			TBC	

Lois Mellor – Director of Midwifery
Version 1

	External funding ringfenced for training			Board safety Champion	
	➢ 90% of staff trained			TBC	Currently 84% , positon may worsen due to training team vacancies
4	Risk stratification in place at booking			ANC Manager & CD	
	Identified maternal medicine centre in the ICS			TBC	
	New guideline for maternal medicine pathways			TBC	
	Audits in place to assess compliance with above			TBC	
5	Risk assessments documented and place of birth			IT Midwife	Now mandated in K2 system Audit needs to be completed on compliance
	Audits in place to check compliance			TBC	
6	Full compliance with SBLCB v2				
	2 x 0.4 WTE CTG midwives in place				
	Obstetric lead for fetal monitoring				
	Weekly OCR meetings in place			Fetal monitoring MW	
	PROMPT / CTG training in place (IEA 3)			Education Leads	At risk
7	Trust website with information to assist with informed consent	RW		NEEDS IT LEAD	LM to review and consider options for redesigning of the website Information on handheld devices in K2 for access by women
Section 2					
	BR+ assessment undertaken			DoM & Chief Nurse	Reassessment in Jan 2022 booked
	Plan to achieve BR+			DoM	
	Confirm there is a HOM/ DOM accountable to the exec director			Chief Nurse	
	Meets strengthening midwifery leadership			DoM	

	More Consultant Midwives			DoM	Business case for 2022/23
	Specialist midwives in place			DoM	22/23 Workforce model in development to meet and support the maternity transformation programme
	Strengthening & supporting sustainable leadership in education and research			DoM	New research midwife in post
	Professional support in the appointment of midwife leader			DoM	
	Guidelines in line with NICE guidance	EM / ?			
Audits Required					
	PMRT Reviews	100%		Bereavement MW	
	HSIB	100%		Gov MW	
	NHSR	100%		Gov MW	
	Ward Rounds twice daily (day & night / 7 days a week)	100%		CD & DD	
	Named Consultant for women referred to maternal medicine	1% notes			
	Women with complex have early specialist involvement & management plan	1% notes			
	Audit of all SOP related to complex pregnancy				
	Personal care and support plans in place risk assessment & place of birth risk assessment	1% notes			
	Women's participation & informed choice	1% notes			
	Reference made to how women's choices are respected and evidenced	5% notes			

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Purpose of Report: For Board adoption and subsequent monitoring of a plan to achieve Midwifery Continuity of carer as the default model of care.

Continuity of Carer Report Maternity			
Agenda item:		**Enclosure Number:**	
Date:			
Title:	**Plan to Board for Default Midwifery Continuity of Carer (MCoC)**		
Author /Sponsoring Director/Presenter	Lois Mellor – Director of Midwifery		

Purpose of Report		Tick all that apply ✓	
To provide assurance	√	For discussion and debate	√
For information only		For approval	√
To highlight an emerging risk or issue		For monitoring	√

Summary of Report: *(Include key points and additional information as necessary regarding purpose of report- amend for your situation)*

This paper outlines:

- Background
- Current position including
  - Activity
  - Imports and exports
  - Current staffing
- Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
- Framework of activities that will ensure readiness to implement and sustain MCoC
- Time frame and monitoring process.

Recommendation:

- Accept the contents of this report
- Support maternity service in delivery of transformed model of care.
- National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review
- Provides XY or Z for staffing/equipment or estate requirements
- *Amend or add to as appropriate for your organisation*

Background:

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Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks (see appendix/ A for assurance framework) are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

What does it mean to offer Midwifery Continuity of Carer as the 'default model of care'?

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be in a position to receive continuity of carer, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.

As a first step, Local Maternity Systems (or and neonatal systems) agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022; so that Continuity of Carer is the default model of care offered to all women. This plan will include:

- The **number of women** that can be expected to receive continuity of carer, when offered as the default model of care
- **When** this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision, that is phased alongside the fulfilment of safe staffing levels
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity
- How **rollout will be prioritised** to those most likely to experience poor outcomes, including the development of enhanced models of continuity of carer
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set
- **Building blocks** that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.

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Current position:

- Current bookings – 3663 at DRI and 1347 at BDGH
- Current predicted births will be 3113 at DRI and 1145 at BDGH (Total – 4258) Of these
    - Currently a small number of women have AN and PN care only at DRI but who go out of area to give birth. This is usually because the other hospital is geographically closer to their home address. However BDGH tend to import women from other providers and provide only intrapartum care. These women will not be able to have MCoC because not all elements of care are provided by DBTH.
- Our current midwifery staffing position is challenging with 30 WTE vacancies we are continuing to recruit when possible, and are progressing international recruitment to increase the number of midwives. Birthrate plus reassessment is booked for Jan 2022 to update our staffing requirements to implement MCoC.

The Plan:

DBTH aims to provide MCoC to 4234 out of 4515 number of women. The remainder of the women receive care from other maternity services and are unlikely to change their position due to being located out of area. Out of these 5.4 % at DRI and 3% at BDGH are Black, Asian, or Mixed ethnicity and live in central Doncaster. (Describe *here about what approach you are going to take to target these women dependent on your local situation).* We have x% (*number*) of women that do /do not live in a postcode from there bottom decile of deprivation (*describe here what you will do to capture your poorest women*).

MCoC teams will be prioritised for roll out in the highest areas of Black, Asian and Mixed ethnicity populations and the postcodes of the lowest deciles as mapped in our Perinatal Equity and Equality Analysis. This ensures that we target women who are most likely to experience adverse outcomes first.

The planning guidance sets out that building blocks need to be in place prior to and during rollout of MCoC. They are set out as a readiness to implement and sustain MCoC assessment framework (appendix A of the planning guidance and this document). This provides an opportunity to RAG status all the building blocks that need to be in place to achieve and monitor sustained transformation. These building blocks are the key elements in the plan to roll out MCoC from the current position to default MCoC for most women.

Safe staffing:

The maternity service has funding for birthrate plus recommendations, however the service currently has significant vacancies. There are currently 30+ WTE vacancies despite significant recruitment drives, there is a background of a national shortage of midwives.

The service is continues to strive for full recruitment of midwives by ongoing adverts for Band 5 & 6 midwives, and undertaking international recruitment for eight midwives. Mitigation is in place to manage the risk of the ongoing vacancies.

McoC is currently paused at DBTH due the current vacancy position and will not be recommenced until the service 10 WTE vacancies or less. This is to ensure that any further launch of MCoC is successful and sustainable. The service will review this position on a quarterly basis, and make a risk assessment about recommencing MCoC. Once the service is near to the agreed recruitment levels the service will recommence the roll out plan, including engaging unions and HR.

Planning spreadsheet demonstrating who will receive care where and ratios to evidence safety
You can use the one in the toolkit

We will develop our plan over five waves with a total of eleven teams. Based on best evidence our MCoC teams will comprise of mostly mixed risk geographically teams, where the lead midwife will follow the woman as necessary/ appropriate where specialist input is required.

This will enable the service to ensure that the teams are stable, and sustainable before moving to the next phase. This will enable us to consider teams with a high proportion of clinical high-risk women. We also want to manage the flow well by keeping the system as simple as possible – each midwife picking up 3-4 women per month and birthing 3 women per month, in this way we know that every woman will have a midwife at any given time.

We have used the NHSE/I toolkit to plan the phased role out. (Appendix B). This will demonstrate, time frames for roll out, recruitment plan – (how many midwives and when). The toolkit account for staffing ratios, demonstrating planned safe staffing at any given time during this process, providing assurance that appropriate staffing ratios have been considered in this plan.

Before we can commence phased roll out of MCoC we need to recruit 20 WTE midwives. This represents wave one. In order to proceed to phase two we need to maintain the midwifery staffing levels, and continue to recruit midwives with an aim to be fully recruited as soon as possible.

We intend to under-take an evaluation at each phase to check that all our systems and processes work as per plan. We also want to observe if there are any emerging patterns such as a reduction in foot fall in postnatal ward/triage etc. We want to check there are no unintended consequences. At each phase we will use the PDSA cycle to consider if our plans need amending and make any changes accordingly.

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The calculations on the spreadsheet show that we do not require extra midwives, in addition to the Ockenden funding midwives. However this will be reviewed once the BR + assessment is received in early 2022.
Review Process
1. Quarterly review at board for assurance and escalation. *2.* Oversight via LMNS and region for assurance.

Appendix A Readiness to implement and sustain MCoC assessment framework:

Item	Detail/Notes	RAG
	The plan needs to written first and presented to board. The remainder of the work should roll out in accordance to specific Trust needs. Work that is already in place should not need to cease unless there is an urgent reason to do so.	
Planning spreadsheet	Demonstrates safety from a staffing perspective: • How many women can receive MCoC -reviewing in area and out of area, cross boundary movement. • Where women are cared for at any given time, now and in MCoC models (see NHSE/I toolkit for example of this. • Midwifery deployment plan for MCoC including timescales and recruitment plan for a phased scale up to default position.	
Safe Staffing	• How many midwives required • How many in post • Recruitment plan to optimal midwifery staffing with time frames	
Communication and engagement	• Provides evidence of staff engagement and logs responses/counter responses • Gives opportunity to share vision • Whether or not you plan to do a consultation	
Skill mix	• Review of skill mix, including number of band 5 midwives placed in MCoC team. B5 midwives those working in the core ensuring appropriate support throughout. Band 5 (usually 1 per team) report being very well supported whilst undertaking preceptor programme. • Appropriate and planned use of MSW particularly in teams working in areas of greatest need. • Ensure preparedness of band 7 DS coordinators to support programme of change.	

Training	Each midwife has planning on working in the team has a personal Training Needs Analysis (TNA) examples planned for the tool kit or existing ones can be used.	
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working. Consider organisational development support	
Linked Obstetrician	Has there been obstetric involvement and linked obstetricians identified? Is the referral to obstetrician process clearly set out in the SOP as well as other clinical guidance?	
Standard Operating Policy (SOP)	Each Trust needs a SOP that outlines roles and responsibilities to support delivery of care in this way, it should pass through the maternity service governance processes as with other guidance documents.	
Pay	RCM requests that no midwife should be financially disadvantaged for working in this way. Each Trust needs to review and manage but there is helpful information in the NHSE/I toolkit	
Estate and equipment	Place for midwives to see women. Equipment with which to provide care. Where problems are encountered this should be escalated at Trust Board quarterly review and to ICS.	
Evaluation	There will be local, regional, and national evaluation and reporting in place. Is there a system for this to occur smoothly?	
Review Process	Date for initial plan to be review by Trust Board. Quarterly review dates set. Dates set for LMS and regional and national review.	

Appendix B – Staffing deployment plan to deliver MCoC with dates and recruitment plan.

	midwifery staffing	Deployment of midwives	Women on path	bookings and remaining women	Deliveries: % receipt C of C and remaining women
Starting position	**146.35 budget=BR+**		**0%**	**3500**	**3500**
C of C team	0	0	0		
CDS	49.5	8.5			
ANAU	1.8				
AN ward	13.4	2.3			
PN ward	19.8	3.4			

community	29.55	ratio 1 to 118			MSW
ANC	3				
specialists	16.4				
managers 7	4.2				
managers 8a up	4				
TOTAL	**141.65**				
Wave 1	**1 teams**	202	**5.70%**	3298	**5.70%**
C of C team	7.2	0	0		
CDS	47.5	8.1			3298
ANAU	1.8				
AN ward	13.4	2.3			
PN ward	19.8	3.4			
community	27.55	ratio 1 to 119			MSW
ANC	3				
specialists	15.4				
managers 7	4.2				
managers 8a up	4				
TOTAL	**143.85**				
Wave 2	**3 teams**		**22.00%**		**22%**
C of C team	21	0	588+202=790		504+202=706
CDS	41.18	7.1			2794
ANAU	1.8				
AN ward	11.6	2			
PN ward	17.4	3			
community	26	ratio 104			MSW
ANC	3				
specialists	15.4				
managers 7	4.2				
managers 8a up	4				
TOTAL	**145.58**				

Wave 3	5 teams		39%		35%
C of C team	35	0	1176+202=1378		1008+202=1210
CDS	34.8	6.1			2290
ANAU	1.8				
AN ward	11.6	2			
PN ward	17.4	3			
community	20	ratio 106	2122		MSW
ANC	3				
specialists	14.4				
managers 7	4.2				
managers 8a up	4				
TOTAL	**146.2**				

Wave 4	7 teams		59%		50%
C of C team	49	0	2058		1764
CDS	31.9	5.5			1736
ANAU	1.8				
AN ward	11.6	2			
PN ward	17.4	3			
community	13	ratio 110	1442		MSW
ANC	2				
specialists	12				
managers 7	4.2				
managers 8a up	4				
TOTAL	**146.9**				

wave 5	11		92%		79%
C of C team	77	0	3234		2772
CDS	17.4	3			728
ANAU	1.8				
AN ward	11.6	2			
PN ward	14.5	2.5			

community	3	ratio 110	300		MSW
ANC	1				
specialists	12				
managers 7	4.2				
managers 8a up	4				
TOTAL	**146.5**				

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Doncaster & Bassetlaw Teaching Hospitals Foundation Trust – Continuity Action Plan Maternity

December 2021

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion	Embedded test outcome and date (Initially at 3 months from completion)
1.1	Continuity of Carer (CoC) should be the default model of care by March 2023	Continue to recruit to BR+ recommendations (funded establishment) for midwives & MSW	Lois Mellor DoM	October 2022			
1.2		Undertake engagement work with the midwives, medical staff and the RCM		Summer 2022			
1.3		Provide psychological training for the midwives to support them to deliver CoC	LMNS	Summer 2022			

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion	Embedded test outcome and date (Initially at 3 months from completion)
1.4		Undertaken training needs analysis for all midwives who are moving to CoC models	Stacey Potter	3 months prior to creation of the team			
1.5		Deliver training requirements of the midwives prior to them working in CoC teams	Stacey Potter / Education team	Before working in the CoC models			
1.6		Monthly assessment of staffing levels for commencement of CoC with quarterly report to board	Lois Mellor	Ongoing			
2.1	Deployment of teams	Aim to deliver CoC in the areas of highest deprivation and BAME population first	Charlotte Standing	Autumn 2022			
2.2		Consider deploy team in cohorts to support each other	Charlotte Standing	Autumn 2022			
		Ensure teams are stable and sustainable before deploying further teams	Charlotte Standing / Lois Mellor	TBC			

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion	Embedded test outcome and date (Initially at 3 months from completion)
3.1	Evaluation of the deployed teams	Ensure that data sheets are completed	CoC midwives & Stacey Potter	When teams established			
3.2		Collect outcome data for all women on the CoC pathway		When teams established			
3.3		Collect families feedback who are in receipt of CoC	Stacey Potter	When teams established			

Maternity Self Assessment Action Plan

UPDATED 5TH Nov 2021

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		On the Hive			
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes					
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		DoM JD			
		Agenda for change banded at 8D or 9		DoM JD			
		In post		Lois Mellor in post			
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		DoM and GM JD's	CD line management to be reviewed		Eki Emovon
		Clinical director to executive medical director		Not for CD ?	Review CD JD		Eki Emovon
		DoM to executive director of nursing		DoM JD			
		General manager to executive chief operating officer		GM JD			
		Maternity services standing item on trust board agenda as a minimum three- monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Perinatal surveillance tool and narrative report			Lois Mellor & David Purdue

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Tool sent to Board monthly			Lois Mellor & David Purdue
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Perinatal surveillance tool at board meetings monthly			Lois Mellor & David Purdue
		There should be a minimum of three PAs allocated to clinical director to execute their role			Review CD job plan		
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team					
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		HR Business partners in place Assurance meetings with Matrons	Set up monthly meetings Meetings commenced on 2nd Nov weekly meetings with matrons and ward managers & DoM / DHoM. Business partners , eroster etc supporting		Lois Mellor
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		Finance Business partner in place			Scott Sykes
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area			Set up Monthly meetings with Finance, HR and E Roster Sep	Dec 2021	Scott Sykes
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways					
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Gov Meeting mins Perinatal Meeting SMT			

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		Mixed			
		Leadership culture reflects the principles of the '7 Features of Safety'.			Continue culture work with MDT Consider external facilitation to improve culture	April 2022	Eki Emovon & Lois Mellor
	Leadership development opportunities	Trust-wide leadership and development team in place			OD in place		
		Inhouse or externally supported clinical leadership development programme in place			Mixed offer New offer starting in 2022		Jane Collingwood
		Leadership and development programme for potential future talent (talent pipeline programme)					Jane Collingwood
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		University modules RCM leadership programme			
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy			???		
		Organisational vision and values in place and known by all staff		True North			
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]			HR Policies in place Trust Values and behaviours in place		
		Maternity strategy in place for a minimum of 3–5 years		David leading on	Develop a Maternity strategy with the MDT Scoping starting in Jan 2022	Dec 2021	David Purdue

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
	Maternity strategy, vision and values	Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan					David Purdue
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.				April 2022	David Purdue & Sarah Ayre
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]				Jan 2022	Sarah Ayre & MVP chairs
		Maternity strategy aligned with trust board LMNS and MVP's strategies				April 2022	Lois Mellor & Manju Singh
		Strategy shared with wider community, LMNS and all key stakeholders				April 20222	Lois Mellor
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		Pat Drake in post	Pat Drake retiring in March 2022 New NED needs appointing to take over		
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Meeting mins			Pat Drake & Sarah Ayre
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		In progress			

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		QEC meeting	Ockenden progress, CNST progress and MVP action plan presented regularly at QEC		Pat Drake
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		In progress			Lois Mellor & Manju Singh
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		Meetings in place but nor chaired by the Triumvirate		June 2022	Lois Mellor & Manju Singh
		Record of attendance by professional group and individual		Mixed			Admin
		Recorded in every staff member's electronic learning and development record			Linked to ESR & Log books		??
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		In place			Education teams
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority					
		All staff given time to undertake mandatory and job essential training as part of working hours		Need to check medical staff			
		Full record of staff attendance for last three years		ESR records			Education Leads

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Record of planned staff attendance in current year					Education Leads
		Clear policy for training needs analysis in place and in date for all staff groups		Annual TNA			
		Compliance monitored against training needs policy and recorded on roster system or equivalent		E Roster ESR			
		Education and training compliance a standing agenda item of divisional governance and management meetings		Governance meeting minutes			Governance Midwife
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		PROMPT attendance MDT	Faculty in place Education lead posts vacant at present – alternative plan to continue education being considered		CD & DD DoM
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal					CD & DD DoM
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation					
		Compliance with annual appraisal for every individual		In progress but delayed			All Line managers
		Professional validation of all relevant staff supported by internal system and email alerts					
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Trust Appraisal Document Strategic Objectives			All Line Managers

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings					Governance Midwife & Divisional Governance Lead
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups		RCM to be invited to all interviews Band 7 and above	Senior appointments have MDT interview process		DoM CD & DD
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place					HR Department
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures		Led by Midwives			
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints					
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		PMA and matrons for midwives	Medical staff offer ?		DD & CD DoM
		Schedule of attendance from multiprofessional group members available					
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.		No medics			Sarah Ayre & MVP chairs
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design			Doncaster and Bassetlaw MVP groups merged to support and sustain chairs and ongoing work		Sarah Ayre
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users					Sarah Ayre

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		QI Strategy			
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		QI projects undertaken			QI team & relevant clinical leads
		Identification of the source of evidence to enable provision of assurance to all key stakeholders					
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access			All items stored on the B drive (shared) however some access is restricted		
		Clear communication and engagement strategy for sharing with key staff groups					
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements					
		Weekly/monthly scheduled multiprofessional safety incident review meetings			Incident review meeting set up weekly and lead by the governance midwife OCR meeting weekly		Governance Lead and Governance Midwife
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS					Governance Lead and Governance Midwife
		Positive and constructive feedback communication in varying forms					
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]			DoM. Deputy HoM, Matrons and managers support staff CD & DD together with Obs leads provide support for medical staff Needs formalising		
		Schedule of focus for behavioural standards framework across the organisation					
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month					???
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]					DD CD & DoM
		All policies and procedures align with the trust's board assurance framework (BAF)					
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		Risk Management Policy			
		Staff across services can articulate the key principles (golden thread) of learning and safety					
		Staff describe a positive, supportive, safe learning culture		Culture survey undertaken recently with mixed results			
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		JD's	Governance & Risk Midwife in post Divisional Governance lead in Post Risk and Audit Midwife to go for job matching		

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Gov MW JD under review to 8A Risk MW B7 Jd being job matched No practice development midwife Admin place Cons – no. of PA's ? Clinical educator posts in place Recruitment and Retention Post matron Pastoral care midwives (temporary	Risk Governance post now 8A No clinical educators at present (posts vacant or LTS)	DoM & CD	
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Matron			
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales			Extensions to timescales occasionally required		
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF					
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF					
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board					
		Mechanism in place for trust-wide learning to improve communications					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication					
		Governance communication boards					
		Publicly visible quality and safety board's outside each clinical area					
		Learning shared across local maternity system and regional networks					
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups					
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.					
		Multi-agency input evident in the development of the maternity specification					
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process					
		In date and reflective of local maternity system plan					
		Full compliance with all current 10 standards submitted					
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.			Awaiting the outcome of the year 3 submission		
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines					
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.					
		All guidance NICE complaint where appropriate for commissioned services					
		All clinical guidance and quality standards reviewed and updated in compliance with NICE					
		All five elements implemented in line with most updated version					
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.					
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan					
		All four key actions in place and consistently embedded					
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy					
		All actions implemented, embedded and sustainable					
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE			2 x 0.4 WTE in post		
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs			Consultant Obstetricians in post		
		Plan in place for implementation and roll out of A-EQUIP					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		1 PMA currently 2 further qualified & 1 further on course this year			
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		Training plan in place			
		Service provision and guidance aligned to national bereavement pathway and standards					
	Maternity bereavement services and support available	Bereavement midwife in post					
		Information and support available 24/7					
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities			Bereavement suite to be created on level 3 with the refurbishment of M2 commencing late 2021 completion early 2022		
		Quality improvement leads in place		In Trust			
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation					
		Recognised and approved quality improvement tools and frameworks widely used to support services					
		Established quality improvement hub, virtual or otherwise					
		Listening into action or similar concept implemented across the trust	? ? ? ?				
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan					
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)					
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees					
		FTSU guardian in post, with time dedicated to the role					
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		FTSU Guardian in post			
	Human factors training available	Human factors training part of trust essential training requirements					
		Human factors training a key component of clinical skills drills					
		Human factors a key area of focus in clinical investigations and formal complaint responses					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.			Ward Rounds in place Recent audit showed inconsistent attendance		
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern			Process in place – compliance inconsistent		
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's			Twice daily huddles in place at 10.00 and 15.30 MDT attendance achieved inconsistently		
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date			Huddles in place at 10.00 & 15.30 SOP needs writing		
		Audit of compliance against above					
		Annual schedule for Swartz rounds in place					
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time					

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
		Broad range of specialties leading sessions					
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse					
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit					
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		Sharing how we care			
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes					
		In date business plan in place			Business plan reviewed at accountability meetings		
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance					
		Business plan supports and drives quality improvement and safety as key priority					
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups					
		Consultant job plans in place and meet service needs in relation to capacity and demand					
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans			In place ? have PA's in job plans		

Area for improvement	Description	Evidence	RAG	Action Plan to achieve Compliance Or Evidence of compliance	Progress	Target Date	Lead
System plan)		Business plans ensures all developments and improvements meet national standards and guidance					
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.					
		Business plans include dedicated time for clinicians leading on innovation, QI and Research					
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.					
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.					
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.					

Glossary of Terms for Maternity

CTG	Cardiotocography (a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour)
FH	Fetal Heartbeat
FMU	Fetal Medicine Unit, specialist tertiary centre for complex pregnancy
MTOP	Medical Termination of Pregnancy
HSIB	Healthcare Services Investigation Branch
MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	21 December 2021	**Agenda Reference:**	C1		
Report Title:	**Ambulance Handovers**				
Sponsor:	Rebecca Joyce, Chief Operating officer				
Author:	Andrea Squires, Divisional Director of Operations for Urgent & Emergency Care				
Appendices:	N/A				
Report Summary					
Purpose of report:	To provide information and assurance in relation to actions ongoing to improve the number of patients waiting more than 15 minutes for ambulance handover from time of arrival				
Summary of key issues/positive highlights:	• NHSE (2020) guidance states that ambulance handovers should reliably be completed within 15 minutes and that an handover escalation process should be enacted where time to handover exceeds or is likely to exceed 30 minutes • The current national standards state that all patients should be handed over within 15 minutes with none waiting over 30 minutes for handover • Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trusts (DBTH) current performance for patients waiting less than 15 minutes for ambulance handover is 42.18%, with 33.37% of patients waiting over 30 minutes • Doncaster Royal Infirmary (DRI) are currently the 4th highest reporting Trust for 30-60 minute ambulance handover breaches in Yorkshire, whilst Bassetlaw District General (BDGH) Hospital are in position 22 • Key actions are being implemented immediately to ensure ambulance handover times across DBTH are in accordance with national guidance and ensures patients receive safe and high quality care • Further work around pathways such as Same Day Emergency Care is also being completed to improve ambulance handover times as part of the UEC Recovery and Transformation programme • The month of November has already seen an improvement in the number of patients waiting less than 15 minutes for ambulance handover as a result of this work • This paper will provide a monthly update against national standards and highlight improvements moving forwards				
Recommendation:	For information/assurance purposes only				
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:	*Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation*
Corporate risk register:	*Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6* • *Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards* *Report outlines actions plan to make progress on this specific requirement related to ambulance handovers, no change to risks on CRR*
Regulation:	NHS England (2020) Reducing Ambulance Handover Delays: key lines of enquiry
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:		Divisional Management Board for Medicine	
Date:	15/12/21	**Decision:**	TBC
Next Steps:		Continued monitoring of recovery & associated action plans at Divisional Management Board for Medicine, Finance & Performance Committee and monthly escalation to Board. Work forms part of Urgent and Emergency Care Programme.	
Previously circulated reports to supplement this paper:		N/A	

Doncaster Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 35.17% for Doncaster.

Current Trend: Performance against the Ambulance handover within 15 minutes has seen an improvement over the month of November with 54 additional patients handed over within 15 minutes of arrivals in the final week compared to the first week.

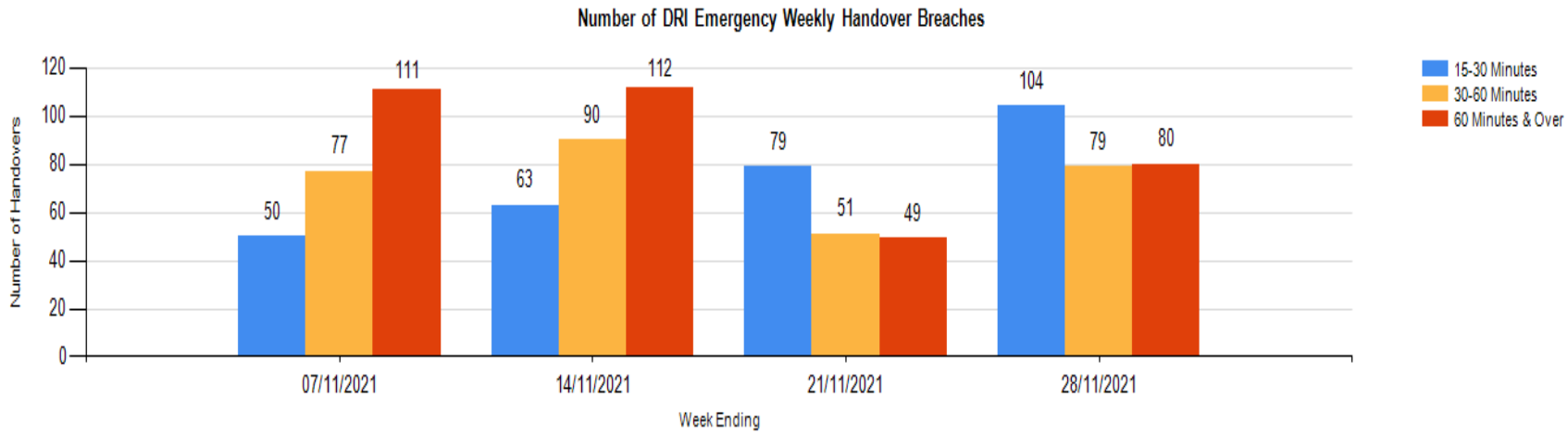
Metric Owner: Divisional Director of Operations (DDO) for Urgent & Emergency Care

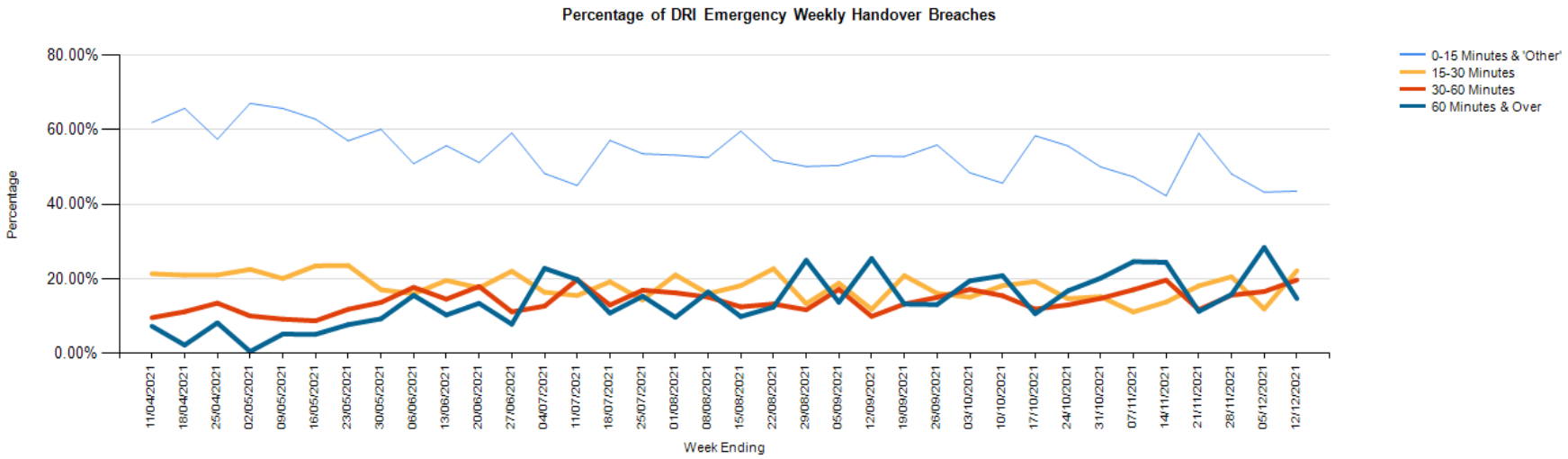
Metric: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes

Desired Trend:

November Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 30 minutes	Longest Wait (hrs & minutes)
Nov 2021	**Doncaster**	1982	49.60%	15.24%	35.17%	6 hrs 22 mins
	Bassetlaw	730	22.05%	49.45%	28.49%	2 hrs 51 mins
	Trust	2712	42.18%	24.45%	33.37%	N/A





Key associated metrics that also support the standard:	
>15 minutes Time To Initial Assessment (TTIA)	November performance was 55% against the 95% target. This is a deterioration from 62% reported in October. Delays are expected over the winter period and a UEC recovery action plan is in place to improve delays at the ED front door.
Average Length of Stay (LoS) in ED	Average time in department for November was 275 minutes against the 240 minute target. This is a deterioration from 263 minutes reported in October. The Patient Flow Steering Group will focus on reducing length of stay
>12 hours in ED from Arrival	November performance was 6.34% which is slightly above the national standard of 5% target. This is a deterioration from 5.76% reported in October. Delays are impacted by a current Trust bed occupancy of 98%. The Patient Flow Steering Group will focus on reducing LoS.

Bassetlaw Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 22.05% for Bassetlaw. **Current Trend:** Performance against the Ambulance handover within 15 minutes has seen an improvement over the month of November with 3 additional patients handed over within 15 minutes of arrivals in the final week compared to the first week.	**Metric Owner**: Divisional Director of Operations (DDO) for Urgent & Emergency Care **Metric**: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes **Desired Trend**: ↑

November Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 30 minutes	Longest Wait (hrs & minutes)
Nov 2021	**Doncaster**	1982	49.60%	15.24%	35.17%	6 hrs 22 mins
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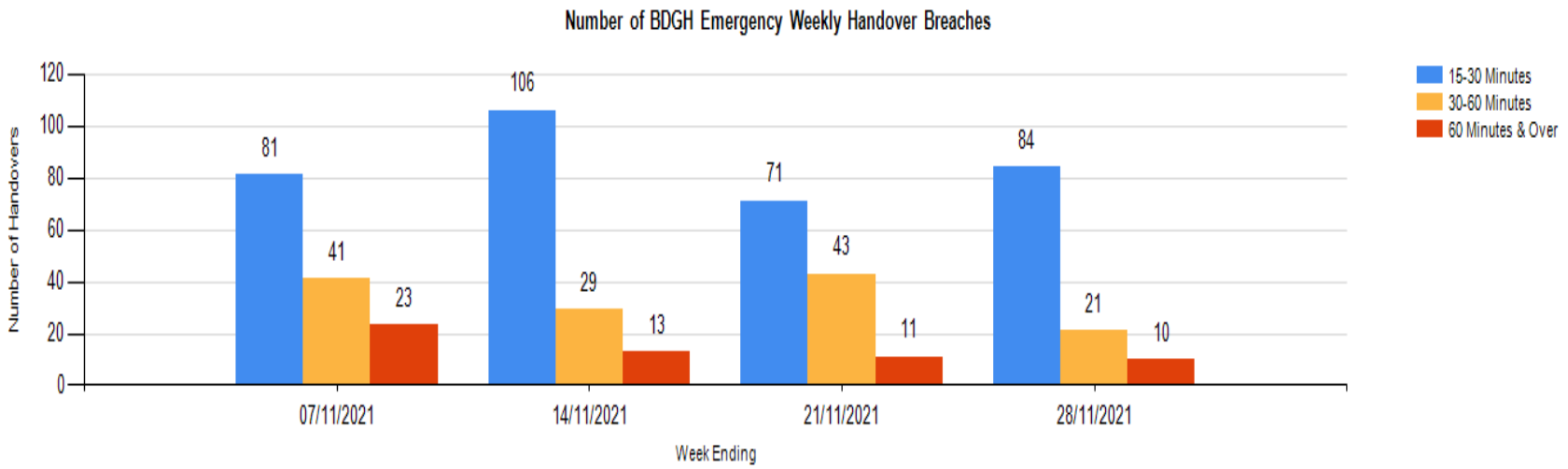
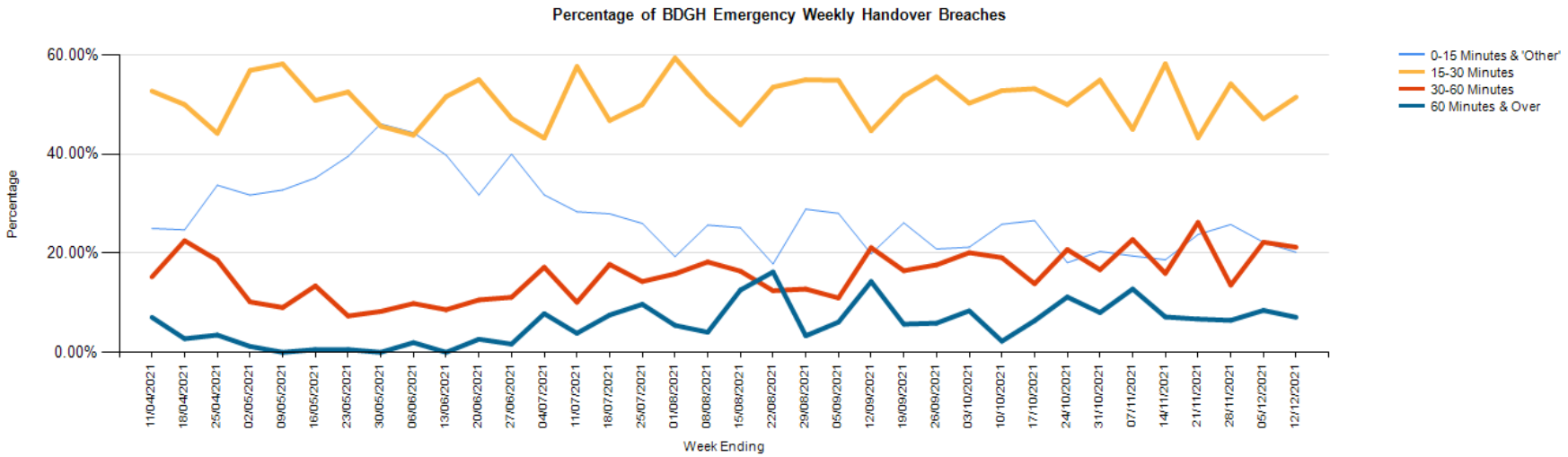




Key associated metrics that also support the standard:	
>15 minutes Time To Initial Assessment (TTIA)	November performance was 60% against the 95% target. This is an improvement from 56% reported in October. Delays are expected over the winter period and a UEC recovery action plan is in place to improve delays at the ED front door.
Average Length of Stay (LoS) in ED	Average time in department for November was 202 minutes against the 240 minute target. This is in line with the 202 minutes reported in October and better than the national standard.
>12 hours in ED from Arrival	November performance was 1.53% which is better than the national standard of 5% target. This is an improvement from 2.12% reported in October. Delays are impacted by a current Trust bed occupancy of 98%. The Patient Flow Steering Group will focus on reducing LoS.

Key Summary & Actions: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Top contributor	Potential Root Cause	Countermeasure	Owner	Due Date
Pre-hospital / Front Door Issues	• Difficulty accessing primary care services for advice and guidance • Difficulty accessing assessment services for advice and guidance • Difficulty accessing community response services	• Additional GP hours in urgent primary care to support ambulance crews where discussion needed with GP • Extend Same Day Health Centre offer to YAS and South Yorkshire Police for patients that need minor injuries support • Pilot with new geriatrician at DRI to support conveyance avoidance particularly around frailty • Work underway to promote the Rapid Response service with ambulance crews • YAS direct pathway to medical and surgical same day emergency care services now implemented, to be duplicated at Bassetlaw • Single point of access for GPs to facilitate direct admission to medical and surgical same day emergency care services • Early senior review in ambulance bay to identify patients suitable for medical and surgical same day emergency care services and fit to sit • Implement Screening and Redirection tool, supported by signposting away and early senior review	Fylde Coast Medical Services (FCMS) FCMS DDO for UEC / Care of the Elderly Consultant CCG DDO for UEC / Clinical Director (CD) DDO for UEC / CD DDO for UEC / CD DDO for UEC / CD	Dec-21 Dec-21 Dec-21 Dec-21 Dec-21 Dec-21 Dec-21 Dec-21
Patient Flow issues	• Current Trust bed occupancy of 98% resulting in lack of available beds to move patients into from ED • Increased LoS across the Trust (7,	• Re-configuration of acute medicine to include re-location of 12 beds to existing Early Assessment unit in ED to become an Acute Medical Decisions Unit resulting in an additional 12 beds for Care of the Elderly and General Medicine	DDO for UEC / CD	Dec-21

	14 and 21 days) • Lack of available beds in community	• Additional 10 beds to be opened on Ward 22 for respiratory patients • A full review of the Discharge Lounge to increase capacity to support decompression of ED in a morning has been completed • Implementation of Criteria to Reside, Red to Green, and MDT Long Stay Wednesday walk-arounds aim to reduce LoS and increase discharges • Mutual aid is also in aid at Place and across SYB • Partnership winter plans to identify additional community bedded capacity and increased care homes and domiciliary care capacity	DDO for UEC / CD DDN for Medicine DDNO (new post) Chief Operating Officer (COO) COO	Dec-21 Dec-21 Jan-22 Dec-21 Dec-21
Operational Grip and Escalation	• Lack of awareness of new clinical national standards for emergency care • Lack of awareness of Trust position for ED and on call teams • Delays in escalation process within and outside of ED	• Trust wide roadshow to share new clinical standards for emergency care • Development of new Inter-professional standards for emergency care • Development of Clinical Harm Review for patients waiting longer than 60 minutes for ambulance handover • Fully revised Emergency Care Escalation Protocol incorporating an Ambulance Handover Escalation Protocol • Fully revised Trust OPEL policy • Development of guidance and training for all on call managers	DDO for UEC DDO for UEC DDO for UEC DDO for UEC COO COO	Dec-21 Dec-21 Dec-21 Dec-21 Dec-21 Dec-21
Improving accuracy of handover data between YAS / DBTH	• Delays in entering handover pin to confirm handover has been completed due to competing other tasks • Previous ‘double pinning’ system	• Daily validation of ambulance handovers to re-commence with a monthly report to highlight any difference in handover time recorded • ‘Double pinning’ system to be re-commenced to ensure crews pin out prior to leaving the	DDO for UEC YAS/DDO	Dec-21

	stopped pre-Covid as automatic system was being trialed. This was never implemented due to Covid-19 pandemic • Internal daily validation was stood down as a result of the above	department and DBTH staff also pin out to confirm handover time. Supporting Protocol to be developed • YAS to share data and investigate why the time stamp is no longer visible on the Electronic Patient Record Form (EPRF) • Monthly meetings to be held with YAS/DBTH operational teams • NHS England and Emergency Care Intensive Support Team to undertake site visits across South Yorkshire and Bassetlaw to ensure consistent approach	DDO for UEC YAS DDO for UEC	Dec-21 Dec-21 Dec-21 Jan-22

Doncaster and Bassetlaw Teaching Hospitals – The Green Plan

Simon Chiva | Senior Solutions Engineer, Inenco

Dr Kirsty Edmondson-Jones | Strategic Director of Estates & Facilities

Agenda.

- Introduction
- The Green Plan
- Priority Interventions
- Next Steps

Introduction

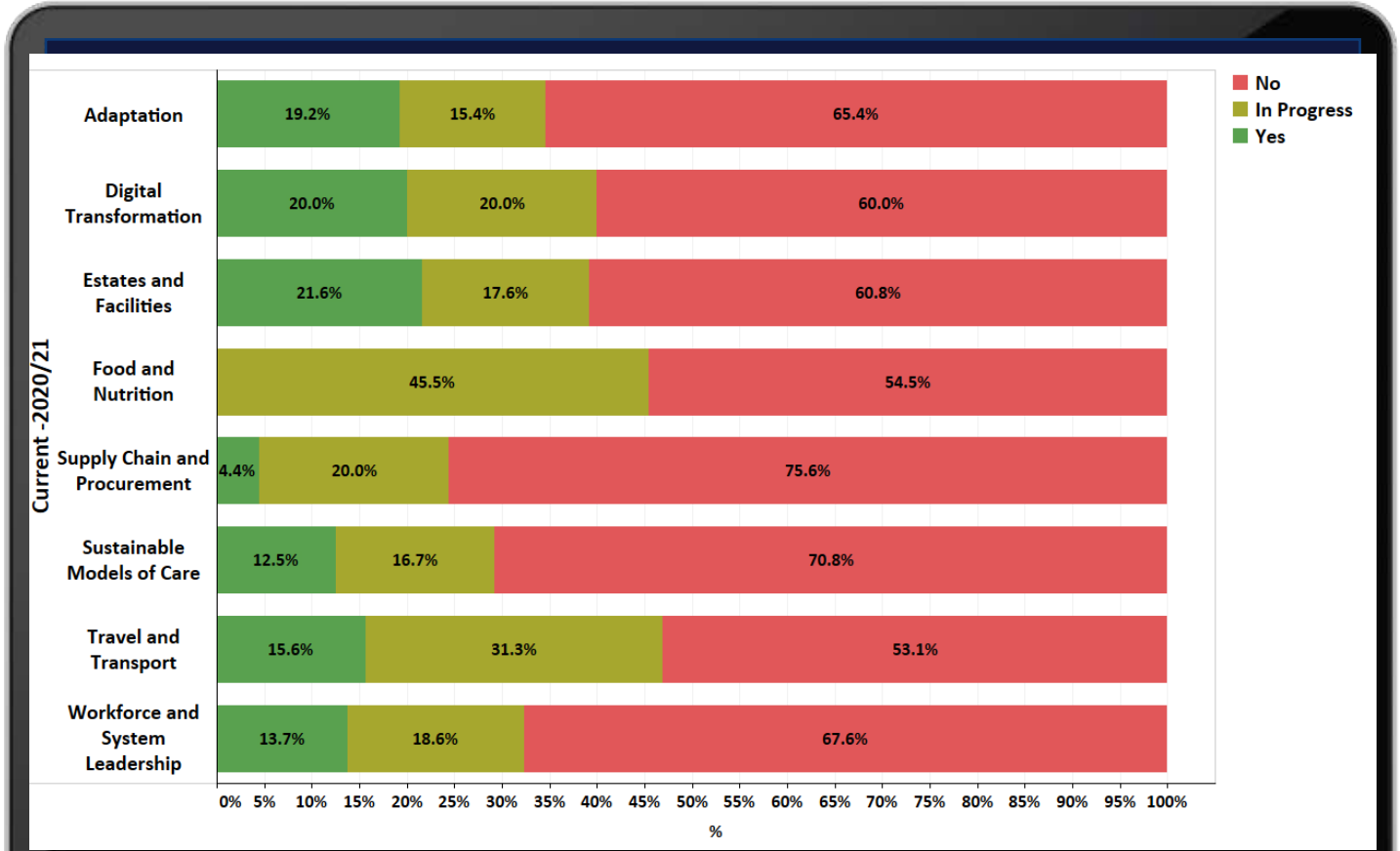
DBTH is finalising its Green Plan

- Achieve a Net Zero status before 2045.
- Deliver sustainable healthcare for the benefit of our patients and our local community
- 4 year plan to 2026

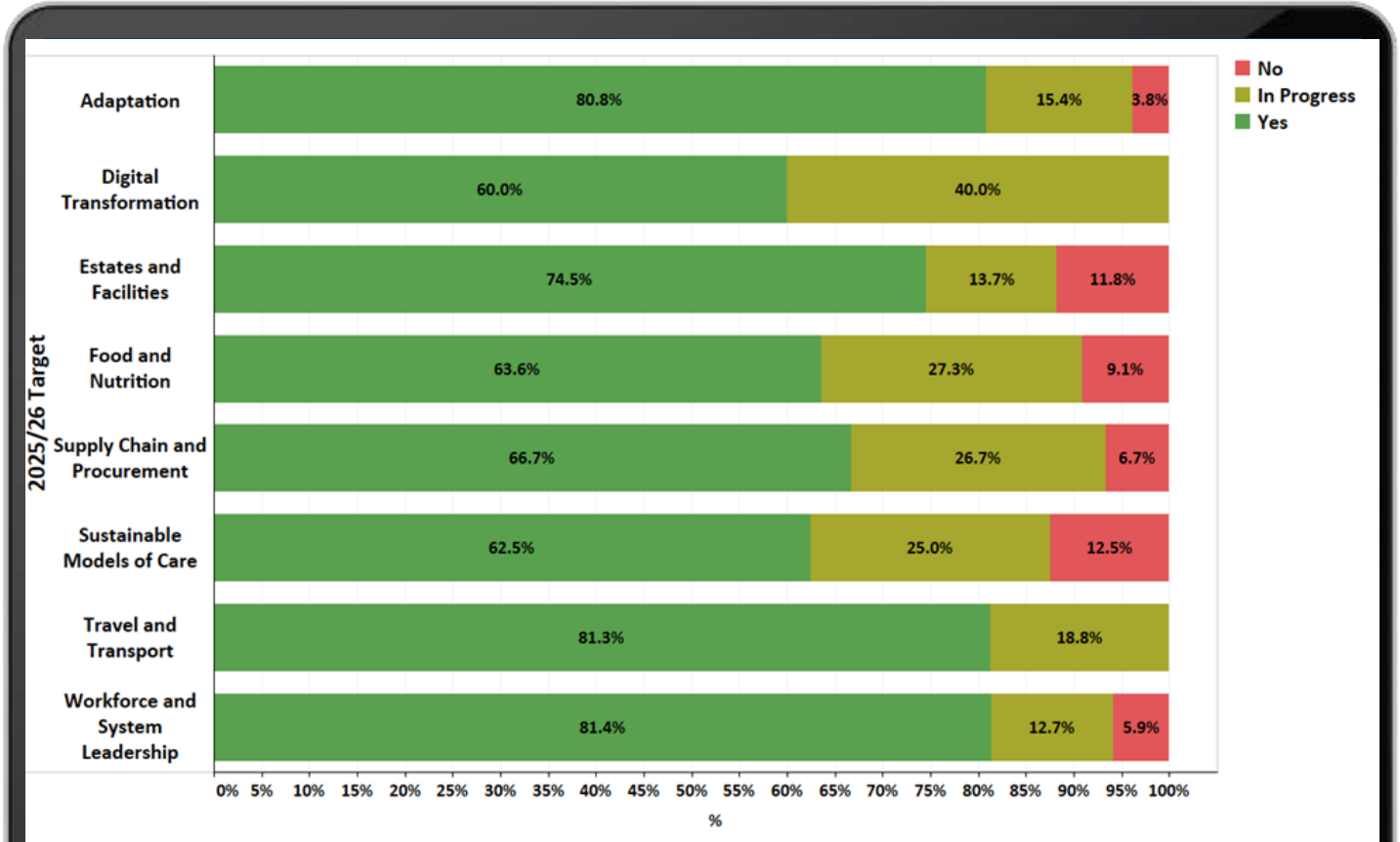
The Green Plan

Areas of Focus	Summary
Workforce and system leadership	Approach to governance, plus engaging and developing your workforce and system partners
Sustainable models of care	Explore carbon reduction opportunities in the way care is delivered
Digital Transformation	Consider ways to harness existing digital technology and systems to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions
Travel and Transport	Promote use of public transport, ultra and low emissions vehicles, transport of goods and services
Estates & Facilities	Reducing the carbon emissions arising from the organisation's buildings and infrastructure
Medicines	Reduce the carbon emissions related to the organisation's prescribing and use of medicines and medical products
Supply Chain & Procurement	The use of individual or collective purchasing power and decisions to reduce carbon embedded in their supply chains
Food & Nutrition	Consider ways to reduce the carbon emissions from the food made, processed or served within the organisation
Adaptation	Consider plans to mitigate the risks or effects of climate change and severe weather conditions on its business and function

The Green Plan – SDAT Score 2021



The Green Plan – SDAT Target 2026



Priority Interventions – Workforce and System Leadership

Sets out the approach to governance, plus engaging and developing workforce and system partners:

- Develop the Leadership and Governance structures required to deliver the Green Plan
- Engage, develop, and train staff
- Update our internal communication plans to include engagement that promotes the Green Plan.
- Deliver Carbon Literacy Training to staff
- Develop Annual Sustainability Report

Priority Interventions – Sustainable Models of Care

Sets out the approach to embedding net zero principles across all clinical services:

- Raise awareness of sustainable models of care and what it means to the Trust
- Conduct sustainability assessments of current care models
- Support activities that help prevent the need for healthcare interventions
- Work to reduce the carbon emissions associated with equipment use
- Evidence at least one example of a sustainable care model

Priority Interventions – Digital Transformation

Sets out the links between the digital transformation agenda and net zero NHS:

- Incorporate Digital Transformation and technology into sustainability assessments
- Review and update the scope and content of our Local Digital Roadmap
- Establish a system for assessing the suitability of established technologies
- Develop a process for Horizon Scanning for new ideas and technologies
- Engage with national demonstration projects and best practice organisations

Priority Interventions – Food and Nutrition

Sets out the approach to reducing the carbon emissions from the food made, processed or served within the organisation:

- Develop and implement a food and drink strategy and action plan to promote and support health choices
- Review and assess the steps the caterers are taking to ensure they are acting on guidlines
- Improve the promotion of healthy eating and lifestyles
- Work with contractors and concessions to develop ways to reduce and promote a reduction in food and drink waste

Priority Interventions – Estates and facilities

Sets out the approach to reducing the carbon emissions from the operation of the organisation's buildings and infrastructure:

- Development of a decarbonisation strategy
- Reduce energy and water consumption, through the deployment of optimisation strategies
- Increase the reuse of medical equipment
- Reduce waste by employing the principles of the waste hierarchy
- Maintain and enhance the biodiversity of our green space
- Development of a criteria for assessing the sustainability of refurbishments and new construction works
- Implementation of whole life costing policy for refurbishment and new buildings
- Implementation of efficient design principles and new technologies

Priority Interventions – Adaptation

Sets out the approach to mitigating the risk and effects of climate change:

- Complete a Climate Change Risk Assessment

- Develop a Climate Change Adaptation Plan for our facilities and estate

Priority Interventions – Travel and Transport

Sets out the approach to reducing the carbon emissions arising from the travel and transport:

- Develop a green travel plan aimed at reducing air pollution
- Development of a Vehicle Strategy aimed at reducing emissions and air pollution for fleet vehicles
- Invest in the infrastructure required to support the electrification of our fleet

Priority Interventions – Supply Chain and procurement

Details how the Trust can use its individual purchasing power and decisions to reduce carbon embedded in its supply chains:

- Promotion of the Green Plan to our suppliers
- Establish a system that enables the assessment and selection of more sustainable goods, products, and services
- Assess what products and services in the supply chain pose a higher ethical, labour, and environmental risk and mitigating that risk
- Establishing a set of standards that suppliers must adhere to for example to achieve social value
- Reviewing our existing supplies of goods and services to confirm they meet those standards
- Ensuring that environmental, social, and economic impacts and opportunities are appropriately considered and evaluated in the assessment of value for money
- Managing tendering and procurement strategies that ensure fair access to contracting opportunities for businesses of all sizes and types and invite local companies to tender

Priority Interventions – Supply Chain and procurement

NHS Standard Contract:

- 18.4.3 single use plastic products and waste, and specifically how it will, no later than 31 March 2022 take action:
- 18.4.3.1 to reduce waste and water usage through best practice efficiency standards and adoption of new innovations;
- 18.4.3.2 to reduce avoidable use of single use plastic products, including by signing up to and observing the Plastics Pledge;
- 18.4.3.3 so far as clinically appropriate, to cease use at the Provider's Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxodegradable plastics;
- 18.4.3.4 to reduce the use at the Provider's Premises of single use plastic food and beverage containers, cups, covers and lids; and

Priority Interventions – Medicines

Details the approach to reducing the carbon emissions from the use of medicines:

- Reduce atmospheric emission from the use of anaesthetic gases, by replacing gases with high global warming potential and by capturing and destroying the gases
- Reduce the use of metered dose inhalers and switch to low carbon alternatives

Next Steps

- *15 December 2021* - Completion of Draft Green Plan
- *21 December 2021* – Presentation of Draft Green Plan to Board for review and approval
- *14 January 2022* - Every trust is mandated to have a finalised Green Plan approved by their Board or Governing Body and submitted to the ICS.
- *31 March 2022* - The ICS is to develop a consolidated system-wide Green Plan

Thank You
Any Questions

DRAFT

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 16 November 2021 at 09:30 via Star Leaf Video Conferencing

Present:	Suzy Brain England OBE - Chair of the Board (Chair) Mark Bailey - Non-Executive Director Karen Barnard - Director of People and Organisational Development Alex Crickmar – Interim Director of Finance 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 Kath Smart - Non-Executive Director	
In attendance:	Sam Debbage – Deputy Director of Education & Research Fiona Dunn - Deputy Director Corporate Governance/Company Secretary Angela O'Mara - PA to Chair & Chief Executive (Minutes) Adam Tingle – Senior Communications Manger	
Public in attendance:	Peter Abell - Public Governor Bassetlaw Hazel Brand – Public Governor Bassetlaw Richard Mangeolles – Member of the Public Vivek Panikkar – Staff Governor Pauline Riley – Public Governor Doncaster Clive Tattley – Partner Governor Mandy Tyrell – Staff Governor Lynne Logan - Public Governor Doncaster	
Apologies:	Jon Sargeant – Interim Director of Recovery, Innovation & Transformation Emma Shaheen – Head of Communications & Engagement	
P21/11/A1	**Welcome, apologies for absence and declaration of interest (Verbal)**	
	The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and the members of public in attendance, via the audience functionality. The above apologies for absence were noted. No further declarations of interest were noted, pursuant to Section 30 of the Standing Orders.	

P21/11/A2	**Actions from Previous Meetings (Enclosure A2)**	
	Action 1 - Escalation to Board – Job Planning Internal Audit Board – action closed Action 2 - Diagnostic Framework Self-Assessment – Board Leadership – action not yet due Action 3 - Safeguarding Information to Board – action not yet due, to be included in the Chief Nurse Update in January 2022 and quarterly thereafter Action 4 - Civility Training – update included in the Our People Update Action 5 - Nursing Budgets and Establishments - update included in the Chief Nurse Update	
	The Board: - ***Noted the updates.***	
P21/11/C1	**Board Assurance Framework – SA1 (Enclosure C1)**	
	The Board received an updated Board Assurance Framework (BAF) in respect of risks to the achievement of the Trust's strategic aim 1 – To provide outstanding care and improve patient experience. The following additions had been incorporated: • Risk to patient safety and poor patient experience relating to waits in the Emergency Department and ambulance handovers • Gaps in registered workforce, pending completion of preceptorship for new registrants and international nurses • High levels of bed occupancy (95%) • In respect of the hyperlinks within the assurance element of the BAF Sheena McDonnell asked if this could be provided to Board members in an accessible format. • Following the recent maternity safety meeting with the Chief Midwifery Office, Kath Smart requested inclusion of the maternity risk strategy, and also highlighted a typographical error on the initial risk rating to be corrected to 4 (C) x 5 (L) = 20	**RJ/FD** **DP**

P21/11/C2	**Chief Nurse Update (Enclosure C2)**	

The Chief Nurse update provided information, outcomes, and assurance on the key deliverables for patient safety and experience, maternity services and safe staffing numbers for nursing and midwifery.

Safety Report

The following headlines were reported for October 2021:

	October	Year to Date
Serious Incident	1	22
Never event	1	1
After Action Review	4	10
Hospital Acquired Pressure Ulcers (HAPU)	69 (54 patients)	550 (447 patients)
Falls	132 104 no harm, 24 low harm, 2 moderate & 2 severe	

All associated learning had been shared and where appropriate, support had been provided to individuals. A great deal of work had been undertaken by the Skin Integrity Team to ensure early interventions for lower category HAPUs, in order to proactively manage further deterioration.

A summary of hospital acquired, and community onset infections was provided. All cases of Clostridium difficile were subject to a post infection review and no care issues had been identified.

A review of the number of complaints received by month and year to date showed an overall reduction when compared to 2020/21, trends and learning outcomes were also analysed and considering the pressures that clinical teams continued to work under the number of closed complaints was encouraging.

Maternity Report

The Board received the Maternity report, which provided an overview of:

- Findings of perinatal death reviews
- Healthcare Safety Investigation Branch (HSIB) referrals
- Training compliance
- Service user feedback
- Regulatory concerns
- Prevention from Future Death Reports
- Progress of achievement of Clinical Negligence Scheme for Trusts (CNST) 10

The Chief Nurse confirmed the Trust had met with the Chief Midwifery Office on 12 November, as part of the national campaign to discuss maternity safety matters, this was the first within the region and was reported to be a positive meeting.

	Nursing and Midwifery Staffing The paper provided an overview of planned staffing hours as compared to actual hours worked for September and October 2021. Actions to fill rota gaps were proactively progressed through bank and agency and a process agreed to secure executive approval of tier two agency work. Divisional Directors of Nursing and Matrons were working closely with the e-Roster team to ensure that rotas were effective. The Chief Executive acknowledged the challenges of Covid 19, the recovery of diagnostic services and the elective workload and suggested that as the Trust prepared to address these issues and to avoid inequalities some rebasing was required due to increased acuity. The Acting Director of Finance confirmed that should the CNST standards in maternity be met the Trust should expect to receive a rebate, the impact of agency nursing would be covered in more detail in the finance paper later in the agenda. Neil Rhodes acknowledged that agency spend was often considered purely from a financial perspective, however, there was a need to step back and look at what was required from a nursing/healthcare perspective and to plan the finances around this. The Chief Nurse confirmed that a workforce plan was in place and adverts for Healthcare Support Workers would go live in November 2021, via Indeed. In addition 25-35 registered nurses were expected to start in March and a further cohort of international nurse recruitment was planned. Once complete the Trust would then be over recruited against budgets, although natural loss and movement of colleagues would offset this. Increasingly nurses who would have once retired and returned at 55 were now simply retiring. It should be noted that as of September 2021, Doncaster College offered part time nursing courses, which provided a great opportunity for local residents, widening participation and access to a career in nursing. It was also noted that Sheffield Hallam University was oversubscribed for its nursing degree courses, placement of students was expected to extend to primary and social care. In response to a question from Sheena McDonnell it was confirmed that feedback to improve customer experience was sourced from CQC patient surveys, cancer/chemotherapy service feedback and more recently via the strategy review listening exercise in addition to that received via concerns and complaints. Civility training was being undertaken and where issues arose which related to staff behaviours these were addressed promptly to avoid further instances or escalation. In respect of the perinatal death reviews, and to provide some context, the Chief Nurse confirmed that the Trust delivered approx. 5,000 babies each year. A concern was shared in respect of those still births which noted a change to the placenta linked to Covid 19, the potential of an increased risk of still births had been the subject of a number of studies. The Trust was taking all steps to encourage vaccination in all groups including pregnant ladies. In response to a question from Kath Smart, the Chief Nurse confirmed that work to ensure functionality of the Trust's local risk management system, Datix, had been undertaken. In order to ensure compliance with the Patent Safety Incident Response Framework colleagues were reminded there was a need to procure a replacement. Pat Drake welcomed the rebasing of budgets and staffing which was acknowledged to be a significant but vital piece of work. Updates would be received at both the People and Quality & Effectiveness Committee.	

	In response to a question from Pat Drake in respect of ambulance waits, it was confirmed that where a patient was deteriorating, they would be brought into the department/resus area. All ambulance waits over one hour would be subject to a joint clinical review by the nurse in change/medical colleague and a member of the ambulance crew, which would include consideration of the patient's personal hygiene and nutritional needs.	
	The Board: - ***Noted and took assurance from the Chief Nurse Update.***	
P21/11/C3	**<u>Executive Medical Director Update & Q1 2021/22 Learning from Deaths Report (Enclosure C3)</u>**	
	The following headlines were noted from the Executive Medical Director Update: • 97% of patients on the admitted referral to treatment (RTT) active waiting list had been stratified • Summary Hospital Mortality Indicator (SHMI) was reported to be marginally above our selected comparator peer group. 1.13 for the period July 2020 - June 2021, as compared to 1.11 January – December 2020 • The Medical Examiner Team were now scrutinising all deaths in hospital and 90% of Medical Certificates of Cause of Death (MCCDs) had been completed within three days. Three additional Medical Examiners and a Medical Examiner Officer had been appointed with a view to rolling out scrutiny in the community • A full review of clinical governance had been completed and the new structure would take effect from 1 April 2022. Terms of Reference for all committees were under review • Compliance with the Medical Profession (Responsible Officers) Regulations 2010. The annual report was received by the People Committee on 2 November 2021 • Compliance with Human Tissue Authority guidance in respect of mortuary security The Quarter 1 Learning from Deaths report, previously reviewed at the Quality & Effectiveness Committee, was received for information. In response to a question from Neil Rhodes the Chief Executive and Chief Nurse shared their feedback on the modular units in situ on the Women & Children's site. The quality of the build was noted to be of a high standard, constructed off-site and to current Health Technical Memoranda (HTM) standards, and brought on site to allow final fix and fixtures to be completed. The facilities would support provision of modern standards of care for an extended life and offer flexibility in terms of mobility. The Chief Nurse had recently signed off the theatre for use and the official opening of the units was planned for 10 December. In respect of the learning from deaths report, Mark Bailey asked how the effectiveness of the learning was assessed. The Executive Medical Director identified that learning, supported by an action plan, would be subsequently reviewed and audited to evidence the impact and ensure changes were embedded into practice. As many key points of learning	

	were included within the Sharing How We Care newsletters Mark Bailey suggested this may also be a source to reflect on. Kath Smart referenced concerns in the report relating to being unable to visit palliative care patients and difficulties making telephone contact with the ward. The Chief Nurse acknowledged there was a balance to be found between acting with compassion and protecting staff and patients. The Chief Executive accepted the challenges faced by visitor restrictions, the key driver being compliance with infection, prevention and control measures to safeguard the health and safety of staff, patients and visitors. In response to a question from Pat Drake it was confirmed that the Medical Examiner's team now had full system access for medical records to support the review of deaths within the community. The Chief Nurse confirmed that work with divisions in response to feedback around appropriate timing of end of life and special palliative care was in progress. It was also noted that the trust had been an early adopter of ReSPECT forms, which allowed a patient plan for care and treatment in an emergency situation to be taken out into the community.	
	The Board: - ***Noted and took assurance from the Executive Medical Director Update.***	
P21/11/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. Both documents had been updated to reflect involvement in the strategy review listening exercise, internal audits, the impact of the international nurse recruitment and the Qi training approach. The Board Assurance Framework was reviewed at the People Committee to ensure as full a picture as possible was captured.	
P21/11/D2	**<u>Our People Update (Enclosure D2)</u>**	
	The following key headlines were noted from the Director of People & Organisational Development's report: • Assurance that colleagues were taking appropriate levels of annual leave, the importance of which was noted from a health & well-being perspective during continued operational pressures • An increase in covid and general sickness absence was reported from last month. • Good progress had been made with the vaccination programme – 82% of eligible colleagues had received their covid booster and efforts to reach out to unvaccinated colleagues continued. 60% of colleagues had received their flu vaccination, the offer	

	had been extended to Saba, Sodexo and NHSP colleagues working on site. Detailed guidance on the mandating of Covid 19 for frontline healthcare workers was expected in December. A task and finish group had been established which included medical, nursing, operational, HR and occupational health representatives. A consistent approach would be agreed across SY&B ICS. • A marked increase in the use of the Employee Assistance Programme was noted, face to face counselling was now available at Bassetlaw and would be introduced at Montagu. Additional funding had been secured for complimentary therapies and for additional capacity to reach out to colleagues as part of the know your numbers campaign – promoting aware of blood pressure, BMI and signposting to other health services • The Workforce Plan and People & OD Strategy were currently being refreshed and would be taken to January 2022's meeting of the People Committee • A new programme, Everyone Counts - Civility and Respect had been introduced to bring to life the "We Care" values and to support positive workplace cultures. The programme had been incorporated into the organisational development work within the Emergency Department and would support Trauma & Orthopaedic development plans too In response to a question from Sheena McDonnell, the Chief Nurse and Executive Medical Director confirmed that the Trust adhered to the national NHSE guidance in respect of isolating when family members were Covid positive. The current number of staff affected was reported to be approx. 30. It was noted that some trusts had undertaken a risk assessment to determine the individual's ability to return to work, however, as this often involved minors there remained a responsibility on the staff member as carer. In preparation for compulsory vaccinations work was underway to establish vaccination records for cross referencing to the electronic staff record, it was noted that there may be a need to verify vaccination through the NHS app. In respect of the mandating of covid vaccines for front line healthcare workers Mark Bailey noted the potential impact on recruitment. Once detailed guidance had been received the Director of People & OD confirmed the trust would be better placed to understand the impact, a need to ensure the requirement and supporting arrangements were incorporated into recruitment procedure would be required.	
	The Board: - ***Noted and took assurance from the Our People Update.***	

P21/11/E1	**<u>Board Assurance Framework – SA4 (Enclosure E1)</u>**	
	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. The Interim Director of Finance confirmed that those risks and opportunities identified as part of H2 planning guidance had been incorporated.	
P21/11/E2	**<u>Finance Update (Enclosure E2)</u>**	
	The Interim Director of Finance's report identified the following key headlines: • Month 7 position was a breakeven position, with a year to date surplus of 5k • Pay spend continued to increase, agency spend was high and tier 2 agency was being utilised to fill 90% of shifts (£200k less if tier 1) • Unidentified CIP of £2.6m in H2 plan, although the system underspend was currently offsetting this pressure, this may be subject to change • Month 7 capital expenditure was £2.7m, £16.4m year to date against a planned £9.7m. The year to date variance to plan was mainly driven by the W&C Major Incident Works (£10.6m), offset by underspends on medical equipment, IT and estates. • The cash balance at the end of October was £42.6m, an increase of nearly £9m from last month, due to funding received from commissioners for the back dated AfC pay award and advance monies received from Health Education England. The year-end forecast position was c.£15m, due to the significant capital programme. The recently published provider and ICS segmentation for the NHS System Oversight Framework identified the Trust and SY&B ICS in support category 2. From a trust perspective this recognised plans that have the support of system partners in place to address areas of challenge, with the potential for targeted support to address specific identified issues. The offer would be flexible and include peer support, clinical network and the universal offer from NHSE/I. Alternatively, a bespoke package via one of the regional improvement hubs could be offered. Neil Rhodes recognised the operational challenges and the difficulties in balancing these against financial pressures, including careful consideration of agency spend. In respect of the segmentation announcement, he enquired what opportunities there would be to learn from organisations within segment one. The Chief Executive recognised the Trust's segmentation was a strong position within the ICS, the focus on operational challenges would be to safely staff, whilst reinforcing improvements to work in an efficient, effective and sustainable manner. Staffing was a significant challenge and with increased levels of absence levels, the impact of the Women's and Children's incident and higher patient acuity the use of tier 2 agency had been necessary to keep services safe.	

	A consistent approach across the ICS was important to avoid loss of staff to those trusts within easy commutable distance, the Chief Nurse was working closely with his peers and NHS Professionals on this matter. Prior to August there had been minimal use of agency staff, as a result there was now a need to build relationships. Kath Smart asked that the use of medical agency be considered at the Finance & Performance Committee later that week.	
	The Board: - ***Noted and took assurance from the Finance Update.***	
P21/11/E3	**<u>Operational Update – Looking Forward</u>**	
	The Chief Operating Officer's report and supporting presentation summarised the following: • Operational trends • H2 key planning expectations • Progress on winter plans • Operational Plan next steps • In response to a question from Pat Drake the benefits of the vaccination programme continued to be actively promoted and all opportunities taken to maximise uptake. Communication from the Director of Public Health and the Chief Executive had recently been shared with the communities to confirm this message. Kath Smart thanked the Chief Operating Officer for the comprehensive update and work on the winter plans, of particular interest was the wide ranging work to get the basics right, which the Chief Operating advised should be fully embedded by December 2021.	
	The Board: - ***Noted and took assurance from the Operational Update – Looking Forward***	
P21/11/E4	**<u>Performance Update (Enclosure E4)</u>**	
	The Board received the Chief Operating Officer's Performance Report which provided the, performance headlines, operational context and next steps. Supporting performance appendices were included at H4 for information/review.	
	The Board: - ***Noted and took assurance from the Performance Update.***	
P21/11/E5	**<u>Ambulance Waits</u>**	
	The Board received the Chief Operating Officer's report on ambulance handovers, which would be received on a monthly basis going forwards. Both Yorkshire Ambulance Service (YAS) and East Midlands Ambulance Service (EMAS) had been operating under significant and sustained pressures over the summer months, similar to that seen in the severest of winters.	

	The report provided an overview of the current operational context, ambulance handover performance by site, the requirements of NHSE, set out in their letter to Trusts of 26 October, and the improvement plan developed as part of the Integrated Urgent and Emergency Care Transformation Programme. In response to a question from Neil Rhodes the Chief Operating Officer confirmed that both YAS and EMAS were actively engaged in monthly partnership meetings. Changes to practice to support improvement were discussed as part of these meetings but also in day to day collaborations and through a presence in the site room. The Chief Executive reminded colleagues that flow was a place based and system issue, not solely attributable to the trust and therefore the focus was required on the end-to-end process from admission to discharge and not simply the reduction in ambulance waits. Pat Drake enquired of the work being undertaken to reduce admissions and of the reporting of patients who were brought to hospital unnecessarily, it was confirmed the latter was reviewed as part of the monthly meeting.	
P21/11/F1	**<u>Doncaster & Bassetlaw Teaching Hospitals Strategy Review Listening Exercise (Enclosure F1)</u>**	
	The Director of Strategy & Improvement's paper and supporting presentation provided a high level overview of the feedback sourced as part of the strategy review listening exercise, undertaken by Stand, an external partner. It also confirmed the intention to move forward with actions. The response had been positive and provided a good insight to inform development of the strategy and short-medium and long term action plans. Ongoing engagement would be required and action plans would be progressed through the Quality & Effectiveness and People Committee. In response to a question from Kath Smart, the Director of Strategy & Improvement confirmed that the translation of outputs to British Sign Language and Polish had been in response to a specific request and offered assurance that there would be a wider offer to match with the needs of local communities. In response to a question from Mark Bailey the Director of Strategy & Improvement confirmed that much of the feedback was in line with expectations. The focus on carers was strongly represented in the exercise.	
	The Board - ***Noted the update and supported the progression of action plans through the relevant sub-committees of Board***	

P21/11/F2	**<u>Bassetlaw Children's Services Engagement (Enclosure F2)</u>**	
	The Director of Strategy and Improvement shared with the Board a briefing paper which outlined the steps to seek a permanent solution for the provision of urgent and emergency care for the children of Bassetlaw. The comprehensive paper detailed the background, case for change and the development of options, which would be considered at the Nottinghamshire Health Scrutiny Committee (HSC); the need for consultation and engagement would be determined at the HSC meeting. Neil Rhodes confirmed it was appropriate to receive this ahead of HSC, it was suggested that a more detailed oversight, as part of the major schemes update, would be received at the Finance & Performance Committee, with safety and governance arrangements reported through the Quality & Effectiveness Committee. Pat Drake confirmed plans for the item to be discussed at the meeting of Quality & Effectiveness on 7 December, when senior management of the Children & Families division would be in attendance. The proposal was a real positive for the Trust and the people of Bassetlaw.	
	The Board - ***Noted the Bassetlaw Children's Services Engagement Update.***	
P21/11/F3	**<u>True North, Breakthrough & Corporate Objectives 2021/22 Q2 Update (Enclosure F3)</u>**	
	The Chief Executive shared with the Board a progress update in respect of the directors' contribution to delivery of the breakthrough objectives up to and including Quarter 2 2021/2022. Assurance on the delivery of the specific elements of the objectives and on the delivery of the Trust's performance was sought via the sub-committees of Board and the information available would be strengthened through the provision of refreshed business intelligence. Measures and actions to mitigate the risks and restore the Trust's progress towards the 'True North' were being taken forward through the creation of a new Directorate, Recovery, Innovation and Transformation, which would focus on those key elements likely to have the greatest impact on quality, safety and sustainability, namely: • Strategy and Improvement • Digital information • Information and informatics • Programme management; and • Contracting and planning This would then enable the Trust's operational teams to concentrate on the delivery of the operational and winter plans. Jon Sargeant would take on the role of Interim Director of Recovery, Innovation, Information and Transformation. The achievement of the directorate would be assessed in	

	approximately six months and if successful the appointment would go out to national recruitment.	
	The Board - ***Approved and took assurance from the update***	
P21/11/G1	**<u>Corporate Risk Register (Enclosure G1)</u>**	
	No 15+ risks had been escalated, monitoring would continue alongside increased scrutiny at Board sub-committees and the Trust Executive Group. Following discussions at October's Audit & Risk Committee Kath Smart had hoped for a more comprehensive update, Fiona Dunn confirmed this would be brought to the next meeting. Updates to Estates & Facilities risks relating to the Grainger report would be required.	**FD**
	The Board: - ***Noted the Corporate Risk Register.***	
P21/11/G2	**<u>Use of Trust Seal (Enclosure G3)</u>**	
	The Board noted and approved the use of the Trust Seal by Richard Parker, Chief Executive and Jon Sargeant, Director of Finance.	
	The Board: - ***Approved the use of the Trust Seal***	
P21/09/H1-	**<u>Information Items (Enclosure H1 – H9)</u>**	
	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	**<u>Minutes of the meeting held on 19 October 2021 (Enclosure I1)</u>**	
	The Board: - ***Approved the minutes of the meeting held on 19 October 2021.***	
P21/09/I2	**<u>Any other business (to be agreed with the Chair prior to the meeting)</u>**	

	There were no items of any other business.	
P21/07/I3	**<u>Governor Questions regarding the business of the meeting (10 minutes) *</u>**	
	Hazel Brand, Lead Governor shared the following governor questions <u>What are the difficulties in discharging to social care settings and the resultant impact on families?</u> The Chief Nurse confirmed a national discharge policy was in place where the criteria to reside was not met. Issues within social care setting were known and system wide work to improve discharge was in place, six discharge beds had recently been purchased to facilitate discharge from hospital. <u>In view of the need to recover elective surgery was there an additional money to facilitate use of the private sector?</u> Throughout the pandemic the Trust had continued to work closely with the on-site independent sector provider to maintain delivery of urgent services and to provide additional capacity. All opportunities to explore insourcing and outsourcing had been pursued and bids for all available funding, including the Targeted Investment Fund submitted. In addition the development of the Community Diagnostic Centre/Hub would provide additional MRI/CT capacity on a non-acute site. The Chair of the Board thanked governors for their continued engagement.	
	The Board: - ***Noted the comments raised.***	
P21/11/I4	**<u>Date and time of next meeting (Verbal)</u>** **Date:** Tuesday 21 December 2021. **Time:** 09:30am **Venue:** StarLeaf Videoconferencing	
P21/11/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.***	
P21/11/J	**<u>Close of meeting (Verbal)</u>**	
	The meeting closed at 12:50	