Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 25 January 2022 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	Board Assurance Framework *David Purdue, Chief Nurse*	*Assurance*	5
B2	Maternity Update *David Purdue, Chief Nurse*	*Assurance*	15
B3	Infection Prevention & Control Board Assurance Framework *David Purdue, Chief Nurse*	*Assurance*	10
B4	Covid Response • Latest COVID-19 position – keeping patients and staff safe & required public support *David Purdue, Chief Nurse* *Rebecca Joyce, Chief Operating Officer*	*Assurance*	10
B5	Winter/Covid Nursing Workforce Board Assurance Framework *David Purdue, Chief Nurse*	*Assurance*	10
C	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**		**10:25**
C1	Our People Update *Karen Barnard, Director of People and Organisational Development*	*Assurance*	10
D	**PERFORMANCE**		**10:35**

D1	Ambulance Handovers *Rebecca Joyce, Chief Operating Officer*	*Assurance*	10
E	STRATEGY		10:45
E1	Strategic Outline Case – DRI New Build *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Approve*	30
F	**OTHER ITEMS**		**11:15**
F1	Minutes of the meeting held on 21 December 2021 *Suzy Brain England OBE, Chair*	*Approval*	5
F2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	
F3	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10
F4	**Date and time of next meeting:** **Date:** Tuesday 22 February 2022 **Time:** 09:30 **Venue:** StarLeaf Videoconferencing	*Information*	
F5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. Suzy Brain England OBE, Chair	*Note*	
G	**MEETING CLOSE**		**11:30**

***Governor Questions**

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

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Hazel Brand, as Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Hazel to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Hazel by e-mail by 5pm the day before 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. Please note the "chat" function will not be used for questions during the meeting.

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

- Questions at the meeting must relate to papers being presented on the day.
- Questions must be submitted in advance to Hazel Brand, Lead Governor by e-mail.
- 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: 20 January 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	21 December 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: 20 January 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**~~ **February 2022**	To be included in the Chief Nurse Update Full Board agenda postponed to February 2022 due to planning/response to Omicron

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do			
True North Strategic Aim 1 – To provide outstanding care & improve patient experience.			
Risk Owner: Trust Board – Medical Director/Chief Nurse **Committee: QEC**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : January 2022**	
Strategic Objective To provide outstanding care and improve patient experience **Breakthrough Objective** Achieve measurable improvements in our quality standards & patient experience	**Risk Appetite:** The Trust has a **low appetite** for risks **Measures:** • Ward/department quality assessment scores, recommencement of quality frameworks. Work on the roll out of the Perfect ward to commence in quarter 3. • Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes • Focus on key safety risks – IPC Outbreaks - waits, falls, milestones set through business planning for each division aligned to the division's breakthrough objectives • Clinical effectiveness, processes to include the following of NICE guidance • IQPR measures • Feedback from patients via compliments and complaints. • Patient survey outputs and effectiveness of action plans • Co-production of changes with patients • Insights profiles from CQC • Board Assurance Frameworks	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 16 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low
Risks: • Risk of patient harm if we do not listen to feedback and fail to learn • Risk of not using available quality assurance data to best effect in order to identify areas to improve or manage patient care. • Risk to safety and poor patient experience as a result of failure to improve the estate and infrastructure. • Risk of non-delivery of national performance standards that support timely, high quality care • Risk to safety and poor patient experience if we do not improve emergency flow in our capacity constrained environment • Current gaps in registered workforce whilst New registrants and international nurse's complete preceptorship with increased reliance on agency staff. • Risks to patient both in terms of flow and communication as a result of the pathways relating to Infection, Prevention and Control measures	**Rationale for risk current score:** Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients • Impact on patient experience • Potential delays to treatment • Possible Regulatory action	**Future risks:** • Impact of COVID on elective restoration • Staff engagement post covid • Patient expectations following Covid • Staff working in separate areas following the incident in the women's hospital. **Risk references:** Q&E9, F&P 6 and F&P 8. **Opportunities:** • Change in practices, new ways of working • Advent of more digital care • Greater opportunity for collaboration at place / system level • Implementation of National Safety Strategy • Restructure to focus on patient experience • Quality improvement processes focused on Falls in the 10 high risk areas • Workforce development plan • Review of quality processes within the ICS	

Appendix Level1

Controls / assurance (mitigation & evidence of making impact):	**Comments:**	**Assurance (evidence of making an impact):**
• BIR Data targets & exceptions • Clinical effectiveness measures • Quality framework outcomes o Quality control to Quality Assurance • Quality Improvement outcomes • Clinical Governance Review • Integrated Quality Performance Report • Accountability Framework • Annual planning process • External compliance review action plans • Urgent and Emergency Care Improvement Programme	• Need to ensure Trust Values are effective • Need to develop quality/patient safety strategy • Need to sustain improvements in QI initiatives • Need to widen the focus on patient and user feedback **Gaps in controls / assurance (actions to achieve target risk score):** Uncertainty re COVID recovery outcomes Uncertainty re SYB ICS changes	Output from Board sub committees Internal Audit reviews on quality outcomes, falls documentation compliance 20/21, DToC 2019/20, Complaint process 2020/21. Action plans completed against internal audit and reviewed at QEC in June. Positive feedback from people on the services BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022 Nurse staffing CNST 10 elements to be uploaded on the 22nd of July. SNCT undertaken to ensure safe staffing completed in June 2021. Nurse Staffing Assurance Framework shared at Board on the 25th of January 2022 Okenden feedback received from the LMNS, action plans developed to achieve 7 key actions Action plans to respond to CQC patient surveys

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	25 January 2022	Agenda Reference:	B2		
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:	1				
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. Thematic review of the areas where work is being undertaken to address issues identified in reports.				
Recommendation:	To approve				
Action Require:	Approve	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	***Everybody knows their role in achieving the vision***	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*	

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

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

December 2021

The perinatal mortality monitoring tool is reviewed each month at the Board of Directors, to ensure oversight of any themes emerging from incidents in maternity services. The report is to be read in conjunction with the Board surveillance report.

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
22+4	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 November meeting
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 November meeting
33	Multip previous severe PET, Previous C/S, slight PV spotting, Delivery in DRI carpark	Awaiting Grading. Coroners PM received. Initially investigated as NND but deemed stillbirth.
29	Covid 19 positive	Awaiting review and full PM investigations
23	Mutligravida, Abruption, 23 weeks, DIC, multiple transfusion, Hysterostomy. Prev 29 week	Awaiting review and full PM investigations
25	Multigravida, 25 weeks, Learning Difficulty, self-discharge	Awaiting review and full PM investigations

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 for postnatal opinion. Supported by Bluebell wood until death at 12 days. Declined bereavement support	Date of death 18/06/21 Cytogenetics normal, awaiting follow-up joint review with NNU team and FMU consultant to discuss care	Grading A & A
21+3	MTOP for severe spina bifida, Arnold Chiari malformation and cerebellum banna and severe bilateral	HR detected following delivery Referred to coroner and rapid review and child response.	PMRT Not applicable due to MTOP

	ventriculomeglay. Born with signs of life.	Informed open and closed case. Awaiting investigations	

1.3 Action Plan for Quarter 3

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

	MBRRACE National rate for England & Wales Per 1000 births	Yorkshire & the Humber Per 1000 births	MBRRACE trust crude rate Per 1000 births	DBTH per 1000 births (excluding TOP)
2015	3.87	4.54	4.16	3.73
2016	3.93	4.1	3.35	3.54
2017	3.74	2.9	3.51	3.07
2018	3.51	3.2	3.32	2.93
2019	3.35	3.9	2.55	2.44

2020	Not Yet Published	Awaiting Figure	Not yet Published	2.97

Stillbirth Rate - The National Picture vs DBTH

The national stillbirth rate is calculated by MBRRACE (Mothers and Babies: Reducing Risk through Audits and confidential Enquiries across the UK). MBRRACE do not include TOP in their national statistics. They do however, contrary to guidance from the Department of health, Royal College of Obstetricians of Yorkshire and Humber include babies where the IUD was diagnosed before 24 weeks, but the baby was delivered at 24 week or afterwards.

Key Themes for 2021

- **Reduced fetal movements**
    - Guidelines updated, Staff education increased and awareness to invite in for assessment at appropriate location depending on gestation
    - Documentation of DFM leaflet to be improved when distributed
    - Continuation of staff education to ensure the same advice is followed as per guidance

- **Bereavement Suite**
    - Bespoke area to be created away from labour ward following the National Bereavement Care Pathway
    - Approved funding gained in December 2021. Building of specific bereavement suite for families in planning process with aim for completion by June 2022
    - Additional Bereavement room on delivery suite at Doncaster Royal Infirmary incorporated into new delivery suite design

- **Covid-19**
    - The present of massive perivillous fibrin deposition, trophoblast necrosis and focal chronic intervillositis are features now found and being described along with a massive perivillous fibrinoid deposition (maternal flaw infarction) is described in the setting of maternal SARS-covid 2 (COVID-19) infection. Massive fibrin deposition, affecting 30% or more of the placental parenchyma are associated with fetal death. (Gardosi 2005)
    - Lesions affecting over half the villious tissue are rare, but findings have increased in COVID-19 positive mothers. It has also been reported that: COVID-19 placentitis, Stillbirth and neonatal death are variable in up to 45% of COVID-19 positive mothers (Libbrecht 2021)
    - Within our trust placental Histological findings, evidence of massive fibrin deposition has occurred in as much as 85% of placental volume. No women who suffered a stillbirth whilst positive for COVID-19 required hospitalisation and remained at home.
    - Of our Trust figures, 4 stillbirths (including 1 set of twins) have been attributed to COVID-19. This has been confirmed via histopathological immunochemical staining. These 4 stillbirths have been causative of a 22.2% increase in stillbirths within our trust. There is still ongoing investigation of 1 COVID-19 positive mother where we await full post-mortem, histological and genetic testing results. The World Health Organisation (WHO) have estimated a worldwide increase of Stillbirths by 28% due to COVID-19 (Chmielewska 2021). This contradicts initial findings and opinions in 2020 worldwide for outcomes in pregnancy.

- Our trust has been proactive in the review of our standard operating procedure (SOP) regarding COVID-19 in pregnancy and follow Royal College of Obstetricians and Gynaecologists (RCOG) guidance closely.
- Our antenatal clinic team have been proactive in setting up administration clinics for pregnant woman to have access to the COVID-19 vaccines.
- K2 electronic notes have been updated to include a more quantifiable data collection report capability to monitor COVID-19 compliance/administration numbers of pregnant women.
- Oxygen saturation monitors are being supplied by Community Midwifery staff to aid the early deterioration of our patient group who have tested positive for COVID-19.

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

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 further two submissions of evidence have been sent to the MIS team, which were submitted by 10 am 27th December 2021 9as requested).

Year 4 standards – a letter has been received from the MIS declaring a pause in the reporting procedure for 3 months due to the current pressures on the NHS.

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: December 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	1;29.8	16%	89.7%
Nov	1:29.8	16%	
Dec	1:29.8	16%	

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%	13.1%
	Emergency	<15.2 %	19.7	21.2%	22%
Preterm birth rate	≤26+6 weeks	0	0	3	1
	≤36+6 weeks	<6%	8.5%	4.3%	6.1%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.4%	2.9%	3.1%
Term admissions to NICU		<6%	3.8%	2.7%	3.7%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.2%	0.6%	2.7%
	Instrumental (assisted)	<6.05 %	13.6%	5.3%	0%
Right place of birth		95%	100%	98%	99.9%
Smoking at time of delivery		<11%	12.4%	12.9%	15.2%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0% 0 %	0% 0 %	0% 0 %
	Area of				

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2021/2022	Oct	59	36	0	0	0	0	0	0	0	0	1	0	0	0	0
	Nov	37	9	0	0	0	1	1	0	0	1	0	0	0	0	0
	Dec	63	10	0	1	0	0	1	0	0	0	0	0	0	0	0
	Q3	159	55	0	1	0	1	2	0	0	1	0	0	0	0	0

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	59	35	55
2	Delay in elective work	0	2	0
3	Unable to give 1-1 care in labour	0	0	1
4	Missed/delayed care for > 60 minutes	0	0	7
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	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)

		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%	8.9%
	Emergency	<16.9 %	28.3%	21.1%	20.7%
Preterm birth rate	≤26+6 weeks	<6%	0	0	1
	≤36+6 weeks		7%	1.8%	8.1%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	5.5%	7%	5.9%
Term admissions to NICU		<6%	3.9%	7.2%	4%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.9%	3.1%	0%
	Instrumental (assisted)	<6.06 %	0%	0%	6.7%
Right place of birth		95%	100%	100%	99%
Smoking at time of delivery		<11%	7.1%	3.6%	7.5%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0%
	Area of deprivation		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	0
	Nov	15	5	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dec	20	2	0	1	0	1	1	0	0	0	0	0	0	0	0
	Q3	44	20	0	1	0	1	1	0	0	0	0	0	0	0	0

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	18	14	8
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	1	0	1
4	Missed/delayed care for > 60 minutes	6	1	9
5	Delay of 30 minutes or more between presentation and triage (LWAU)	1	0	2

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

		Octo	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		<90% >80%
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	Postpartum Haemorrhage Unexpected weight below the 10th Centile
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	1 HSIB met criteria, poor tone, seizures, reviewed by SHO paediatric sent home returned following morning for planned NIPE observations undertaken PAWS 20 should have triggered sepsis pathway, sent home to await blood results – blood results abnormal attended DRI Children's wards hypoglycaemic and seizing Internal Serious Incident missed opportunity to conduct speculum examination on high risk patient who later miscarriage at 21 weeks gestation.
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	Last three cases reviewed, No partogram, maternal observations not undertaken as per policy (labour cares). Graded cases in December meeting: 1 case graded B and A
Themes / main areas from complaints	Communication / staff attitudes Care pathways Delay in care	Communication / staff attitudes Care pathways Delay in care	One maternity complaint in December: Patient reports wrong medication given for third stage of labour
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		
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		
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	Live drills now cross site
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	Posters produced in relation to SI regarding wrong medication WHATS HOT shared with case reviews of Sis and HSIB reports CTG classification re-iterated as theme of two HSIB reports which were received October 2021

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			

Glossary of Terms for Maternity

CTG	**Cardiotocography** is 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** carry out maternity investigations as a national and independent investigating body to: • Use a standardised approach to maternity investigations without attributing blame or liability. • Work with families to make sure we understand from their perspective what has happened when an incident has occurred. • Work with NHS staff and support local trust teams to improve maternity safety investigations. • Bring together the findings of our reports to identify themes and influence change across the national maternity healthcare system.
MBRACE	**Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries** National body working with the NHS to reduce risks
PET	**Pre-eclampsia**
DIC	**Disseminated Intravascular coagulation**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	25 January 2022	**Agenda Reference:**	B3
Report Title:	**IPC Board Assurance Framework**		
Sponsor:	David Purdue - Chief Nurse and Deputy Chief Executive		
Author:	Dr Ken Agwuh, Director of Infection Prevention and Control Miriam Boyak, Lead Nurse Infection Prevention and Control David Purdue, Chief Nurse		
Appendices:	0		

Report Summary	
Purpose of report:	The Board are asked to approve the updated version of the Board Assurance Framework for Infection Prevention and Control.
Summary of key issues/positive highlights:	NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic. Effective infection prevention and control is fundamental to our efforts. NHSE/I have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections. The general principles can be applied across all settings; acute and specialist hospitals. The framework is be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards. Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.
Recommendation:	To approve

Action Require:	Approve	Information	~~Discussion~~	~~Assurance~~	~~Review~~

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

Implications			
Board assurance framework:	*None*		
Corporate risk register:	*None*		
Regulation:	*CQC - Safe Care and Treatment and Patient Centred Care. Achievement of Outstanding.*		
Legal:	*Trusts licence to operate*		
Resources:	*Nil*		
Assurance Route			
Previously considered by:	*Board of Directors, Quality and Effectiveness Committee*		
Date:	November 2021	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		
Previously circulated reports to supplement this paper:	None		

Classification: Official

Publication approval reference: C1501

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.
The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

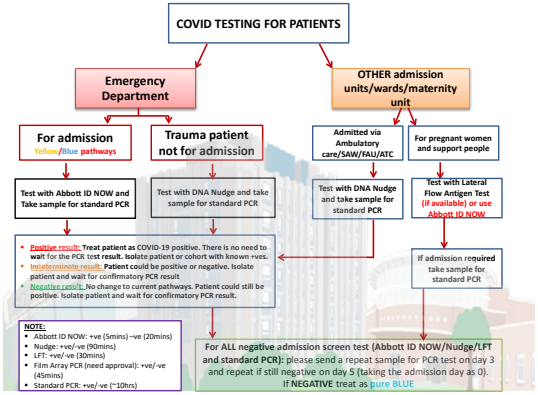
2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements. Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

Infection prevention and control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on the pathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	**Rapid POCT (ABBOTT ID Now is in place in all admission areas to facilitate testing for COVID-19, for Influenza and for RSV (in Paediatrics). This supports optimum patient placement/segregation and pathway to minimise the risk of cross infection. Trust has designated wards and areas in order compartmentalise cases, with the facility to step up and down as demand changes.** **A multidisciplinary team approach including Senior leaders, estates and facilities, IPC and clinical staff is applied in reviewing services and buildings, via joint walk rounds.** 		

• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	**Safer working risk assessments are completed and risk mitigated against. For example screens at receptions and in office areas. Natural ventilation, PPE. Maximum occupancy signage is displayed accounting for safe social distance.** 1a-1b.-COVID-19-Safe-Working-Risk-Asses		
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. o applied in order and include elimination; substitution, engineering, administration and PPE/RPE**.** o communicated to staff.	**Estates are working across the Trust to assess ventilation in all areas and put into a RAG prioritisation plan for work with regard to ventilation. Where ventilation is not optimum, extraction is being put in place, air scrubbers are being used and where there are high numbers of COVID-19 positive patients with respiratory symptoms and AGPS staff wear a higher level of RPE.**		

• safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	**Risks are discussed and reviewed through local governance processes.**		
• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	**National IPC guidance is being followed. Care pathways remain unchanged. Any deviation from guidance is assessed through governance processes and escalated to Execs as appropriate.**		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	**Workplace risk assessments are undertaken by staff who have the skills and knowledge to recognise hazards associated with infectious agents. This work is supported by the members of the IPC team.**		

• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	**Wards/departments where there are high numbers of COVID positive cases with respiratory symptoms/AGPS FFP3 masks are used as standard.**  covid-19-flowchart (8) 280121.pdf		
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	**Patients are not moved unnecessarily except for clinical need or if there is a change in their infectious status. Where patients are moved this is done with consideration of the clinical context and where the patient can receive the most appropriate care.**		
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	**In place** **Senior leaders are visible in both clinical and non-clinical areas and check and challenge IPC practice where appropriate to do so** **IPC Ward Accreditation processes are ongoing for wards and departments. IPC practice education material has been put out together as**		

• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • the application of IPC practices within this guidance is monitored, eg: o hand hygiene**.** o PPE donning and doffing training. o cleaning and decontamination. • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board. • the Trust Board has oversight of ongoing outbreaks and action plans.	**part of essential standards that are expected from NHSP/Agency staff when they book shifts in the Trust.**  NHSP educational material.pdf **Hand Hygiene, PPE audits are completed by IPC staff.** **In place** Exec representative is invited to outbreak control meetings. Divisional managers and matrons attend outbreak control meetings and action any points raised at the time of the meeting.	Due to high COVID activity in relation to the resource within the IPC team, face to face donning and doffing training cannot be facilitated. There is a delay on writing up of outbreak control meetings due to IPC workload and increased number of outbreaks and no	At the outset of the pandemic large numbers of staff were trained in donning and doffing correctly and PPE safety officers were in place. PPE safety officers have since returned to clinical practice. Re-working of the IPC budget has occurred and a band 3 admin assistant has been appointed to release specialist nursing time. The

		admin support within the team.	post is at the employment check phase.
the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	**Staff are fit tested on Reusable GVS masks and these are issued to individuals. In addition the Trust has a supply of UK make FFP3 masks should they be required and FIT testing for these are ongoing**	The majority of new groups of staff to the organisation are fit tested if they are working in clinical practice, by the education department. New starters who are not in clinical practice are referred to the IPC team for FIT testing.	Re-working of the IPC budget has occurred and a band 3 admin assistant has been appointed to release specialist nursing time. The post is at the employment check phase. National fit testers are supporting the Trust in Fit testing currently but can only test on disposable masks using the qualitative method and not the quantitative method.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	**National Cleaning standards have been reviewed by Estates and facilities colleagues with IPC. Risk stratification and gap analysis has**		

	been completed. Plan is to implement by May 2022.		
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	 B0271-national-stand ards-of-healthcare-cle **The Trust has a Space Utilisation Group where functionality is reviewed and agreed. Any changes are discussed with the DIPC/IPC team.**		
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	**Environmental audits are completed by the IPC team. Cleanliness audits are completed by estates and facilities staff, frequency dependent on the risk stratification. Any required action is taken to maintain cleanliness standards.**		
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	**Areas where there is a higher risk of transmission of infectious organisms received enhanced cleaning twice per day and ad hoc as required.**		

• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	**Peracide is used – Peracetic acid** PERACIDE SDS V5 28.05.21.pdf		
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	**Prior to implementation of Peracide, work was undertaken by Microbiology colleagues and IPC team to test and approve the agent for cleaning. It is effective against enveloped viruses and other infectious organisms.**		
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	**In place**		
• a minimum of twice daily cleaning of: o patient isolation rooms. o cohort areas. o Donning & doffing areas o 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. o where there may be higher environmental contamination rates, including:	**In place. Estates and facilities clean all except commodes which is done by nursing staff.** **In Place.**		

▪ toilets/commodes particularly if patients have diarrhoea. • A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions. o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); o following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: o between each use**.** o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or	**RAG rate has been devised to assist with level of cleans required and to clarify cleaning roles and responsibilities.** A3 cleaning RAG.pdf **In place** **In Place.** **Cleaning checklists are held at ward level and reporting on the electronic dashboard.** **Cleanliness is audited by estates and facilities and patient equipment is audited by IPC team and is included in the Ward Accreditation.** **Ventilation is not adequate in some wards and departments**		**Estates are undertaking review of ventilation and are RAG rating**

mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.			**areas for work and working to prioritise areas with IPC. Air scrubbers have been purchased to improve air filtration**
• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	**The ventilation safety group is in place including estates, ventilation engineer and IPC to inform ventilation assessments and work.**		
• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	**This is in progress** **All external windows and doors are opened where possible to improve natural ventilation.**	**In older parts of the estate, windows cannot be opened.**	**Work is planned for estates to construct extraction panels in the windows.**
• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	**HEPA Filtered Air scrubbers have been purchased with a plan to purchase more. Priority list has been drawn up and first machines have been placed in clinical areas.** **Assessments for screens are undertaken and fitted by Estates colleagues where appropriate and are incorporated into cleaning regimes.**	**When switched on fully the machines are noisy which may be difficult for patients trying to sleep.**	**Machines are being set to 50% to reduce the noise.**

• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.			
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: o to reduce inappropriate prescribing. o to ensure patients with infections are treated promptly with correct antibiotic.	**The Trust has an antimicrobial pharmacist who is works with Microbiologists to optimise antimicrobial stewardship advice. Antibiotic audits are undertaken by Microbiologists, antimicrobial pharmacist and IPC team.** **Trust guidelines are in place and updated according to guidance.**	**Frequency of auditing has reduced due to increased workload in the Microbiology team and IPC team. The previously fulltime antimicrobial pharmacist has returned from maternity leave on part time hours therefore affecting the pharmacy resource for antimicrobial stewardship**	
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	**In place. Regular audits of high risk antibiotics are completed for wards/departments and are shared through governance processes.**		
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	**Antimicrobial guidance and advice is given to minimise the risk of consequences of other pathogens such as Clostridioides difficile and others. Post Infection Reviews**		

	identify themes in prescribing of antibiotics which are reviewed via governance processes.		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	**Compassionate visiting guidance is in place to support visiting wherever possible. Visiting at the end of a patient's life and where patients require a relative or carer to be with them is supported as much as possible. When infection prevalence is high in the community and during outbreaks, visiting is restricted.**  C1519 Visiting healthcare inpatient s‹		
• national guidance on visiting patients in a care setting is implemented.	**In the most part in place. Visitors will be asked to complete a lateral flow test prior to visiting.** **During outbreak this is restricted except at end of life and where**	**Difficulty in policing lateral flow testing and gaining evidence that test has been completed.**	**Questions are asked of visitors on arrival, whether they are symptomatic or have had any known contact with a positive case. Temperatures are taken. Visitors attend by prior arrangement.**

• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	**patient needs a carer or relative to be with them throughout their admission. Where visiting in these circumstances is in place, staff communicate the risk to individuals and provide support to minimise risk, such as wearing of PPE, hand hygiene.**		
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	**There is signage in place.**	**The signage varies between departments**	**Identified member of the IPC team is to work with Comms/medical illustration to rationalise and standardise posters/written information**
• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	**In place. Type 2R masks are in dispensers in selected high traffic entrances for patients and visitors to take and wear.**		
• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential	**All visitors to wards and department are asked standard questions relating to them feeling unwell, having respiratory symptoms or whether**		

for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	**they have been a contact of a positive case of COVID-19. Where there is a question of status and to facilitate compassionate visiting, POCT is performed to have a COVID-19 test result within twenty minutes.**		
• visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	**Visitors are not present during AGPs. If a patient is at the end of their life or where it is essential that a patient is accompanied a hood can be provided for the visitor to Provide respiratory protection whilst visiting their loved one.**		
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	**Elements of the toolkit appropriate to the Trust is implemented.**		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	**Patients are asked on arrival to departments**	**Notices are not consistently displayed.**	**Member of the IPC team is working with comms and medical illustration to rationalise and standardise signage.**
• infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	**In place**		
• staff are aware of agreed template for screening questions to ask.	**In place. Clear and consistent signage will also help.**  Screening questions.pdf		
• screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	**Patients attending for elective procedures are screened 72 hours prior to attendance and asked to isolate until their procedure.**		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	**Patients are triaged in admission areas for suspected or confirmed COVID-19. All patients admitted are screened using the ABBOTT ID NOW point of care machine and patients are set on the appropriate patient pathway (Yellow or blue)**		

• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	**In place**		
• there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	**Compliance with testing protocols is monitored by the IPC team and where compliance is problematic, screening regimes are altered to minimise the risk of infection based on the patient group and area. For example weekly testing in some inpatient areas where there have been outbreaks. DBTH screening regimes have always been more frequent and robust than national guidance.**		
• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	**In place. In patients are given FRSM Type 2 R.**	**Some patients will not wear masks because they are exempt or due to**	**Where masks are not tolerated, other IPC measures are optimised. For example**

• patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	**Outpatients are requested to change face covering to FRSM Type 2R (provided) on arrival to department.** **Patient with Respiratory symptoms are segregated and POCT test completed on arrival. They are then either segregated or cohorted dependent on results and retested on day 3, day 5, and day 7 of their admission (if they remain negative)**  SOP OPD final.doc **Patients who have respiratory symptoms are treated as suspected COVID 19 until proven otherwise. They are therefore isolated or cohorted. They are tested at the first available opportunity. POCT results are returned within 20 minutes and**	**cognitive impairment**	**segregation from others, social distancing and hand hygiene. Staff are asked to wear visors where patients do not wear masks to protect them from COVID-19 passing from infected respiratory secretions to the eyes of the member of staff.**

	the patient is placed on the appropriate pathway.		
• patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	**Patient placement is risk assessed by clinical teams with advice and support from the IPC team. Patients who are high risk are accommodated in side rooms where possible or segregated from others. To further minimise risk, weekly screens are performed on at risk groups. For example Haematology, Chemotherapy patients, Renal patients and other groups of patients. Patient placement is based on risk assessment by clinical teams with IPC support and advice. Compassionate visiting is in place.**		

	The clinical condition and appropriateness of delay is assessed by the clinicians on a case by case basis. Wherever possible treatments/procedures are delayed until symptoms have resolved. Where procedures are not delayed, a higher level of PPE is worn by staff.		
• face masks/coverings are worn by staff and patients in all health and care facilities.	**All staff wear face masks wherever possible.**	**Some patients cannot tolerate masks for clinical reasons or they are exempt.**	**Where masks are not tolerated, other IPC measures are optimised. For example segregation from others, social distancing and hand hygiene. Staff are asked to wear visors where patients do not wear masks to protect them from COVID-19 passing from infected respiratory secretions to the eyes of the member of staff.**
• where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.			
• patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	**In place**	**At times of increased demand, Patients in ED**	**All attendees are asked to socially distance where**

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	**In place wherever possible. Screens are in place in reception areas and some office spaces.** **Where patients become symptomatic and COVID is suspected, they are isolated promptly and screened. This does not happen often due to DBTH screening regimes. All patients are screened on day 0, day 3, day 5, day 7 and day 28 if they remain negative. If they are identified as a contact of a positive case whilst in hospital, they are screened at least weekly for two weeks. Since prevalence has increased with Omicron variant, the initial screening regime of day 0, 3, 5 and 7 is reset when they are identified as contacts on review by IPC. This means that COVID-19 in asymptomatic patients is detected and action taken to cohort/isolate before symptoms begin.** **Contacts are traced on each positive case detected whilst in hospital and a 'pink shield' electronic label is put on to CAMIS, patient placement of contacts are closely monitored and advice given by IPC on a daily basis.**	**cannot be socially distanced.**	**possible, wear FRSM and practice good hand hygiene, hand sanitisers are available for patient use as well as staff. Air scrubbers have been sited in the ED department to improve air filtration.**

• isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	**In place as above** **In place. Patients are who attend for appointments are asked screening questions. If identified as having symptoms, they are segregated from others until a clinical decision is made by the clinician as to whether the appointment can go ahead. The patient is advised accordingly.**		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors.	**Staff receive induction – this is via eLearning currently.** **Departments are expected to provide IPC principles to visitors. Ad hoc face to face education is provided by members of the IPC team in the ward or department environment.**	**No formal face to face training is provided by IPC due to increased COVID-19 activity and workload.**	
• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	**The majority of new staff are Fit tested on FFP3 masks by the education team at induction. Those staff who are not working in a high risk area are not fit tested at induction but are referred to the IPC team for Fit testing at a later date.** **IPC team aim to FIT test one day per week.** **National fit testing team are supporting the Trust with fit testing.**	**Since the onset of the pandemic, the demand for Fit testing has far outweighed what the IPC team can provide. At times of increased workload, the Infection Control Nurses are unable to provide Fit testing once per week.**	**A Band 2 who will provide Fit testing one day per week has been approved at VCF and is going to advert.** **National fit testers are supporting the Trust with fit testing and the education team are supporting also.**

• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	**At the onset of the pandemic large groups of staff were trained on appropriate use of PPE and how to don and doff safely. PPE safety officers were trained but returned to clinical practice after the first wave of the pandemic. IPC provide ad hoc PPE training. Guidance is provided on the HIVE and posters are available on how to don and doff safely.**	**Due to increased workload and COVID activity, IPC team cannot provide formal training in donning and doffing.**	**Reworking of IPC budget has release funds to appoint a band 3 admin worker to release IPC Nurses time. This is at the pre-employment check stage of the appointment process. Band 2 post has been approved at VCF and is going to advert. The band 2 will audit basic IPC practice in addition to fit testing.**
• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	**Ad hoc audits on the use of PPE is completed by the IPC team. Themes are discussed with clinical teams. Guidance is reinforced through HIVE.**	**Due to increased workload IPC team cannot regularly audit.**	**Reworking of IPC budget has release funds to appoint a band 3 admin worker to release IPC Nurses time. This is at the pre-employment check stage of the appointment process. Band 2 post has been approved at VCF and is going to advert. The band 2 will audit basic IPC practice in addition to fit testing.**

• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	**In place**		
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	**There are no hand dryers in use in the clinical areas. Absorbent paper towels are available and appropriately sited.**		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	**Staff are aware to maintain social distancing. Reminders are placed in buzz and social media. Posters are in place.**		
• staff understand the requirements for uniform laundering where this is not provided for onsite.	**Staff are aware of requirements for laundering uniform. This is covered in SET. In addition staff are instructed not to travel to and from duty in their uniform.**		
• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	**Staff are aware of current guidance which is available on the HIVE. The COVID Advice team and IPC give advice throughout the day to staff on isolation requirements. ABBOTT POCT testing is facilitated by the Occupational Health colleagues for rapid testing of staff identified as**		

	having contact with a COVID positive case. This is facilitated Monday to Friday 08:00 until 10:00 and 16:00 until 18:00.		
• to monitor compliance and reporting for asymptomatic staff testing	**Staff are encouraged to undertaken LFT testing routinely and to report results. Results are fed back to clinical areas periodically on levels of testing. Reminders to test via LFTs are given regularly via different channels and guidance is available on the HIVE.**		
• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	**Cases and contacts are reviewed daily. Local rates are reviewed and discussed in local partner calls and a response. Rates are reviewed in enhanced ops and inform actions.**		

• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	**All cases that meet the UKHSA criteria for probable or definite hospital acquisition of COVID-19 are reviewed. DATIX completed and PIR completed. Clusters are reviewed by DIPC and identified and reported as outbreak accordingly.**	**Due to number of cases, PIRs from wave one and two are completed retrospectively.**	**Admin post in IPC team appointed to, awaiting pre-employment check and date to start.**
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	**Where tolerated all patients wear face masks when moving around the Trust.** **Screening questions are asked on arrival. Where patients are identified as having respiratory symptoms, they are segregated and a PCR swab is taken. A clinical decision is then sought as to whether the appointment should continue to be rescheduled. This decision is made on a case by case basis and is driven by clinical need.**		

• patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	**Where appointments go ahead, IPC precautions appropriate to the high risk setting pathway are put in place.**		
• patients are appropriately placed ie, infectious patients in isolation or cohorts.	**In place and reviewed daily by IPC (Monday to Friday)**		
• ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	**In place. Senior leaders and clinical staff along with IPC conduct frequent walk rounds considering IPC risk and precautions.**		
• standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	**In place**		
• the principles of SICPs and TBPs continued to be applied when caring for the deceased	**In place**		
8. Secure adequate access to laboratory support as appropriate			

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals.	**Screening is undertaken by clinical staff. Where ABBOTT ID POCT machines are in place, staff are appropriately trained on their use.**		
• patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	**Screening for Respiratory viruses are done on admission, day 3, day 5, day 7 and day 28 if negative. If positive then screening is done at day 14 and every seven days until one negative us obtained in order to step down IPC precautions.**		
• staff testing protocols are in place	**Staff testing protocols are in place and guidance provided on the HIVE.**		
• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	**In place**		
• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	**In Place**		
• screening for other potential infections takes place.			

• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	**In place** **All emergency patients are testing using PCR and using rapid point of care testing in order to facilitate appropriate care and treatment within 20 minutes.**	
• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	**In Place**	
• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	**Screening takes place on admission, day 3, day 5 and day 7.**	
• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.		
• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	**Not in place** **Patients being discharged to care homes are tested via PCR within 48 hours. If result is not available to avoid further delays and associated risks, a Rapid POCT is performed. This is communicated to the home and PCR result is followed up by the IPC team who confirm the result with the care homes.**	**Not considered necessary currently**
• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	**In place. DBTH work closely with partners to ensure this happens.**	

• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	**All patients planned for elective procedures are screened 72 hours prior to the procedure and are asked to isolate until their procedure.**		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	**Ward Accreditation is in place, including regular audits. IPC team audit IPC practices.**		
• staff are supported in adhering to all IPC policies, including those for other alert organisms.	**IPC team advise on all aspects of infection prevention and control and support teams to apply best practice**		
• safe spaces for staff break areas/changing facilities are provided.	**Break areas and staff changing facilities are in place.**	**There are limited changing facilities and break areas. Some spaces have been designated staff break areas to assist staff to maintain social distancing during break times and mask removal.**	

• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	**Policies and procedures are available. Outbreaks are reported on the NHS electronic reporting system.**	**Written summaries of outbreak meetings are behind due to increased workload and no admin support in the IPC team. Admin post has been appointed to and at the pre-employment stage of the recruitment process. Outbreak meetings are held with key divisional leaders so that actions are agreed and taken forward.**
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	**Linen/laundry segregation is done in accordance with IPC guidance and policies using the red bags for soiled linen and linen from patients with infectious organisms. Linen is processed off site.**	
• PPE stock is appropriately stored and accessible to staff who require it.	**There is no shortage of PPE. Inventory management and procurement colleagues conduct regular stock checks and top ups to clinical areas.** **PPE in clinical areas are stored in Danicentres close to the point of care to facilitate appropriate use in accordance with IPC best practice.**	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Occupational Health, POD and IPC colleagues work together to provide advice and guidance in relation to COVID-19 and other infectious organisms		
• bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency staff are management as permanent staff in terms of deployment.		
• staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Staff are allowed to return to work in accordance with government guidance when they have been a contact of a COVID positive case. Where return to work may be delayed by awaiting PCR results, at times of critical shortages, ABBOTT rapid testing is offered to staff to ensure business continuity and patient safety through safer staffing.		

• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness and absence**.** o facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce o lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 o encourage staff vaccine uptake.	See section 6 above, page 26 See section 6, page 25 The COVID Advice team will speak with all staff who test positive and will conduct an assessment. Any breaches in IPC practices are discussed and further tracing of contacts is done. Advice on isolation and treatment are given. Offers of support with daily living such as shopping etc is offered to assist staff to isolate in accordance with guidance. DBTH also offer TLC service to promote health and wellbeing of staff throughout the pandemic. Flu and COVID vaccination programme is facilitated by OH/HR colleagues and has been very successful. Planning is progress to support the mandated vaccination status of all NHS staff from April 2022.		

• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	All staff whether vaccinated or not are treated the same in terms of PPE requirements and IPC practices. The difference for unvaccinated and vaccinated individuals is around the period of isolation. National guidance is followed in this regard.		
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups**;** o that advice is available to all health and social care staff, including specific advice to those at risk from complications**.** o Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff**.** o A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Individual assessments have been and continue to be carried out for staff in at risk groups. Advice on level of respiratory protection is given and redeployment is advised and put in place according to individual risk assessments carried out by OH colleagues.		
• vaccination and testing policies are in place as advised by occupational health/public health. • staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	In place See section 6. Standards are in accordance with HSE guidance and record of FIT testing is made against individual ESR records.		

• staff who carry out fit test training are trained and competent to do so.	Staff who fit test are trained and competent to do so.	Refresher training needs to be organised formally by Fit2Fit accredited instructor.	Fit2Fit accredited instructor from the manufacturer of the quantitative testing machines provides refresher training to a limited number of testers commensurate with number of machines purchased. As demand for fit testing has increased significantly and with it the number of fit testers required, funding will need be considered to facilitate refresher training for more individuals.
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	In place – see section 6		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	This is in progress	Resource required to fit test on two masks is immense and although is being worked towards, this may be unachievable	Fit testing is on reusable GVS masks in the first instance. A GVS is provided to each individual who passes a Fit test with the GVS mask. This is then to be looked after and used by each individual. Filter changes and replacement when

			damaged or lost is provided.
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Results of the Fit test (pass or fail) and the name of the masks on which the individual has passed or failed is recorded on ESR. Paper record is also provided to the individual.		
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Reusable GVS masks are used. Where the individual fails on this, alternative UK manufactured disposable FFP3 masks are provided after successful fit test. If individuals fail on all masks, hoods are available in departments for staff to use.		
• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	Where staff cannot be fit tested or wear a hood are considered for redeployment. No member of staff is expected to work in a high risk areas without the necessary PPE. Redeployment is offered after assessment by OH colleagues.		
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	In place within OH records. Records are available centrally on ESR, and are provided by Education and Training department on request. Wherever possible staff do not work across pathway		

• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	In Place		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	In Place see above		
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	In place see above	In order to maintain safe staffing levels, staff are sometimes expected to work across pathways	This is kept to a minimum and staff are not moved mid shift. They are expected to wear a clean uniform and shower between shifts.
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	In place		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	COVID Advice Line and Health and Wellbeing team support staff whilst in isolation.		

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	25 January 2022	**Agenda Reference:**	B5		
Report Title:	**Winter/Covid Nursing Workforce Board Assurance Framework**				
Sponsor:	David Purdue - Chief Nurse and Deputy Chief Executive				
Author:	David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:					
Report Summary					
Purpose of report:	In November NHSE/I published a Board Assurance Framework identifying best practice to ensure safer staffing in Trusts and to ensure joint responsibility for safety from the Board.				
Summary of key issues/positive highlights:	Trust board members are collectively responsible for workforce planning, practice and safeguards. The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance. The Document identifies the key elements required, these are; - Planning - Decision making and escalation - Staff training and wellbeing - Indemnity and regulation - Governance and assurance The Board are asked to approve the Framework and agree the next steps in respect of the areas of work which need to be supported, in relation to standardisation of risk assessments and the timescales for the digital tools to aid decision making and assurance.				
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:			
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:	None		

Winter 2021 preparedness: Nursing and midwifery safer staffing

Planning

When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments in Covid-19 pandemic continue to be incorporated into staffing escalation plans.

Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.

Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances.

Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive director of nursing and countersigned by the medical director as joint quality lead.

Decision making and escalation

When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.

Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.

Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.

Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.

Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.

Staff wellbeing should be embedded at every level. For example, team-based check- ins, wellbeing support hubs and wobble rooms.

Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.

Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate risks using available resources effectively and responsibly.

The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. This remains as important as it ever was. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.

To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting.

Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.

Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic - and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance - and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.

Where necessary, CQC and regional NHS England and NHS Improvement teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	Details	Controls	Assurance (positive and Negative)	Risk Reference	Further action needed	Issues currently escalated to Local Resilience Forum /	Ongoing Monitoring / Review
1. Staffing Escalation / Surge super surge plans							
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e., intensive care) or as per the NQB safe staffing guidance	Plans in place for staffing for surge areas, with red line staffing levels agreed at divisional level Additional roles identified to assist at ward and department level. Training plan in place for DCC and ward liaison	Chief Nurse in support of current staffing levels. Clear escalation triggers identified for ward areas if staffing falls below	Q&E9, F&P 6 and F&P 8	Currently reviewing an establishment plan for Covid 19 escalation which requires additional surge capacity to open	NHSE/I aware of staffing. Mutual aid plans in place for the ICS	Staffing checked daily by DDoN and 3 times a week by the DoN
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter	Plans for winter capacity, form part of the winter plan	Ward expansion will only be supported if staffing levels are above red line levels	Q&E9, F&P 6 and F&P 8	Currently reviewing an establishment plan for Covid 19 escalation which requires additional surge capacity to open	NHSE/I aware of staffing. Mutual aid plans in place for the ICS	Staff review meetings

1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Winter Plan shared with staff side	Staff-side supportive of plans. RCN letter to Chief Nurses outlining the approach to staffing levels	Q&E9, F&P 6 and F&P 8	N/A		
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	QPIAs in place when new wards are opened and signed off by CN	QPIAs	Q&E9, F&P 6 and F&P 8	N/A		
2. Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact Local leadership is engaged and where possible mitigates the risk Staffing challenges are reported at least twice daily via Bronze	Staffing levels reported at the 4x daily operational meetings. The Divisional nurse directors review staffing on a daily basis, with a risk matrix	Staffing shortfalls and mitigated actions uploaded to Datix. Any incidents on the wards are triangulated to staffing shortfalls	Q&E9, F&P 6 and F&P 8	Standardisation of the risk tools as different in each division		Reviews occur daily
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained	Formal staffing review meetings held 3 times a week to ensure staffing plans in place. Key issues escalated to enhanced Ops call	A process is being agreed to ensure staffing plans from each division are collated together	Q&E9, F&P 6 and F&P 8	Reviewing the process with the site team overnight and at weekends		

2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs	As part of the staffing plans all areas have at least 1 registered member of staff from the ward or department who overseas the other registrants	Risk assessments of staffing areas on a daily basis. Risk rated according to dependency	Q&E9, F&P 6 and F&P 8	Introduction of the Safecare model on Allocate will support the need to move staff		Safecare roll out May 2022
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over	Staff are inducted into areas and are aware of the ways to report their concerns	Review of the Datix system identifying concerns	Q&E9, F&P 6 and F&P 8			
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting	Induction policy in place for all agency staff, including guides on IT equipment	Feedback from monthly meetings with Agencies and NHS Professionals	Q&E9, F&P 6 and F&P 8			
2.6	The Trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice	Datix is the tool used to report staffing issues. Local support is available through the matrons supporting the areas	Review of Datix reports	Q&E9, F&P 6 and F&P 8			
2.7	The Trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing	Key staff areas are supported by clinical psychologists. Health and Wellbeing offers	Staff feedback mechanisms on support available Review of sickness and	Q&E9, F&P 6 and F&P 8	Review of support mechanisms in place for staff		

	The Trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care	are available to staff through Vivup. Open Events are held for staff to voice any concerns	absence rates Staff survey results				
2.8	The Trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care	Staffing reviewed on a daily basis by Divisional Directors of Nursing and risk rated according to dependency. Staffing reported 4 times day	Triangulation of incidents against staffing levels through Datix. Staffing levels reported to Board of Directors and QEC	Q&E9, F&P 6 and F&P 8	Introduction of Safecare will enhance the visibility of safe staffing. Perfect Ward as a quality tool will triangulate staffing levels with incidents		Safecare roll out May 2022
3. Daily Governance via EPRR route (when/if required)							
3.1	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold)	Discussed and escalated 4 times a day through Operational meetings	Documented actions for staff shortfalls held within Divisions	Q&E9, F&P 6 and F&P 8	Log of staff movements to be developed for out of hours		
3.2	The Trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary	Regional calls are instigated when a Trust develops issues. ICS Chief Nurses will meet to review staffing across the system, which includes representation from NHSE/I and NHSP	Mutual aid policy	Q&E9, F&P 6 and F&P 8		Escalation triggers in place to instigate response	

3.3	The Trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients	Allocate allows the matrons to review staffing levels. Daily meetings assess dependency through Nerve Centre	Board reports on safer staffing. Twice yearly SNCT report to Board	Q&E9, F&P 6 and F&P 8	Safecare will allow improved granularity		Safecare roll out May 2022
4. Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks	Board and Quality and Effectiveness Committee receive staffing updates at each meeting. Identifying areas of difficulty	Board reports on safer staffing Annual workforce planning document	Q&E9, F&P 6 and F&P 8	Perfect Ward roll out will allow for improved triangulation of staffing on incidents		Safecare rollout May 2022. Perfect Ward roll out July 2022
4.2	Information from the staffing report is considered and triangulated alongside the Trust's SI reports, patient outcomes, patient feedback and clinical harms process	This triangulation forms part of the ward and departmental accreditation	Governance meeting minutes Safer Staffing Reports	Q&E9, F&P 6 and F&P 8	Improved through the roll out of the Perfect Ward tool		July 2022
4.3	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis	Winter plan and operational oversite is a standing item at the Quality and Effectiveness Committee	Minutes from QEC and escalation if required to Board	Q&E9, F&P 6 and F&P 8	N/A		

4.4	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee The Board is further assured that active operational risks are recorded and managed via the trusts risk register process	Reports from all sub meetings are shared at Board and escalated risks discussed Workforce challenges, including risks related to Covid are included on the risk registers	Minutes from sub-Board committees with escalated risks Workforce risks reviewed BAF assurances	Q&E9, F&P 6 and F&P 8	N/A		
4.5	The Trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e., risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	Risks reviewed as part of the Board Assurance review Staffing ratios are reviewed daily and risks are mitigated within the agreed limits. Further changes would need to be agreed at Board	BAF reviews for True North objectives	Q&E9, F&P 6 and F&P 8	Covid extreme ward ratios being agreed with DDoNs and will be agreed at QEC in the first instance		February QEC
4.6	The Trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	Staffing and Covid both form part of the BAF	Review of the BAF at each Board	Q&E9, F&P 6 and F&P 8	N/A		

4.7	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	The Board structure is based on the BAF so agenda's will be focused on the key areas	Board planning and BAF review	Q&E9, F&P 6 and F&P 8	N/A		
4.8	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	Staffing forms part of the monthly agenda for CQC relationship meeting. Any key issues are escalated to CQC which may affect patient safety	Key issues identified in the safer staffing paper	Q&E9, F&P 6 and F&P 8	N/A		

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	January 2022		**Agenda Reference:**	C1	
Report Title:	Our People update				
Sponsor:	Karen Barnard, Director of People & OD				
Author:	Karen Barnard, Director of People & OD				
Appendices:	None				
Executive Summary					
Purpose of report:	As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care				

Summary of key issues:	The report this month provides an update to the Board in relation to:
	• Absence, in particular:
	  ○ Sickness
	  ○ Absence line reporting
	  ○ Staff testing and swabbing
	Late December saw a spike in covid absence levels; at the time of writing the paper we are now seeing a reduction in levels. This Trust are on a par with levels within South Yorkshire.
	• Vaccine programme and Vaccination as a Condition of Deployment
	• Health and wellbeing self-assessment update in relation to board leadership (the assessment has taken the compliance figure to 90%) and wider action plan				

Recommendation:	Members are asked to receive this report.				
Action Require:	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:	SA2 & 3 – future risks in relation to morale and resilience of colleagues as we move into the recovery phase				
Corporate risk register:	PEO1 – Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development PEO2 – Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure				

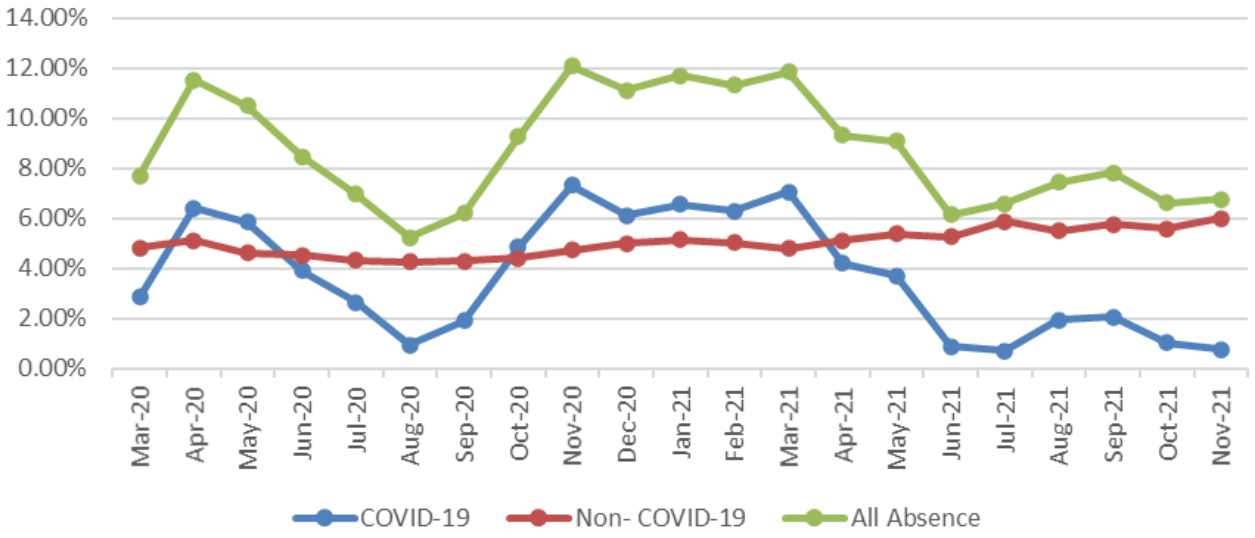
	(ii) Inability to meet and Trust strategy (iii) Inability to provide viable services.		
Regulation:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	People Committee		
Date:	2nd November 2021	**Decision:**	Assurance
Next Steps:	Ongoing discussions at People Committee		
Previously circulated reports to supplement this paper:	None		

1. Absence

Sickness and related absence

As can be seen Covid related absence did reduce after April 2020 and then rose from September 2020 with fairly static levels through to March 2021 followed by reducing levels. However more recently we have started to see a rise in covid related absences. It should be noted that non covid related sickness absence has continued at a similar rate to previous years but more recently we have seen a rise in non covid absences. As the data available is only through to November 2021 the sudden spike in covid related absence levels aren't shown in the graphs below – however Figure 2 demonstrates the rise we saw towards the end of December – this continued into January 2022.

Figure 1 – Absence Graph, March 2020 – November 2021



The table below provides a trend line of the various covid related absences for the month rather than the on the day figures – this demonstrates the rise in covid rates and absences that we are seeing across the Trust.

Figure 2 – Covid Absences, December 2021

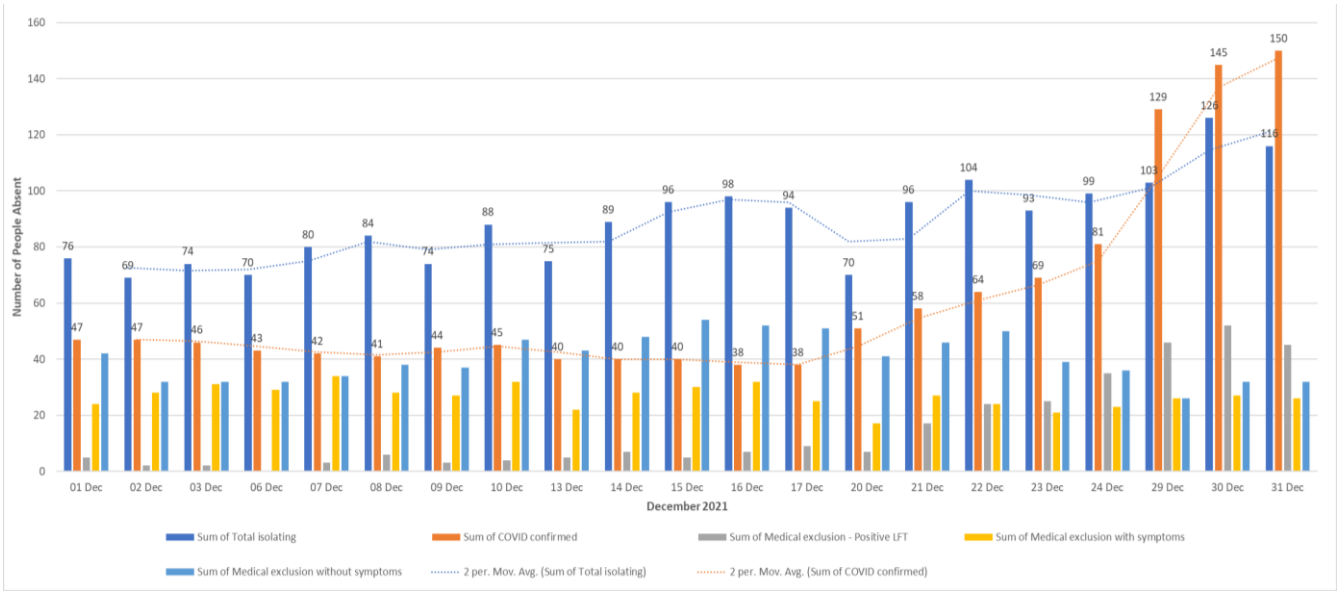
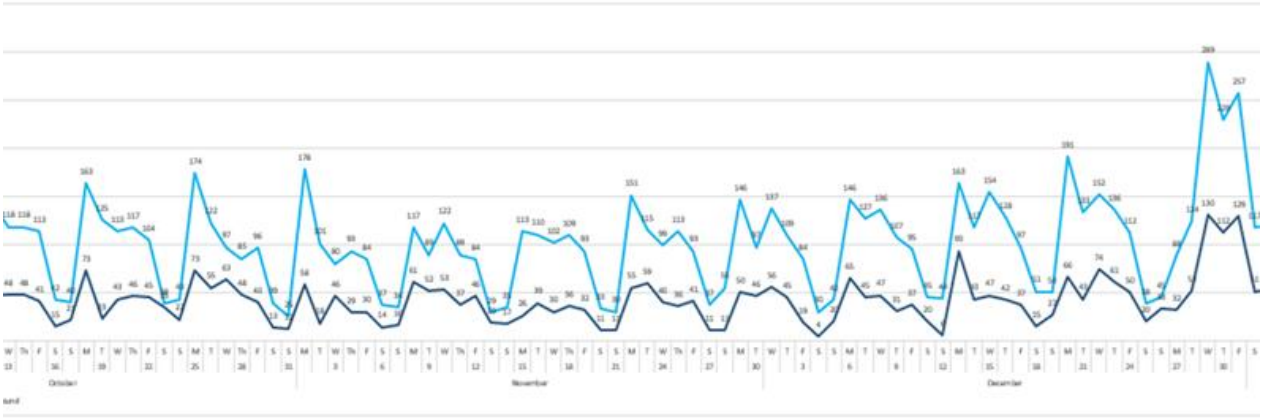


Figure 3 details the volume of calls usually received by the absence line with the sudden rise at the end of December.

Absence line reporting

Figure 3 – Calls the absence reporting line



Staff testing & Swabbing

The graphs below detail the numbers of staff who have been swabbed and tested positive, again the rapid rise toward the end of December and into January being visible.

Figure 4– Swabbing data, March 2020 to December 2021

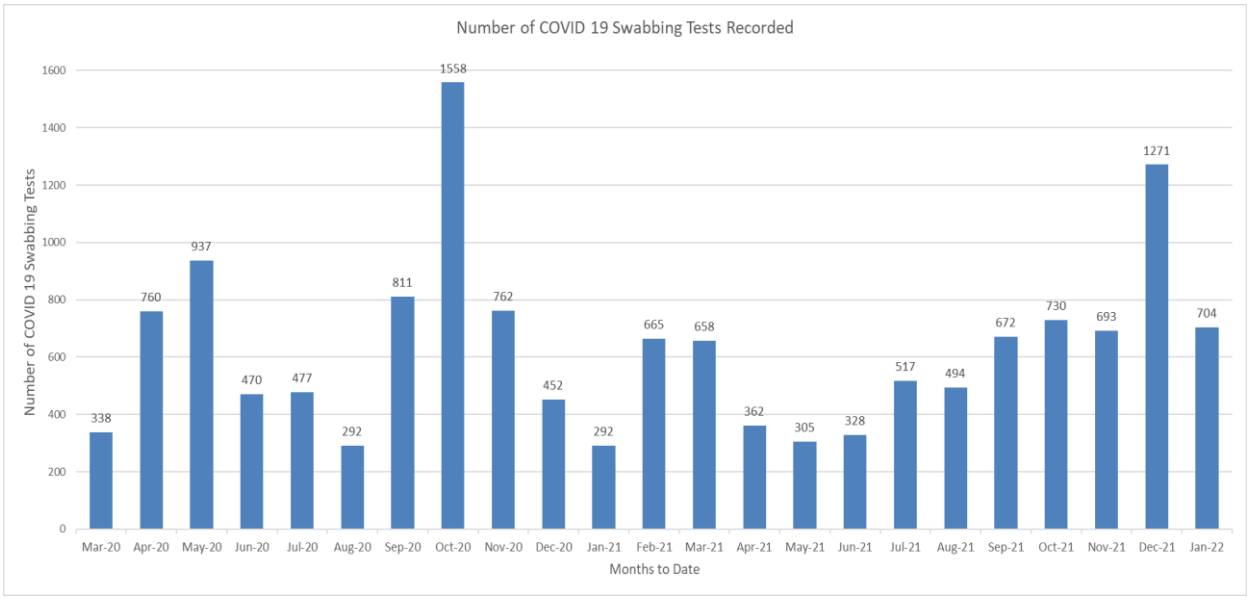
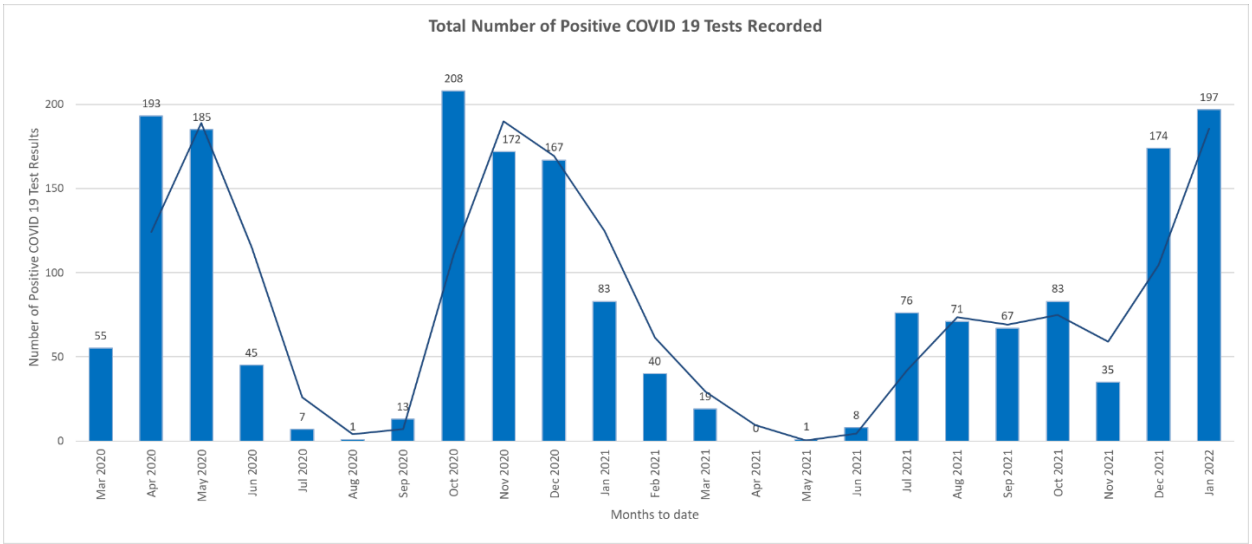


Figure 5 - Positive test data, March 2020 – December 2021



In order to support colleagues back to work quicker where they had been identified as contacts of positives in households we introduced at pace a testing facility (initially in the marquee at Gate 4 and subsequently moved to D block and also in OH at Bassetlaw) where colleagues were fully vaccinated, asymptomatic and testing negative on lateral flow could receive a point of care test (Abbott) which facilitated them returning to work following the test if negative (a handful of colleagues did test positive and were then advised to obtain a PCR test and self isolate). There have been subsequent changes to the national self isolation guidance which we have implemented.

2. Vaccine Programme

The Trust commenced the vaccination programme for this year's flu season on 21 September with the aim of offering all DBTH employees' opportunity to have the vaccination. In conjunction with the flu campaign we have also been required to undertake the covid booster vaccination programme for all DBTH staff and in addition, operate as a hospital vaccination hub and offer the booster vaccination to the wider health and social care staff as provided for both the first and second doses of the vaccination. We have continued to offer both the first and second covid doses of the Covid vaccine in preparation for the introduction of the mandatory vaccine coming into place.

Current Position – Covid vaccine

Although the programme has had multiple challenges, it is proving to be a success story and 86% of staff have now been vaccinated for covid boosters.

All Trust Uptake Comparison

The data shown below shows uptake of the Covid vaccine and boosters in Healthcare Workers on ESR in NHS Trusts with the national covid booster uptake standing at 85%. In terms of first and second doses the national data as at 10 January indicates an update of 94% and 92% respectively.

Table 1 – Covid vaccine & booster uptake, as at 10th January 2022

NHS Organisations	1st Dose	2nd Dose	Booster (Total ESR Population)	Booster (Eligible Population)
North East and Yorkshire	**96%**	**94%**	**79%**	**86%**
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	*97%*	*94%*	*82%*	*90%*

Flu Vaccinations

The data below shows flu uptake in Healthcare workers on ESR in NHS Trusts.

Table 2 – Flu vaccine uptake, as at 10th January 2022

NHS Organisations	Vaccinated	Eligible Population (ESR)	Uptake
North East and Yorkshire	**150,933**	**254,109**	**59%**
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	*4,401*	*6,829*	*64%*

3. Mandatory vaccines as a condition of deployment

On 9th November 2021, the Department of Health and Social Care announced that subject to parliamentary approval, all NHS workers who have face-to-face contact with patients will need to have been fully vaccinated against COVID-19 to continue to work in such roles from 1st April 2022 unless they are medically exempt. This was enacted into legislation on 6th January 2022.

The new legislation is to ensure that both our patients and colleagues gain the greatest possible level of protection against COVID-19 infection. The evidence is now clear that COVID-19 vaccines are the best way of protecting yourself and those around you. The national guidance confirms that:

The regulations apply to all staff who are required to work in a clinical setting where care is delivered, including within the community, and will therefore have face-to-face contact with patients. This includes many DBTH colleagues who may not be directly involved in patient care or may only need to enter such settings occasionally. We have agreed the definition of:

'We determine that only individuals who may enter any clinical areas as part of the patient pathway (e.g., ward areas, outpatients departments etc. rather than corridor areas) during their role are deemed to be within scope. This will limit the impact of the new regulations and ensure redeployment opportunities are available to unvaccinated colleagues, however this will likely necessitate significant work within some services to redefine roles or working arrangements such that there will never be a requirement for an unvaccinated individual to have incidental contact.'

Any unvaccinated colleagues who have patient contact roles will need to have had their first dose of a COVID-19 vaccine by 3rd February 2022 in order to have their second dose by the deadline of 31st March 2022. Anyone who has not received their first and second dose by 1st April 2022 (and who does not have a medical exemption) will then not legally be able to continue working in such roles or entering such settings, and we will need to review their duties, before exploring suitable redeployment opportunities. However, there is a risk that this will impact on our ability to continue to employ individuals in these circumstances if suitable alternative employment cannot be found.

At the time of writing this report we have 234 colleagues employed by us for whom we do not have a vaccination record – some of these colleagues will be applying for a medical exemption or may be pregnant or may be employed in a role which is out of scope. We are gathering that information by writing to them and their managers directly. Discussions will be taking place with colleagues who are not medically exempt from being vaccinated to explain the consequences and to provide the appropriate support. We continue to offer drop in sessions and provide access to various materials in support of having the vaccine. Should there be colleagues who are not vaccinated or medically exempt by 3 February 2022 the Trust is required to commence meetings to serve notice. Options around redeployment will continue to be explored during the notice period. As with any dismissal colleagues will have the right of appeal. It should be noted that this is not an easy process for Trust managers to undertake and we need to continue to support them during this period too but we are required through government legislation to enact this requirement.

4. Health and wellbeing update

Introduction

The *Our NHS People* Promise spells out the national commitment to work together to improve the experience of working in the NHS for everyone. The themes and words that make up *'Our People Promise'* have come from those who work in the NHS in different healthcare roles and organisations and have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace.

The following statements are a direct lift from the NHS People promise and highlight the importance of the wellbeing of people working in the NHS.

We are safe and healthy

- We look after ourselves and each other.
- Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need.
- We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.

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- We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.

We are compassionate and inclusive

- We do not tolerate any form of discrimination, bullying or violence.
- We are open and inclusive.
- We make the NHS a place where we all feel we belong.
- Together, WE make the NHS the best place to work.
- We are the NHS.

We are recognised and rewarded

- A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.

We each have a voice that counts

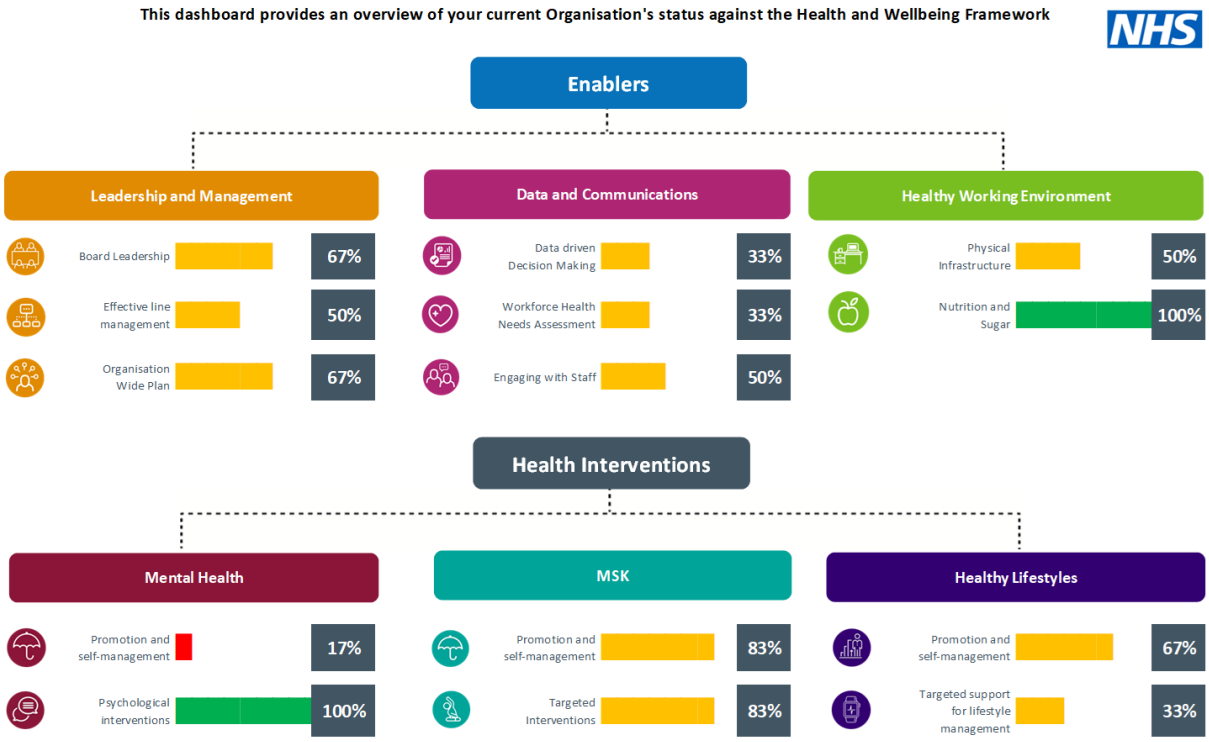
- We all feel safe and confident to speak up.
- And we take the time to really **listen to understand the hopes and fears that lie behind the words.**

Background

The health and wellbeing committee undertook a diagnostic exercise to review against the good practice framework to take stock of our approach and the impact it has upon our workforce.

The summary chart below reflects the collective voice of the committee and our assessment status.

Report Title: Author: **Karen Barnard** Report Date: **January 2022**



From the framework assessment undertaken by our multi-professional committee members a DBTH Health and Well Being action plan has been created to support our organisational commitment to drive improvements in employee health and wellbeing. It is clear that the support of the Board is in place along with the commitment to utilise charitable funds for wellbeing initiatives and roles to support the ongoing commitment to wellbeing. An outline business case has been developed and submitted which includes access to occupational therapy, psychological and mental health support along with complementary and holistic therapies along with the development of a garden room. The Board will regularly receive updates through the Chief People Officer and the Wellbeing Guardian to ensure the demonstration of ongoing commitment to the wellbeing of our colleagues. On the basis of that commitment and support I have reviewed the self assessment in resect of Board leadership and have determined that the specific item against Board leadership would increase to 90% - see below for the specific lines of enquiry.

Is health and wellbeing of staff considered in every leadership decision, equally to that of performance, quality and finance?	- Health and wellbeing is regularly on the agenda of board meetings, is considered a priority and results in a proactive approach - Board (or senior leadership team) regularly review health and wellbeing reports on progress - The board (or senior team) have outlined their responsibilities towards the health and wellbeing of our NHS people
Do the board / senior leaders actively advance and promote a clear vision and strategy for employee health and wellbeing?	- Board set clear vision and objectives for staff health and wellbeing and the strategy is in place/marketed - Board actively and visibly promote health and wellbeing and take part in activities and communications
In the past year have the board or senior leaders provided the funding and resources to effectively meet staff health and wellbeing needs?	- There is a health and wellbeing budget - Clinical expertise and oversight is in place at board level (e.g. from Occupational Health)
Is there a wellbeing guardian in place?	-There is a named wellbeing guardian on the board and they are supported to discharge the responsibilities of this role effectively

Leadership and management

It is known that managers and leaders are fundamental to creating positive and healthy working environment for the people they lead. It is the responsibility of senior leaders to role model what healthy behaviours look like in organisations and important that skilled leader and managers build and sustain cultures of health and wellbeing.

Managers at all levels are at the centre of an individual's work experience and wellbeing and create the climate for their people. The NHS staff survey tells us that there is work to do to support and develop line managers. Investment in managers is critical success factor. The NHS people promise highlights that

"Managers need training and given the right tools to effectively support their teams, " this is the same situation at DBTH.

From our own DBTH diagnostic it is evident there is work to do on:

- Developing Line managers skills and capability in creating healthy and supportive workplace cultures
- Increasing the wellbeing conversations at Board level
- Creating a DBTH plan for wellbeing.

Data and Communications

More work to do on the quality and capture of staff wellbeing data and experience. The new People Dashboard will help with this.

Healthy working environment

The NHS People Promise explains that physical workspaces and the facilities available for our people to rest, recover and succeed. A healthy workplace is one where workers and managers collaborate to continually improve the health, safety and wellbeing of all workers and by doing this, sustain the productivity of the business. Given we spend one third of our lives at work, the working environment can have a significant impact on our health and wellbeing. Getting the basics right, such as clean restrooms with locks on the toilets, proper space dedicated for lunch/breaks and access to drinking water is vitally important and should not be underestimated. Additionally, workers need a work environment in which there is not only an absence of harmful conditions that can cause injury and illness but one that supports healthy choices and offers resources to actively encourage healthy behaviour.

Our diagnostic and wellbeing feedback suggests there is work to do on improving access to wellbeing spaces. Staff breaks, nutrition and hydration.

Improving personal health and wellbeing

Personal health is more than the absence of dysfunction and disease. Mental and emotional health, physical health and a healthy lifestyle all contribute to an individual's health and wellbeing.

The proactive interventions and services that empower our people to manage their own health and wellbeing fall into the following headings.

- mental and emotional wellbeing
- physical wellbeing
- healthy lifestyle.

Mental health conditions are consistently the highest reason for sickness absence in the NHS. Our DBTH tells us that our top reason for staff absence is stress, anxiety and depression. The second reason is musculoskeletal problems such as back, shoulder and knee pain are the leading cause of working days lost.

Fulfilment at work

How our work at the NHS inspires our NHS people and how we support their growth and passion.
Section's cover:

- bringing your whole self to work
- life balance
- purpose, potential and recognition.

Fulfilment at work encompasses not only the work we do on a day-to-day basis but a range of themes and activities that together form a critical component of an individual's health and wellbeing. This includes enabling the diversity of our NHS people to bring their whole self to work, enabling life balance, and helping our talented people reach their full potential.

Key stakeholder feedback

- "Equality, diversity and inclusion themes need to be heavily embedded in our approach to health and wellbeing"
- "Job redesign is essential, but it needs to be enabled by effective and compassionate people policy"
- "Supporting our NHS people to develop will lead to a more effective and engaged workforce"

Snapshot of people's experience

- Disabled NHS people are 9% more likely, compared to non-disabled NHS people, to be pressured to come into work despite not feeling well enough to perform their duties (32.0% vs. 23.0%) (50)
- Just 40.7% of black and minority ethnic NHS people believed that their organisation provided equal opportunities for career progression or promotion compared to 88.3% for white NHS people (52)
- White applicants were 1.61 times more likely to be appointed from shortlisting compared to black and minority ethnic applicants. This is worse than in 2019 (1.46) which itself showed no improvement on the previous year. There has been year on year fluctuation but no overall improvement over the past five years. It was 1.60 in 2017 (106)

Managers and leaders

How our leaders and managers across all levels of the NHS provide health and wellbeing support as part of their role. Section's cover:

- senior manager responsibilities
- healthy leadership behaviours
- skilled managers.

Culture and Relationships

Extensive evidence shows that having good-quality relationships can help us to live longer and happier lives with fewer mental health problems. Having close, positive relationships can give us a purpose and sense of belonging.

We know that leaders create the climate for their teams and are critical to

The ways our teams work together with care and compassion.

- working together
- supporting each other

Key stakeholder feedback

- "Sometimes it's as straight forward as getting the basics right like space to rest, reflect and replenish "
- "Organisations need to strike a balance between pastoral and clinical working environments"
- "The wider economic, natural and community environment needs to be considered".

Snapshot of people's experience

- 4.8 million working days in human health and social work are lost each year due to workplace injury or work-related illness (99)
- Investing in green infrastructure would reduce costs to the NHS alone by £2.1bn (97)
- 14.5% of our NHS people experienced an incident of physical violence from patients, patients' relatives, service users or other members of the public in the last 12 months (3)

Report Title: Author: **Karen Barnard** Report Date: **January 2022**

Enhanced lifestyle promotion, wellbeing interventions, positive messaging and role modelling are the way we do things around here. We will embody the 'We Care' values and demonstrate we care for our Team DBTH colleagues.

The role of board and leaders at all levels in creating an environment where the health and wellbeing of staff is actively promoted, encouraged is a critical success factor within our organisation. For completeness the action plan is detailed below.

Staff Wellbeing Action Plan 2022-23

Activity	Actions	Q1	Q2	Q3	Q4	Update/Achieved
Ensure regular Board level wellbeing conversations	Increase the representation of wellbeing at Board level through the Wellbeing Guardian					In place
Be Well at Work award	Achieve Silver level of the Be well@ work award					Apply for assessment for the Be Well @ Work Award – Doncaster Council
Develop Line managers skills and capability in creating healthy and supportive workplace cultures	Offer support and training for line managers in holding wellbeing conversations					
Build the Garden Room	Secure charitable funds bid to build space to accommodate Complementary Therapies treatments for staff					Receive feedback on the bid and approval
Seasonal Wellbeing Campaigns	Organise and plan 4 Trust wide campaign throughout the year					
Implement Know your Numbers Programme	Implement know your numbers programme and evaluate uptake and impact					
Promote the benefits of walking and exercise	Signage around the organisation to promote active travel. Showing number of steps from x to y and promote using stairs not lift.					Links with estates and facilities and communications needed
Active Travel Plan	Cycle to Work Schemes, National walk to work campaign. Lunchtime walking and cycling, pool bikes, cycle storage					Ongoing Drum Beat Health and well-being Fairs, Buzz articles Sharing how we care conference, Wellbeing champions in work areas
Staff Reiki Service	Continue to promote and evaluate the staff Reiki service					Ongoing
Staff Complementary Therapy Service	Continue to promote and evaluate the staff Reiki service					Ongoing

Report Title: Author: **Karen Barnard** Report Date: **January 2022**

Activity	Actions	Q1	Q2	Q3	Q4	Update/Achieved
Climbing Out Charity	Continue to promote and evaluate the work with Climbing out					Ongoing
communications and engagement plan for Staff Well Being	Develop wellbeing calendar of events for 22/23					
Poster Case Studies Staff Stories	Develop person centred case studies to be used across the organisation to promote the achievements of staff through Health and Wellbeing					Promote through Buzz and Leadership Programmes
Workplace health champions	Continue to recruit, develop and support the team of champions. Ensuring that all wards and departments have at least 1 champion					Identify competencies needed and develop champions role
Analyse the staff survey data for 2021	Identify hotspot wards and areas for general awareness of health promotion activity.					Identify areas of greatest need and focus
Programme of on-site Fitness Classes	Across site access to a range of fitness classes at times and prices that are convenient to staff					Needs a venue to be identified
Promote national and local health and wellbeing Challenges events	Take part in National Challenges supported by the NHS Sport and physical activity network- including Race to Rio, NHS choir					Ongoing signposting and information on Hive and in Buzz, through the Health and Well-being champions
Maintain a range of Team activities	Choir, Netball, triathlon events, walking and running clubs					Regular attendance at the forum
Promote the benefits of walking	Signage around the organisation to promote active travel. Showing no. of steps from x to y and promote using stairs not lift.					
Soundbites on Resilience, Wellbeing, Stress awareness	Modules offered to all staff					Can be delivered virtually
Develop a range of 'Mindfulness' opportunities	Apps/websites Courses Regular sessions Train the trainer approach					

Report Title: Author: **Karen Barnard** Report Date: **January 2022**

Activity	Actions	Q1	Q2	Q3	Q4	Update/Achieved
Continue to provide staff Counselling services though the Vivup	Continue to promote Employee Assistance Programme to ensure all staff are aware of the provision					Monitor uptake and receive quarterly reports

Sources

https://www.mind.org.uk/media/32065329/mind_taw_sports_a4_report_jan19_all.pdf

https://www.nhsemployers.org/retention-and-staff-experience/health-and-wellbeing/the-way-to-health-and-wellbeing/health-and-wellbeing-framework

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Trust Board				
Meeting Date:	25 January 2022	**Agenda Reference:**	D1		
Report Title:	Patients waiting less than 15 minutes for ambulance handover from time of arrival				
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 a 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) December performance for patients waiting less than 15 minutes for ambulance handover was 42.18%, with 31.37% of patients waiting over 30 minutes. There was a notable increase from 49.60% to 51.26% at Doncaster Royal Infirmary for patients waiting less than 15 minutes for ambulance handover in December • Doncaster Royal Infirmary (DRI) in December moved from the 4th highest reporting Trust for 30-60 minute ambulance handover breaches in Yorkshire, to the 6th; whilst Bassetlaw District General (BDGH) Hospital moved from position 22 to position 29 • Key actions continue to be implemented 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 December has seen further improvement in the number of patients waiting less than 15 minutes for ambulance handover at DRI 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:** ✓ *To provide outstanding care for our patients*	**TN SA2:** ✓ *Everybody knows their role in*	**TN SA3:** *Feedback from staff and learners is in the*	**TN SA4:** *The Trust is in recurrent surplus to invest in*	

		achieving the vision	*top 10% in the UK*	*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:	19/01/22	**Decision:**	TBC
Next Steps:		Continued monitoring of recovery and 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 51.26% for Doncaster.

Current Trend: Performance against the Ambulance handover within 15 minutes has seen a further improvement over the month of December with 37 additional patients handed over within 15 minutes of arrival compared to November.

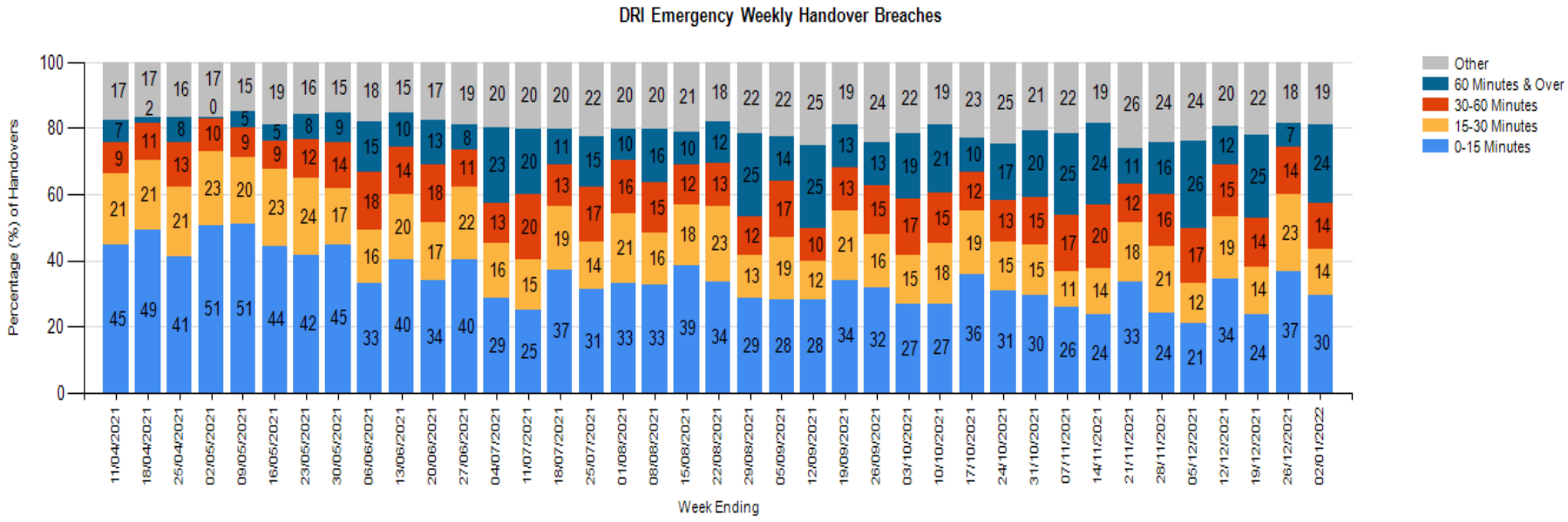
Metric Owner: Divisional Director of Operations (DDO) for Urgent & Emergency Care

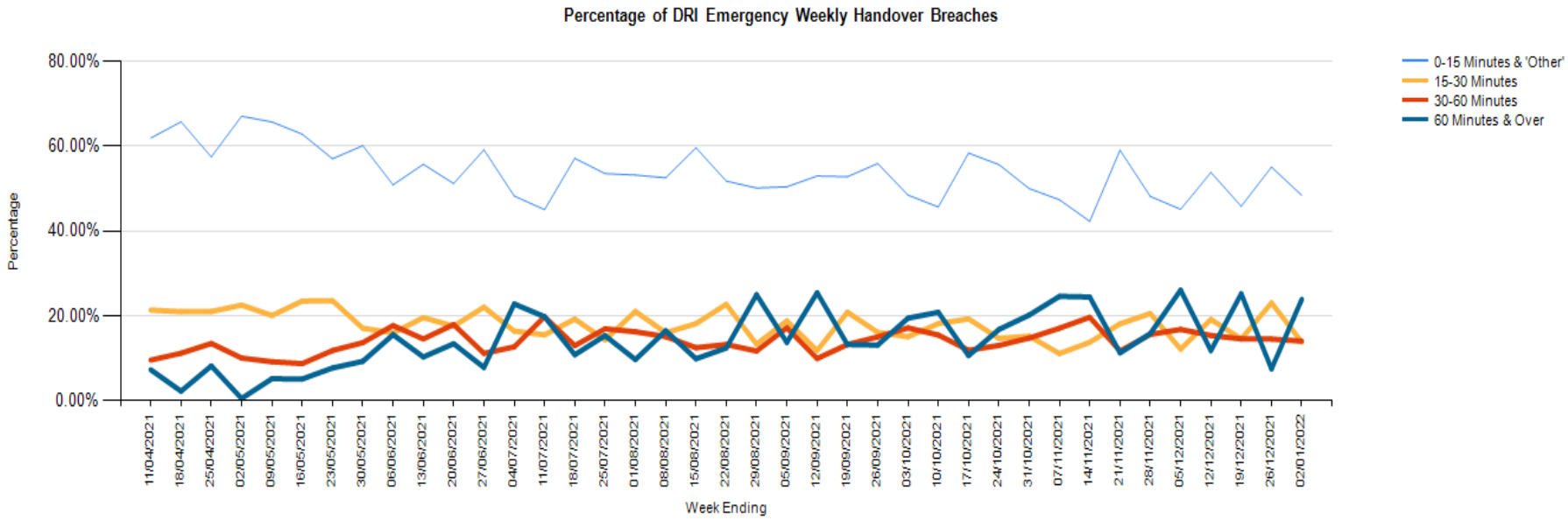
Metric: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes

Desired Trend:

December Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 30 minutes	Longest Wait (hrs & minutes)
Dec 2021	**Doncaster**	1990	51.26%	16.18%	32.56%	5 hrs 18 mins
	Bassetlaw	796	19.47%	50.75%	29.77%	2 hrs 13 mins
	Trust	2786	42.18%	26.06%	31.77%	N/A





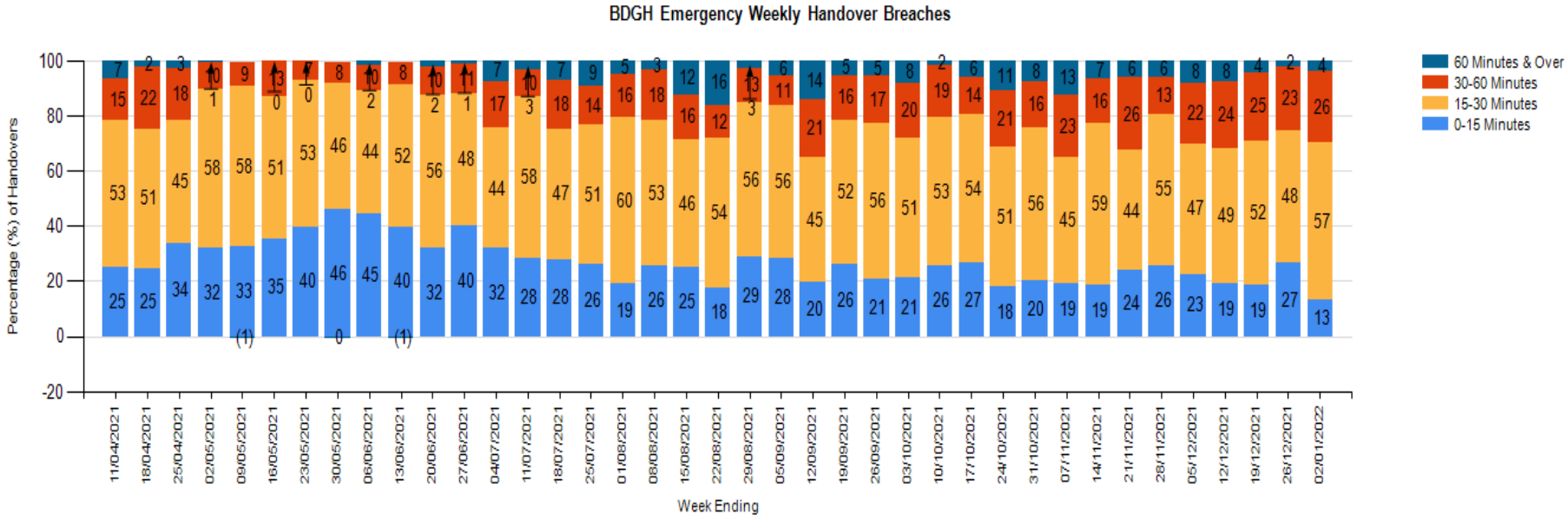
Key associated metrics that also support the standard:	
>15 minutes Time To Initial Assessment (TTIA)	December performance was 37.89% against the 95% target. This is a slight improvement from the 37.62% reported in November. Delays are expected over the winter period and a UEC recovery action plan is in place to improve delays at the ED front door.
Average Length of Stay (LoS) in ED	Average time in department for December was 283 minutes against the 240 minute target. This is a deterioration from 275 minutes reported in November. The Patient Flow Steering Group continue to focus on reducing LoS.
>12 hours in ED from Arrival	December performance was 6.16% which remains slightly above the national standard of 5% target. This is an improvement from 6.34% reported in November. Delays are impacted by a current Trust bed occupancy of 98%. The Patient Flow Steering Group continue to focus on reducing LoS.

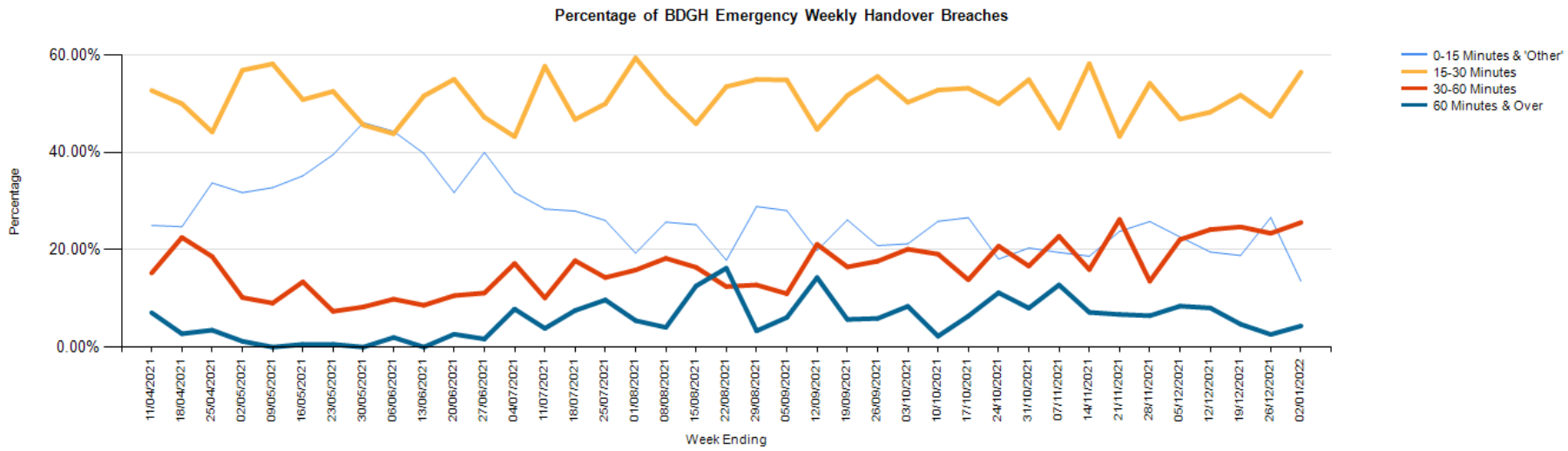
Bassetlaw Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 19.47% for Bassetlaw. **Current Trend:** Performance against the Ambulance handover within 15 minutes has seen a deterioration over the month of December with 6 fewer patients handed over within 15 minutes of arrivals compared to November.	**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**: ⬆

December Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 30 minutes	Longest Wait (hrs & minutes)
Dec 2021	**Doncaster**	1990	51.26%	16.18%	32.56%	5 hrs 18 mins
	Bassetlaw	796	19.47%	50.75%	29.77%	2 hrs 13 mins
	Trust	2786	42.18%	26.06%	31.77%	N/A





Key associated metrics that also support the standard:	
>15 minutes Time To Initial Assessment (TTIA)	November performance was 31.92% against the 95% target. This is a deterioration from the 34.78% reported in November. 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 December was 206 minutes against the 240 minute target. This is a slight deterioration from the 202 minutes reported in November yet remains above the national standard.
>12 hours in ED from Arrival	December performance was 2.39% which is better than the national standard of 5% target. However this is a deterioration from 1.53% reported in November. Delays are impacted by a current Trust bed occupancy of 98%. The Patient Flow Steering Group continues to 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 • Extended 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	Completed Completed Apr-22 Jan-22 Jan-22 Completed Completed Completed
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, 14 and 21 days) • Lack of available beds in	• 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 • Additional 10 beds to be opened on Ward 22 for respiratory patients	DDO for UEC / CD DDO for UEC / CD	Completed Completed

	community	• 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	DDN for Medicine DDNO (new post) Chief Operating Officer (COO) COO	Completed Jan-22 Completed Jan-22
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 • Process delay issues impacting on handover efficiency	• 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 • Time in Motion Study to be support by QI Team to identify any delay in handover processes • Ambulance cohorting plan in place for extremis, agreed with YAS to support release of crews	DDO for UEC DDO for UEC DDO for UEC DDO for UEC COO COO DDO for UEC DCOO, UEC	Completed Completed Completed Completed Completed Completed Feb-22 Completed

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 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	• 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 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 DDO for UEC YAS DDO for UEC	Feb-22 Completed Feb-22 Jan-22 Jan-22

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	25 January 2022	**Agenda Reference:**	E1
Report Title:	Strategic Outline Case – a New Hospital for Doncaster		
Sponsor:	Jon Sargeant, Director of Recovery, Innovation and Transformation		
Author:	James Nicholls, Project Director		
Appendices:	The full Strategic Outline Case and its Appendices form a very large document which is available on request.		
Report Summary			
Purpose of report:	This paper is being presented to Board of Directors for approval and subsequent submission to NHSE/I on 31st January 2022. The Finance and Performance Committee reviewed the Strategic Outline Case (SOC) and following presentation of its key features by the Project Team at the committee meeting held on 19th January 2022, recommended the SOC for approval by the Board of Directors. Additionally, Board of Directors is asked to: • provide approval for the SRO to submit a proposal for funding the next stages of development of the case in order that momentum is maintained and to resource the expected workload associated with the next stages of the New Hospital Programme Expression of interest process; • note that a Memorandum of Understanding with Doncaster Metropolitan Borough Council to govern the collaboration around the development of the Waterfront Site and Basin Site for the new hospital is being developed and will be shared with F&P Committee in due course and prior to submission to Board of Directors; and • acknowledge and support the need for reinvigorated external engagement and communication, particularly with and through local MPs, to boost awareness of the project and promote the need for investment.		
Summary of key issues/positive highlights:	For many years the Trust has focussed its limited capital budget and an increasing revenue allocation on backlog eradication, preventative maintenance and major incident response arrangements. However, this has proved to be a losing battle as the rate of deterioration has accelerated faster than the Trust can respond and has inevitably been at the expense of service development, a key issue in its own right, the financial cost of which, and cost to the delivery of quality patient care, cannot be underestimated. The March 2021 6 Facet Survey identified that 98% of overall functional floor space, including 68% of clinical space, is 'not functionally suitable' but in intensive use. Day to day clinical activities are hampered by undersized facilities with poor layout, and lack of clinical adjacencies which frustrate departmental relationships, clinical flow, patient and staff experience and operational performance. Additionally, the overall capacity of the hospital is insufficient to meet expected demand and is insufficiently flexible to cost effectively manage surge pressure and pandemic impact.		

	This situation is not sustainable. Patients, staff and the public have registered their anxiety, local politicians have regularly raised the issue in the House of Commons and peer organisations across the local ICS and wider NHS region have assessed the risk of major, disruptive failure, with broad implications as unacceptably high. The risk of failure of a major component of the site or enforced closure by a regulatory authority is not manageable within the local health system. The NHS New Hospitals Programme presents the opportunity for investment to resolve the issues at Doncaster Royal Infirmary. The Trust submitted an expression of interest to be included in the next tranche of schemes in September 2021 and understands that the selection process will conclude in July 2022, with feedback on shortlisted trusts by the end of January. The health and safety issues at the DRI site require resolution quickly and our Preferred Way Forward could deliver a new hospital by 2029 with an accelerated construction programme of just circa 4.5 years. Given this context the Trust Board has allocated funds for the development of this Strategic Outline Case. The aim of this document is threefold: 1. To support the successful inclusion of the New DRI project in the New Hospitals Programme; 2. To make the argument for accelerated approval of funding for a new hospital to come into operation by 2029; and 3. To formally register that the Trust and ICS need for national support if they are to avoid the risk of major disruption to services in the region. Our Strategic Outline Case recommends a new hospital on a new site as its preferred way forward at a cost of £1,367m. This investment seeks to deliver benefits for patients and staff through: • A new site for our hospital which offers better access and freedom to design and construct a modern facility with capacity sufficient for future demand levels and an increase of the bed base from 650 to 770 beds. • A new Model of Care which embraces an integrated and holistic approach to system healthcare and the role of the acute hospital working with public and private partners in line with the NHS Long-Term Plan • Design excellence ensuring a highly functional and effective, digitally enabled and pandemic/COVID proofed facility embracing the Green Agenda and adaptable for future needs • Embedding the hospital as an Anchor Organisation within the 'Doncaster University City' economic regeneration • An improved working environment, experience and opportunities for training and development for our staff, which will help us address local challenge relating to recruitment and retention. In addition to improved: • Wellbeing • Patient experience • Access to services • Privacy and dignity • Safety • Compliance

	• Efficiency • Productivity • Recruitment/retention • Patient flow • Infection control • Flexibility/ adaptability • Societal benefits • Quality And demonstrates that in addition to resolving safety issues in the most cost effective and timely way, the investment supports achievement of national priorities including: • Net Zero Carbon; • IT and digital enablement • Model of Care, system integration and population health management • Modern Methods of Construction • Design excellence
Recommendation:	Board of Directors is asked to approve the New DRI Strategic Outline Case for submission to NHSE/I on 31st January 2022.

Action Require:	**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:	
Corporate risk register:	This report updates Board of Directors on areas contained within the following corporate risks: • F&P 4 Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. Note: A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. • F&P12 Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. Note: a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register. • F&P17/Q&E12 Risk of critical lift failure • E&F 2335 Failure to adequately meet the demand of PPM completion due to insufficient resource within the Estates department resulting in a risk of regulatory non-compliance. Note:

	Identified following an NHS/QI review of the Estates workforce at DBTH. For further details please consult the EF risk register.
Regulation:	• Health and Safety at Work Act 1974 (HASAWA) • Management of Health and Safety at Work Regulations 1999 • The Workplace (Health, Safety and Welfare) Regulations 1992 • The Health and Safety (Display Screen Equipment) Regulations 1992 • The Manual Handling Operations Regulations 1992 (as amended) (MHOR) • The Personal Protective Equipment at Work Regulations 1992 • The Provision and Use of Work Equipment Regulations 1998 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR) • The Control of Substances Hazardous to Health Regulations 2002 • Safety Representatives and Safety Committees Regulations 1977 • Health and Safety (Consultation with Employees) Regulations 1996.
Legal:	The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.
Resources:	

Assurance Route			
Previously considered by:		N/A	
Date:		**Decision:**	
Next Steps:		Submission to NHSE/I by 31st January 2022	
Previously circulated reports to supplement this paper:		The Board of Directors has discussed various components of the business case at its Board Seminars, including the development of the options for the New DRI.	

EXECUTIVE SUMMARY

The purpose of this report is to provide Board of Directors members with an overview of the Strategic Outline Case to resolve issues at the Doncaster Royal Infirmary site and provide modern facilities supporting improved outcomes and experience for patients and a better environment for staff to deliver care.

The strategic context and the case for change create a compelling argument for change and option appraisal and economic and financial analysis demonstrate an affordable, value for money solution through a new hospital, on a new site, digitally enabled with a new model of care. The report sets out the estates implications for the project and considers the commercial and management arrangements that need to be implemented for success.

The Board of Directors s asked to consider this report and the supporting Strategic Outline Case and recommend its approval for submission to NHSEI Regional Team on 31st January 2022. It is also asked to:

- provide approval for the SRO to submit a proposal for funding the next stages of development of the case in order that momentum is maintained and to resource the expected workload associated with the next stages of the New Hospital Programme Expression of interest process;
- note that a Memorandum of Understanding with Doncaster Metropolitan Borough Council to govern the collaboration around the development of the Waterfront Site and Basin Site for the new hospital is being developed and will be shared with F&P Committee in due course; and
- acknowledge and support the need for reinvigorated external engagement and communication, particularly with and through local MPs, to boost awareness of the project and promote the need for investment.

CONTEXT AND BACKGROUND

The project started in earnest in the summer of 2020, aiming to complete this Strategic Outline Case as part of the Trusts bid for the second phase of the DHSC Health Infrastructure Plan (HIP2) by the end of 2020. Despite strong support and positive recognition of the importance and urgency of the project from senior NHSEI sources, local politicians and system stakeholders, approval was withheld in November 2020 and the project suspended.

In Spring 2021, the Trust Board considered its options in the face of growing concerns regarding infrastructure risk issues at the Doncaster Royal Infirmary site. Whilst it was recognised that no major investment approvals route existed outside of the Health Infrastructure Programme, the need to formally register the scale and urgency of action required led to the decision to complete and submit a Strategic Outline Case to NHSE/I. The aim being to create a 'line in the sand' and the basis for continued pressure for investment, broader communication of the challenges faced and as a vehicle to strengthen stakeholder support.

On April 27th, 2021, a major incident in the Women's and Children's unit brought into stark relief the impact of infrastructure failure on service delivery. Mandatory reporting requirements engaged regulatory authorities and a regional risk summit was called by NHSE/I on the 24th August 2021, led by Margaret Kitchen, Chief Nurse, NHSE/I, North East and Yorkshire and attended by system leaders including ICS, provider and commissioner representatives. The summit concluded that over time a major failure of a key component of the Doncaster Royal Infirmary's infrastructure or closure of services by an enforcing authority is an unacceptably high risk. As a result, North East and Yorkshire Region have concluded that Doncaster Royal Infirmary is a priority.

On 9th September 2021, the Trust responded to an expression of interest request from DHSC to include the Doncaster Royal Infirmary project in the next wave of 8 hospitals to be funded under the New Hospitals

Programme, part of the Health Infrastructure Plan launched in 2019. We understand that the latest timeline anticipates the confirmation of 30 short listed schemes nationally by the end of January 2022, followed by a period of detailed review and approval of the final 8 successful projects in July 2022. Currently, this is the only formal route to funding for major schemes and is therefore crucial to this project. It is expected that the review period will be intense and whilst the development of this Strategic Outline Case forms excellent preparation, the availability and continuity of the existing project team is essential. **The Board of Directors is asked to confirm that it will consider a subsequent proposal for budget to resource this activity.**

If this scheme is not included in the next wave of New Hospital Programme schemes the Trust will continue to work with NHSE/I colleagues regionally. Whilst there is no requirement or route for the Strategic Outline Case to be approved formally, the priority status of the project and the experienced fluidity of the New Hospitals Programme with approved schemes falling off the programme due to insurmountable barriers or lack of progress, may present the opportunity for later inclusion.

The relationship with Doncaster Metropolitan Council is essential to the development of the project. We need the Council's support to: promote the project as part of the 'levelling up' and economic regeneration agenda for Doncaster; facilitate Trust ownership of identified land at the Basin Site, fully remediated and ready for construction of the new hospital; and provide the necessary planning consents to allow the hospital to be built. Equally, the new hospital project is key to the Council's broad development strategies as the town's largest employer and 'anchor organisation'. At a project level the relationship with the Council has been excellent. They have allocated considerable resource and time to supporting the master planning for the site, developing the societal benefits analysis required for the Strategic Outline Case economic analysis and collaboratively preparing the pre-planning permission application. Additionally, they have been supportive in working with the Trust and MPs in describing the importance of the hospital development in its own right and as part of the towns aspirations to be awarded 'City' status. However, this is a complex project and on occasion communication has been unsatisfactory with conflicting views over commitments made, particularly regarding costs associated with the new site. To manage this, the project has developed a draft memorandum of understanding to govern the collaboration and this needs to be agreed by the Trust and signed off by Doncaster Metropolitan Council. **The Board of Directors is asked to confirm that it will consider a submission of the draft Memorandum of Understanding once reviewed and recommended by the F&P Committee.**

Wider external communication and engagement of the project is essential to promote awareness and gain support both locally and at the highest level. Local MPs have raised concerns around the situation at Doncaster and the need for investment in the House of Commons. Discussions between local MPs, the Council and the Trust resulted in a letter from Nick Fletcher, Ed Miliband and Rosie Winterton to the Secretary of State for Health and a proposed meeting in the Houses of Parliament in December 2021. Unfortunately, the meeting was cancelled due to Covid restrictions, and it is key that once the Strategic Outline Case is approved by the Trust Board reengagement and reinvigoration of communication takes place. **The Board of Directors is asked to acknowledge and support the need for reinvigorated external engagement and communication, particularly with and through local MPs, to boost awareness of the project and promote the need for investment.**

The remainder of this paper provides a summary of the Strategic Outline Case. For further detail please see link to the SOC and appendices which will be emailed separately. Please note – a glossary can be found at the end of this document.

Summary of the Strategic Outline Case: A New Hospital for Doncaster

Introduction

1. Resolution of the infrastructure issues at DRI are a priority for NHS North East and Yorkshire Region. Following work carried out with the regional team based on the risk summit called by NHSE/I on the 24th August 2021 and led by Margaret Kitchen, Chief Nurse, NHSE/I, North East and Yorkshire it is clear over time a major failure of a key component of the Doncaster Royal Infirmary's infrastructure or closure of services by an enforcing authority is an unacceptably high risk. This is view is underlined by the experience of increasing frequency and scale of failure at the DRI site, technical assessments of unmet mechanical, electrical and building compliance with standards and regional review following the latest major incident.

2. The case for major remediation and refurbishment of all the buildings at DRI is therefore incontrovertible and urgent. The Strategic Outline Case considers the options for doing this within the broader strategy and policy framework, value for money and affordability.

3. In summary, options which seek to repair the existing site fall at most hurdles. The cost, complexity, and timescales of major refurbishment within a constrained and intensely operational site do little more than make outdated buildings safe for occupation. They do not support major policy, strategy and societal objectives, do not fully address capacity issues and mostly retain the poor co-location and configuration of clinical services. Value for money is therefore low and affordability problematic with little opportunity to improve efficiency and flexibility into the future.

4. The preferred way forward delivers a new hospital on a new site. This removes all building compliance issues, allows form to follow function with building design reflecting modern care pathways and models of care, supports flexibility and adaptability for growth, surge and pandemic pressure, supports exploitation of the benefits of digital enablement, delivers net zero carbon, and forms a strong strategic fit with the broader Doncaster levelling up agenda, town centre regeneration, economic and societal benefits. This generates strong value for money and sustained financial performance.

Strategic Case

5. The national, regional and local policy and strategy drivers for change set the strategic context for the project. Together they argue for more efficient and effective care to be delivered in appropriate settings with patient experience and outcomes at their heart. Additionally, there is recognition that the NHS must embrace the sustainability agenda reducing carbon emissions and adopt IT and Digital technology to enable a step change in care and building management. The impact of Covid-19 has brought into sharp focus the need for hospitals to both meet the needs of pandemic level infection control and related surge pressures. The Trust's vison and objectives reflect these aims.

6. The DHSC Health Infrastructure Plan (2019) seeks to support the modernisation of health estate through investment in 48 new hospitals. It has multiple aims including eradication of back log maintenance, more efficient use of NHS estate, support for delivery of new models of care and achievement of modern design standards. It also mandates the implementation of net zero carbon in new hospitals and promotes the effective use of IT and Digital as a major enabler for hospital and system transformation. The Trust has expressed interest in the replacement of

Doncaster Royal Infirmary becoming part of the next tranche of new hospital schemes under this initiative.

7. The health of people in Doncaster is generally worse than the England average and whilst there have been key improvements in healthy life expectancy too many people still experience poor health and too many die prematurely. Additionally, the population is growing, and forecasts show that the proportion of older people is increasing with consequent demand on health services in general and the Doncaster Royal Infirmary in particular.

8. Doncaster is an ambitious town with aspirations to regenerate and breath new economic life back into its town centre. It is bidding to become a University City and has recently secured 'levelling up' funding to support its key projects. The Doncaster Royal Infirmary is a key 'anchor' organisation for Doncaster and is the town's largest employer. Its activities as a health care provider and scale as a major employer are highly influential for the development of Doncaster.

9. Based on the strategy and policy context for the Trust the Spending Objectives for the New DRI project are as follows:

- To deliver an estate which enables the best possible: experience for patients, staff and visitors; and clinical quality, patient flow and outcomes performance improvement.
- To create a physical environment that meets statutory and regulatory requirements, eradicates Backlog Maintenance and Critical Infrastructure Risk, achieves a minimum standard of "Condition B"[1], and complies with all relevant national policies and guidance including Net Zero Carbon and Pandemic Proofing.
- To create an adaptable, flexible and digitally enabled estate, scaled for future demand growth, shifts in care setting, improved patient flow and potential consolidation of specialist services.
- To create an estates solution which reduces the overall cost of delivering acute care services for financial sustainability and ongoing value for money in operation
- To redevelop the DRI in a way which maximises the positive economic and social benefits for the region, delivers on the Trust's and broader Doncaster, Green Plans and acts as a catalyst for levelling-up the local population's aspirations, opportunities and outcomes fulfilling the Trust's role as an 'anchor' organisation

10. The case for change is a simple but compelling one: The building infrastructure at the Doncaster Royal Infirmary has deteriorated to such an extent that further failures are not just a possibility but foreseeable. The extent of deterioration means that despite the Trust's best efforts, there is a high and accelerating risk of significant service disruption, that would not just affect the immediate local population and health economy but have impact further afield across the region.

11. Eradication of the infrastructure issue is therefore critical but just making the existing hospital safe ignores the underlying problems associated with an old site, built for a different healthcare era which has evolved organically over time.

12. The March 2021 6 Facet Survey highlights that 98% of overall functional floor space, including 68% of clinical space, is 'not functionally suitable' but in intensive use. Day to day clinical activities are hampered by undersized facilities with poor layout, and lack of clinical adjacencies

[1] Category B meets all the required compliance standards through refurbishment of an existing building. New build options would be expected to meet Category A.

which frustrate departmental relationships, clinical flow, patient and staff experience and operational performance. Additionally, the overall capacity of the hospital is insufficient to meet expected demand and is insufficiently flexible to cost effectively manage surge pressure and pandemic impact.

13. The current Doncaster Royal Infirmary site is intensely utilised and highly constrained. It is situated within a residential area which risks planning objections. Therefore major construction is complicated and difficult to achieve without significant disruption to services and access over a protracted period and may struggle to receive the required planning permissions.

14. Furthermore, existing facilities limit the ability to comply with net zero carbon ambitions and the benefits from smart building technology and digitally enabled people and processes. Broader strategic ambitions of the Trust are also compromised by the estate as it acts as a barrier to service development, hinders recruitment and retention and distracts from initiatives to deliver joined up care across the Trusts sites and the broader health system.

15. In summary, the case for change argues that the current Doncaster Royal Infirmary site is unsafe in the medium term without significant inward investment, poorly configured for modern healthcare and a poor vehicle for the championing of Trust and regional strategies to modernise healthcare. Change is therefore required.

16. In order to meet our Investment Objectives and respond to the existing arrangements at DRI the business case sets out the Trust's ambitions for the future of its Doncaster Hospital. At a high level the investment seeks to deliver:

- A new site for our hospital which offers better access and freedom to design and construct a modern facility with capacity sufficient for future demand levels and an increase of the bed base from 650 to 770 beds.
- A new Model of Care which embraces an integrated and holistic approach to system healthcare and the role of the acute hospital working with public and private partners in line with the NHS Long-Term Plan
- Design excellence ensuring a highly functional and effective, digitally enabled and pandemic/COVID proofed facility embracing the Green Agenda and adaptable for future needs
- Embedding the hospital as an Anchor Organisation within the 'Doncaster University City' economic regeneration
- An improved working environment, experience and opportunities for training and development for our staff, which will help us address local challenge relating to recruitment and retention.

17. In summary, the benefits of a new hospital with a new model of care, digitally enabled and environmentally sustainable achieves a broad range of benefits for staff, patients, the general public and key stakeholders across the following themes:

- Well being
- Satisfaction
- Access to services
- Privacy and dignity
- Safety
- Compliance
- Efficiency
- Productivity
- Recruitment/retention
- Patient flow
- Infection control
- Flexibility/ adaptability

- Societal benefits
- Quality

18. There are risks associated with the scale of change required and these are examined in detail in the Management Case. Key strategic risks include:

Risk Type	Risks
Business Risks	▪ Political risk: National, regional and local support ▪ Reputational risk: Expectation management and delivery ▪ Capacity risk: Further site failures impact resource priorities ▪ Timing risk: Pace of benefit delivery inadequate ▪ Demand risk: Size of hospital predicated on third party OOH delivery ▪ System risk: Activity migration from regional reconfiguration (e.g. NLAG)
Service Risks	▪ Design risk: scope change and national design convergence ▪ Build risk: site constraints ▪ Procurement risk: market capacity/capability ▪ Financing risk: Availability of PDC and other sources of capital ▪ Operational risk: Service disruption during implementation
External Risks	▪ Strategic risk: Evolving national, regional and local priorities ▪ Inflation risk: Uncertain economic conditions – cost increases (Brexit) ▪ Pandemic risk: Disruption, focus and priority ▪ Process risk: Lack of clear national guidance for project approval

19. Constraints are the external conditions and agreed parameters within which the programme must be delivered, over which the project has little or no control. Dependencies are factors outside the scope of the programme that will influence its successful delivery.

20. Constraints:

- Use of Modern Methods of Construction for new build
- Capital affordability
- No deterioration to financial position
- Net zero carbon target
- Covid-19 guidelines
- NHP guidance and assumptions
- Building compliance (BLM/CIR/Cat ‘B’)
- Digital by design
- All services must remain operational throughout
- Limited options for alternative site locations other than the Basin Site.

21. Dependencies:

- Success in the EOI process for 8 additional NHP schemes
- Commissioner/stakeholder support
- Availability and timing of funding streams
- Route to funding
- Construction / Advisor capacity
- Planning approvals
- Clarity of ICS and other strategic initiatives
- Engagement and public consultation
- Collaborative arrangements and grant funding for land

22. The Trust, Council and CCG consider the relocation of the existing hospital services within the town boundary and a short distance from the existing site to be low risk from public challenge.

23. However, there is a statutory duty to involve the public on any proposals for service reconfiguration or change that will impact on how patients receive services. The "manner in which services are delivered" has been generally understood and accepted as including the location from which services are provided.

Economic Case

24. The Economic Case develops a short list of options and identifies the Preferred Way Forward (PWF), the option which delivers best value for money at this stage. The options are taken forward for further, more detailed analysis at OBC stage.

25. A wide range of options were developed by the Project Team and were assessed against agreed critical success factors and reviewed and approved by internal and external stakeholders and Trust governance..

26. The Option choices used to develop the long list are shown in the table below:

Option Choice	Description (HMT Green Book)	New DRI Description
Scope	Coverage of the service to be delivered	What options are available to improve or resolve existing DRI estates issues
Solution	How this may be done	Choices for ways we can make the improvements (refurb/new build) and location of facilities
Delivery	Who is best placed to do this	Alternate contractors and contractual arrangements for delivery
Implementation	When and in what form can it be implemented	Alternative phasing choices
Funding	What this will cost and how it shall be paid for	Alternate potential funding arrangements

27. For each 'Choice' a range of solutions (from least to most ambitious) were identified by the Project Team. Each choice was examined through comparison with the Investment Objectives and Critical Success Factors and were subjected to SWOT analysis.

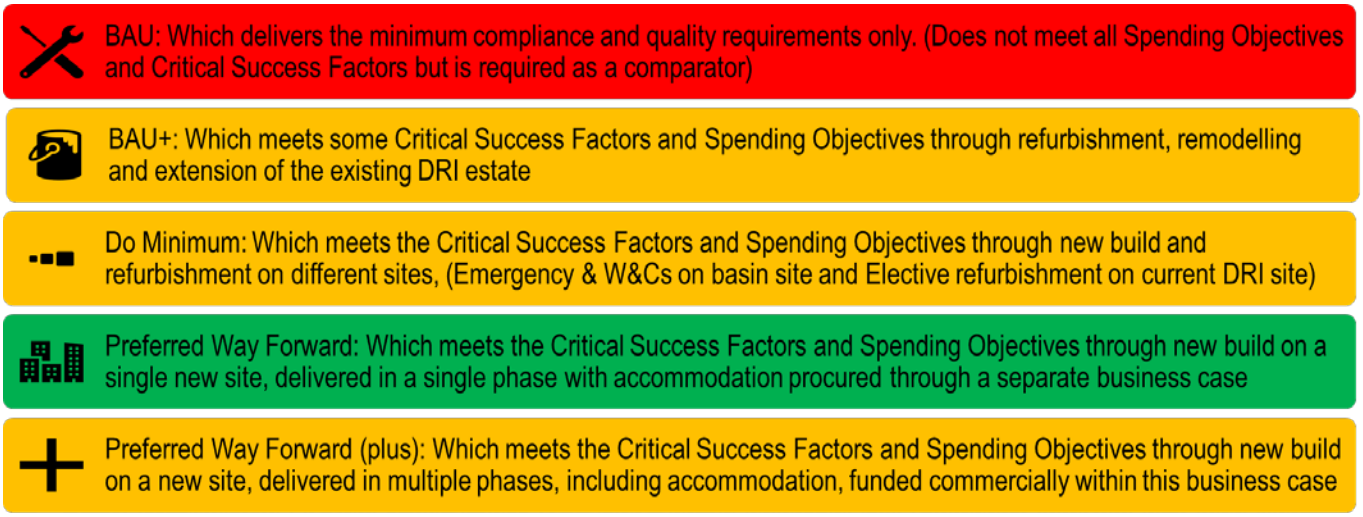
28. The Critical Success Factors used for this exercise are as follows and are compliant with Green Book guidance:

Critical Success Factor	Description
A. Strategic fit and meets business needs	How well the option: meets the agreed spending objectives, related business needs and service requirements provides holistic fit and synergy with other strategies, programmes and projects
B. Potential Value for Money	How well the option: optimises social value (social, economic and environmental), in terms of the potential costs, benefits and risks

Critical Success Factor	Description
C. Supplier capacity and capability	How well the option: matches the ability of potential suppliers to deliver the required services appeals to the supply side
D. Potential affordability	How well the option: can be financed from available funds aligns with sourcing constraints
E. Potential achievability	How well the option: is likely to be delivered given an organisation's ability to respond to the changes required matches the level of available skills required for successful delivery

29. The result of this exercise was to identify the preliminary short list. The Preliminary Short List was then tested with stakeholders. A number of meetings and on-line input opportunities were given to stakeholders which were well taken up. Stakeholders identified some refinements to the short list which were updated prior to approval and the next stage of economic evaluation.

30. The short list selected was as follows:



31. Economic evaluation of the options was undertaken using the Comprehensive Investment Appraisal Model of CIAM. The model seeks to identify the option that delivers the best value for money through comparison with Business as Usual. This is measured by Net Present Social Value (NPSV) which is the sum of the discounted cashflows of each option over the 60-year life of the project and Benefit Cost Ratio or BCR which compares the discounted costs to the discounted benefits in the form of a ratio.

32. The Economic Summary resulting from the population of the CIAM shows that the Preferred Way Forward (Option 3) delivers the highest Net Present Social Value and best BCR as set out in the table below:

Economic Summary Discounted - £	Option 0 - Business as Usual	Option 1 - Business as Usual Plus	Option 2 - Do Minimum	Option 3 - PWF - New Build	Option 4 - PWF+ - New Build & Accommodation
Incremental costs - total	£0.00	-£230,996,732	-£275,351,067	-£139,106,626	-£141,165,088

Economic Summary Discounted - £	Option 0 - Business as Usual	Option 1 - Business as Usual Plus	Option 2 - Do Minimum	Option 3 - PWF - New Build	Option 4 - PWF+ - New Build & Accommodation
Incremental benefits - total	£0.00	£207,786,181	£552,999,626	£1,187,699,820	£1,100,187,039
Risk-adjusted Net Present Social Value (NPSV)	£0.00	-£23,210,550	£277,648,558	£1,048,593,193	£959,021,950
Benefit-cost ratio	0	0.90	2.01	8.54	7.79
Ranking	5	4	3	1	2

33. In order to determine the 'safety' of the Preferred Way Forward as the best option sensitivity analysis has been carried out. The Green Book approach, known as 'Switching Values', is used. It tests how much the alternative options would have to change in order to become the highest ranked option.

BCR Sensitivity (Switching Values)	Option 0 - Business as Usual	Option 1 - Business as Usual Plus	Option 2 - Do Minimum	Option 4 - PWF+ - New Build & Accomodation
Incremental costs - total	N/A	11%	24%	91%
Incremental benefits - total	N/A	949%	425%	110%

34. The table above shows the % of the existing incremental costs and benefits that each option would need to change by to in order for their BCRs to equal that of Option 3-PWF. For Options 1 and 2 these changes are too large to be considered likely. Option 5 would need to demonstrate a 9% reduction in its costs or a 10% increase in benefits. Options 4 and 5 are very similar in nature with the key differences being the phasing of Option 5 and the addition of Key Worker Accommodation. Given this it is unlikely that the costs and benefits of Option 5 would move significantly and differentially to Option 4. Therefore, the ranking of Option 4 is not sensitive to changes in the BCR of alternate options.

NPSV (Switching Values)	Option 0 - Business as Usual	Option 1 - Business as Usual Plus	Option 2 - Do Minimum	Option 4 - PWF+ - New Build & Accomodation
Net Incremental costs and benefits	£1,049m	£1,072m	£771m	£90m

35. The table above shows the net movement in incremental costs and benefits that would be required for each alternate option to become ranked above Option 3. For options 1, 2 and 3 these are considered too significant to be likely and for Option 4 the same logic holds true as described for the switching value of BCR above.

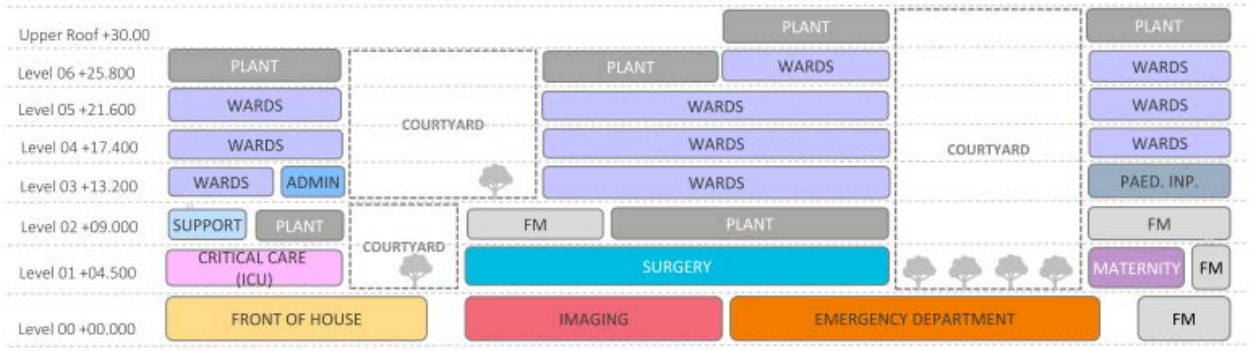
Estates Case

36. The Estates Case is not a Green Book requirement but appears in the Fundamental Assessment Criteria issued by NHSEI. It focusses on the estates solution for the identified Preferred Way Forward and the approach to Net Zero Carbon and land sales.

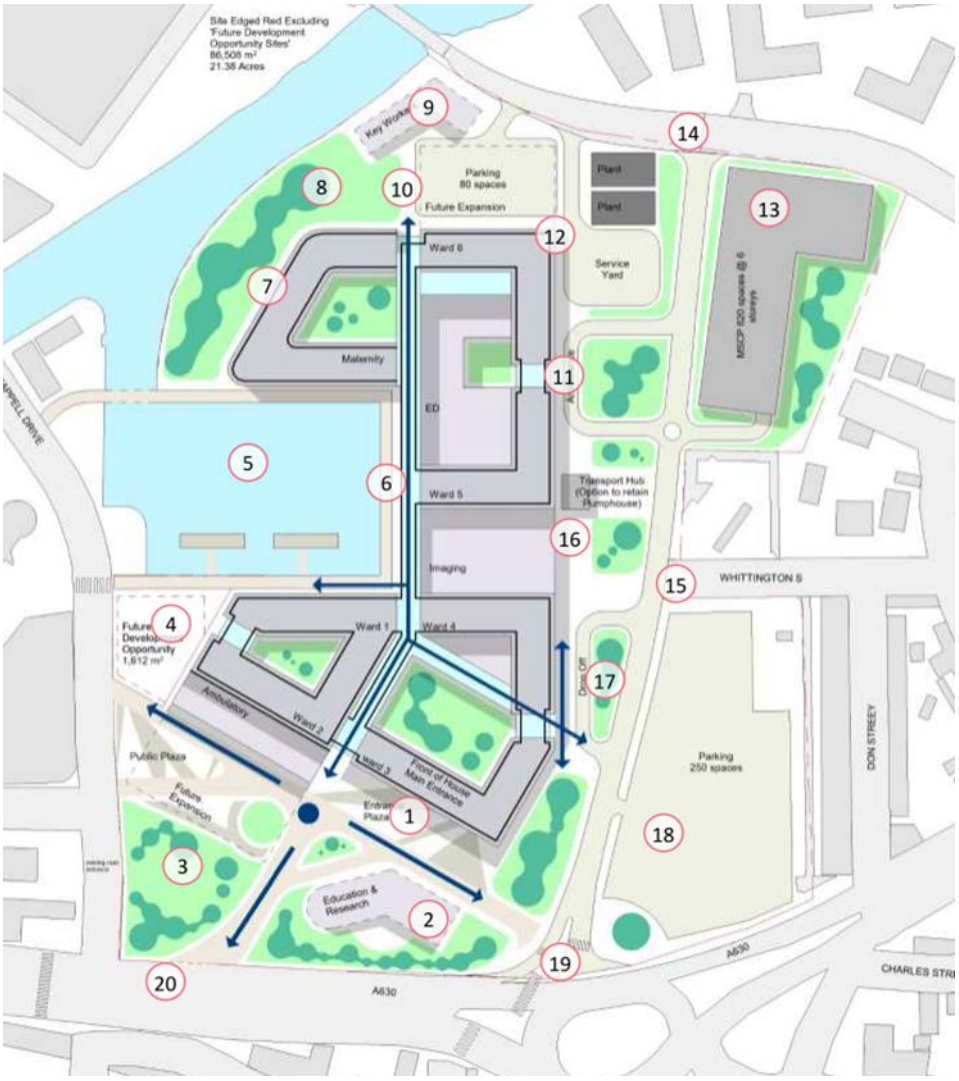
37. The total area of the new hospital is estimated to be 99,098 SQM. The Design Team working with Trust clinicians have configured this area based on key principles including:

- Emergency Department has a separate 'front door' with clear dedicated access
- ED to have direct adjacent relationship with imaging
- Maternity / Women's & Children's department to have dedicated entrances & emergency drop off areas
- Critical Care to have immediate adjacency to Surgery with discrete access to all other key departments such as ED & Wards.
- Neo Natal Intensive Care unit should be directly adjacent to Delivery Suite and Children's Operating Theatre Department
- Outpatients / Ambulatory care to be key front of house department with close adjacencies to the main entrance, public drop off areas & the imaging department

38. Based on these assumptions, the schedule of accommodation and site constraints, the initial massing work suggest the hospital will be seven storeys plus a plant floor, an initial stacking diagram has been developed below.



39. Work has been done to make best use of the natural features of the site, the marina and sight lines associated with existing buildings. Additionally the impact of prevailing winds and the movement of the sun over the site at different times of year has been considered to ensure maximum natural light.



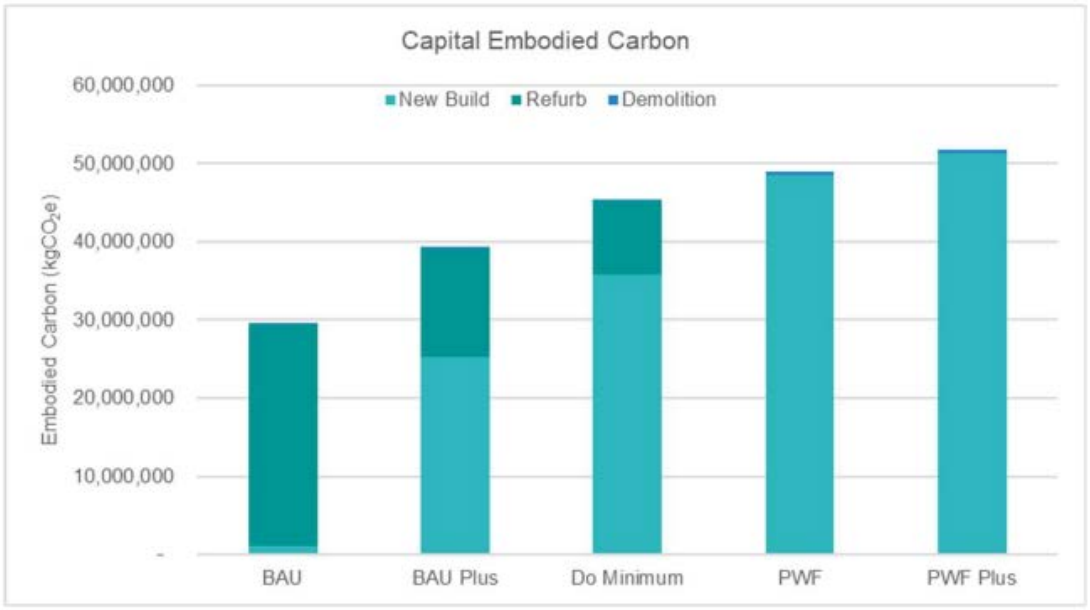
40. Initial discussions have been held with regard to the internal configuration of the hospital and the co-location and clinical adjacency of key functional areas. The detail of this work will be undertaken at OBC stage when larger scale drawings will be prepared through work with clinicians and operational staff.

41. The Design Team has also worked with planners to design the best flows of traffic, both vehicular and pedestrian onto the site and have identified discrete routes for logistics, ambulances, patients and staff. The scheme includes a multi storey carpark.

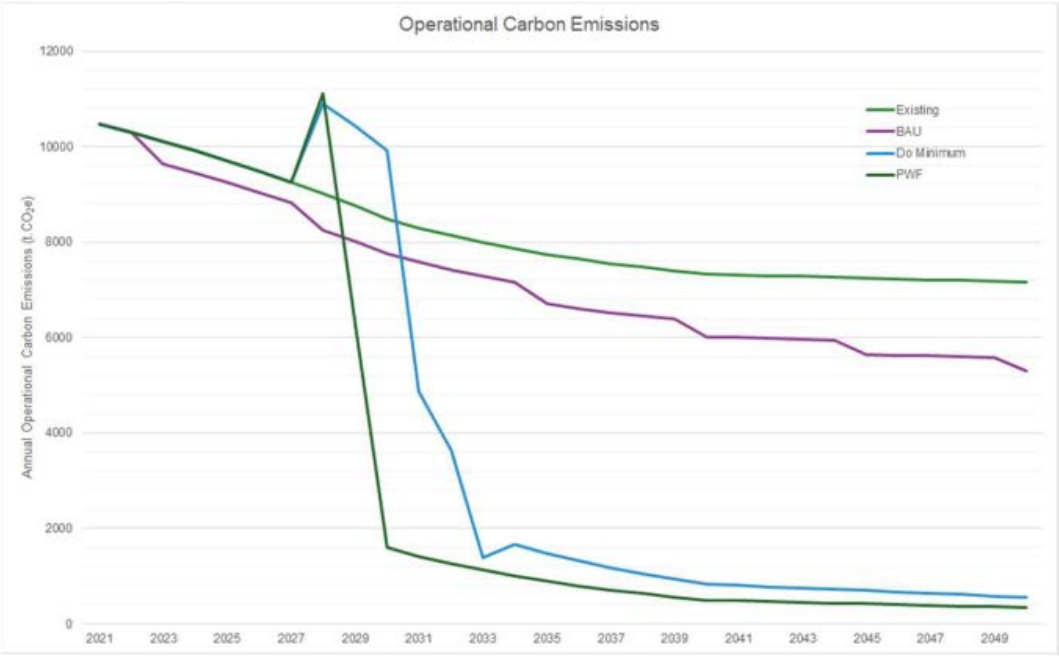
42. The Investment Objectives require that the new hospital is flexible and adaptable. This is addressed both through the use of Modern Methods of Construction which should allow for modular expansion and reconfiguration of space within and beyond the initial structure. The site plans have earmarked space for future expansion as required to the front and west of the footprint. Additionally, space has been identified on site for Key Worker Accommodation and a Research and Education Block.

43. The net zero carbon ambition is an important part of the Trusts overall vision for this project and as part of the developing the SOC, the net zero requirements and broader sustainability are incorporated in two of the investment objectives (IO2 & IO5) to make a very clear commitment.

44. Whilst the new build hospital option does provide a significant opportunity to be designed and constructed to net zero building standards, the embodied carbon of the new build must also be considered because it is higher than refurbishing existing as shown in the comparison graph below.



45. A key part of the initial NZC was to undertake an initial impact assessment of the shortlisted options to compare the long term estimated operating carbon emissions, this is shown below and estimates that PWF will have the lowest operating emissions once built and suggests the PWF will support and achieve the investment objectives.



46. BREEAM is the world's leading sustainability assessment method for masterplanning projects, infrastructure and buildings. It recognises and reflects the value in higher performing assets across the built environment lifecycle, from new construction to in-use and refurbishment. As a new build project we are aiming for a BREEAM excellent rated project utilising the BREEAM NC 2018 v3 Healthcare scheme checklist. The initial pre assessment checklist has been developed

collaboratively with the design team but coordinated by a BREEAM specialist (Mott Macdonald) and is indicating a score of 75.89% rating the project as Excellent.

47. To embed and ensure design quality throughout the project, the trust are utilising the Construction Industry Council Design Quality Indicator for Health (DQIfH2 – September 2020) process. An initial Stage 1 Briefing session was held and recommendations made for the next stage of development.

48. The Trust intends to adopt SABRE, a standard security methodology, Government Soft Landings requirements and Building Information Modelling (BIM) is a process that encourages collaborative working between all the disciplines involved in design, construction, maintenance and use of buildings, as prescribed in the Government Construction Strategy 2011.

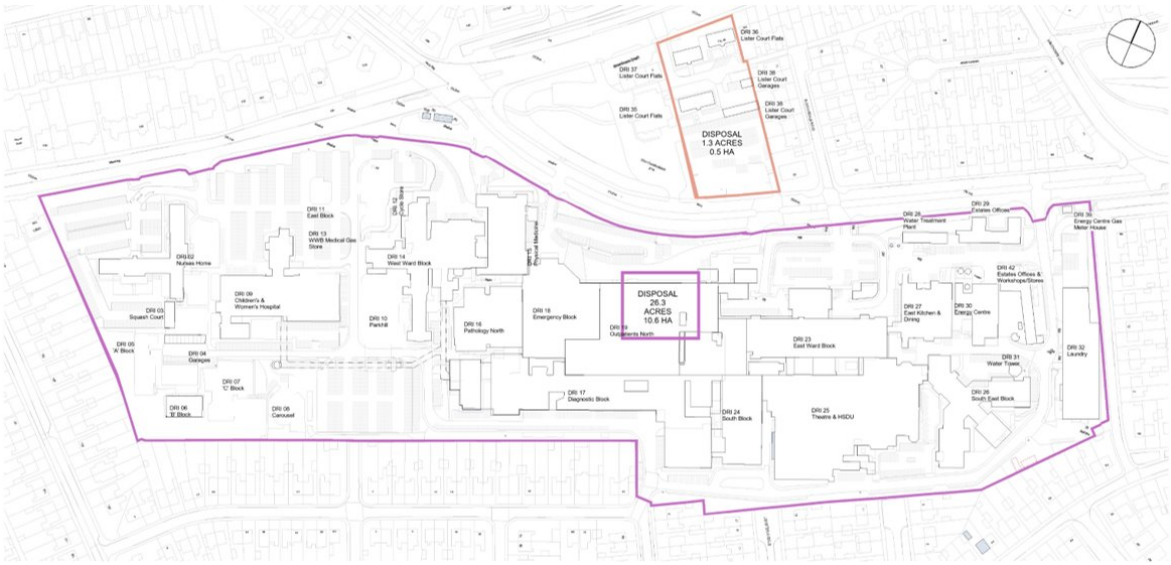
49. The selection of the Basin Site as the preferred location for a new build hospital was undertaken in partnership with DMBC and with professional advice from Avison Young. 40 sites were reviewed and the Basin Site best met our criteria:

- Within 5 miles of Doncaster Town Centre
- Located on or near to arterial road networks
- Good public transport links
- 14-18 acres
- Freehold only
- Suitable for a hospital

50. The Waterfront site also known as the Basin site is located just off the town centre and approximately 1.3km from the existing DRI site shown below.

51. The basin site is deemed to be a very sustainable location in terms of transport and access links due to its close proximity to the bus and train stations plus its central location with in the town.

52. The DRI site available for disposal is made up of the main site and Lister Court, totalling approximately 11.1Ha (27.6acres)



53. Initial valuation advice indicates that the sale proceeds from disposal of the site are likely to be between £250 and £300k per acre.

Commercial Case

54. The commercial case of the SOC outlines our strategy to procure the preferred way forward of a new build solution for DRI, delivered on the basin site .

55. To successfully deliver the new hospital we will require a range of goods and services to be procured including:

- Construction and associated works – construction & enabling works
- Land – the Basin site
- Professional services – legal, project management, technical advisors, accountancy etc.

- Equipment – FF&E
- IT & Digital
- Training Requirements

56. The outcome of our evaluation of potential procurement routes is that the most viable options centre around design and build and, fundamentally, the appointment of contractors via pre-existing frameworks. The appointment of multiple contractors, as relevant specialists in their fields of expertise (infrastructure, equipment and digital) vs. a single PSCP was felt to represent better value for money and offer more opportunities for local/ regional firms to get involved in the project.

57. As a possible project on the New Hospitals Programme, we are aware the DHSC is considering a mandated procurement strategy for projects. Whilst details are yet to be released, the Trust note this strategy will need to evolve and align to the NHP process in due course.

58. The Trust and DMBC have been working in partnership to bring forward a new hospital for Doncaster, supporting the SOC but also bringing forward the Basin site for the hospital development. This partnership includes the collaborative work to bring forward a masterplan for the Basin site known as the “waterfront project” that is shaped around the new hospital.

59. The collaboration between parties on the masterplan and terms for the transfer of the Basin site is being formalised in a Memorandum of Understanding (MoU) document. Both parties are working toward formalising this agreement as soon as possible.

60. The principles of DMBC disposing of the Basin site to the Trust are agreed, key terms included in the draft MOU include:

1. A joint project management committee made up of senior representatives will be established to oversee the development

2. DMBC will assemble the full site required and provide vacant possession – negotiations with third parties are ongoing

3. Remediation specification will be developed collaboratively, DMBC will fund the remediation works from grant funding

4. DMBC will support the planning process and limit planning agreements such as s106, s278 etc

5. Parties will work together to determine final disposal contract/transfer and considerations due but the working assumption is the site would be gifted for health use.

61. We recognise this project will require a diverse team of advisors and professionals which are identified in the management case. The current team have been commissioned up to the end of the SOC only, therefore allowing the Trust to reconsider its team moving forward and also an opportunity to ensure best value for the OBC and FBC stages.

62. The intention to procure the professional team moving forward is to utilise the range of frameworks open to the Trust whether that be NHS SBS, Pagabo etc. It is important to note the professional team procurement will be considered alongside the contractor procurement and their supply chain to ensure conflicts of interest are avoided or proactively managed. The

preferred way forward of a full new build hospital on the Basin site provides a significant opportunity to maximise the adoption and benefits of Modern Methods of Construction. The strategy concluded the PWF has the highest potential to meet the objective test and a high target PMV of 60-70%.

63. The design work to date is feasibility stage (RIBA 1) therefore includes limited detail to assess structural and layout standardisation. The Modern Methods of Construction strategy has been an integral part of the design development process to date. The design team have confirmed work to date is in line with the Modern Methods of Construction strategy to maximise adoption including:

1. Standardised Schedule of accommodation
2. Structural grids, corridor widths and floor to ceiling heights will be standardised
3. Room types and spaces are standardised > 80%
4. Deliver Modern Methods of Construction to high level of maturity across all six pillars.

64. DMBC has been very supportive in planning policy terms of the new build hospital on the Basin site, the recently adopted Doncaster Local Plan September 2021 designates the Basin site as one of the Key Town Centre sites known as the "waterfront site" includes the Basin site for redevelopment. The strategic planning policy for the site intends it to become a thriving neighbourhood and a natural extension of the town centre with excellent pedestrian and cycling links connecting the waterfront with the rest of the town centre. The policy notes acceptable development uses includes health.

65. A formal pre application response from DMBC is expected shortly and will be located in appendix 5C, based on the extensive discussions DMBC have noted the proposed hospital at the Basin is suitable and sustainable in policy terms and we anticipate at this stage the main development constraints of the site in planning terms will be highways capacity, flood risk and land contamination. All of these matters will be consulted on further and extensive technical work will be undertaken during the OBC stage in collaboration with DMBC.

Finance Case

66. The total estimated capital cost for the new build DRI at the basin site with accommodation funded separately (PWF) is £1,367,341,088. This value includes equipment, non recoverable VAT, inflation, optimism bias and planning contingency as shown below.

Cost element	Value £
Works cost	£497,278,864
Fees	£72,883,116
Non works costs	£34,732,844
Equipment costs	£69,465,688
Planning contingency	£49,727,886
Optimism Bias	£144,817,680
Inflation adjustment	£282,692,014

Cost element	Value £
Non recoverable VAT	£215,742,995
Total (OB1)	£1,367,341,088

67. The Long Term Financial Model (LTFM) has been developed for 60 years with year 0 commencing 1st April 2022. This aims to provide a comprehensive picture of the financial impact of the project during development, construction and through its operational lifecycle.

68. In order to be considered affordable the Preferred Way Forward must demonstrate financial performance which improves upon Business as Usual.

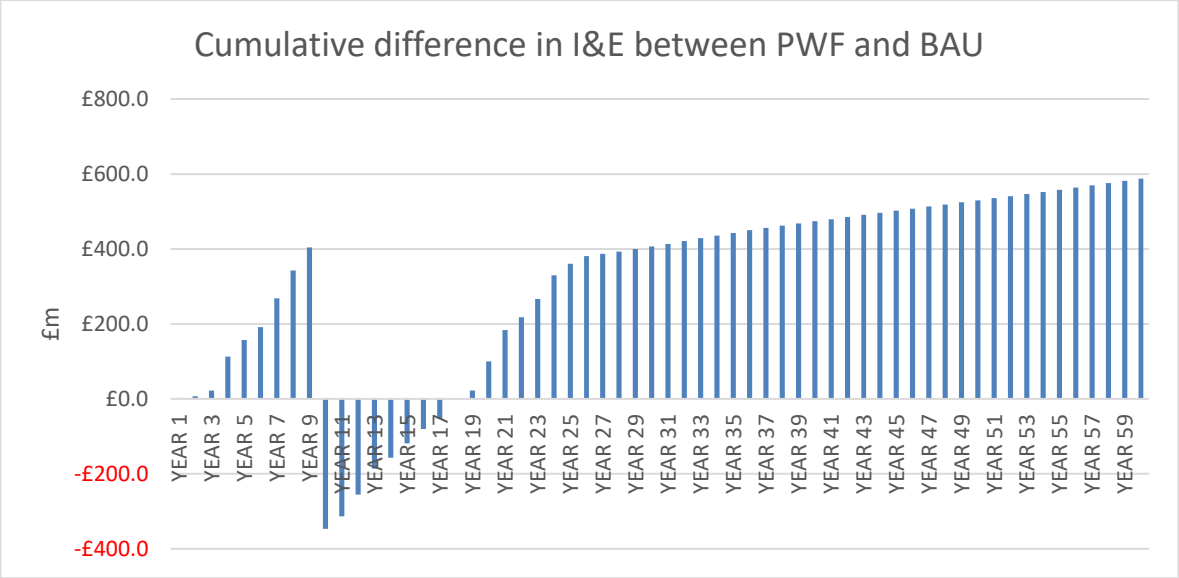
69. The following table sets out the key financial features for each of the options considered.

OPTION	BAU	BAU+	Do Min	PWF	PWF+
Cumulative I&E (60yr)	(£2,347.3m)	(£2,972.8m)	(£2,097.1m)	(£1,759.8m)	(£2,053.3m)
Steady State Start Year	2049	2047	2036	2034	2038
Avg. Steady State Annual I&E Position	(£19.8m)	(£14.6m)	(£18.0m)	(£14.5m)	(£21.6m)
Rank (best cumulative I&E)	4	5	3	1	2
Cumulative net financial benefits	*£70.7m*	*£402.8m*	*£489.5m*	*(£941.3m)*	*(£888.9m)*

70. In summary the Preferred Way Forward demonstrates financial affordability because:

- It generates the best cumulative I&E position over 60 years
- It starts to deliver benefits at the earliest point of any of the options
- Its 'steady state' annual I&E impact is the best and provides the opportunity to achieve a break-even position subject to more detailed examination of the potential efficiencies at OBC stage.
- It delivers the highest net cumulative financial benefits.

71. The following graph demonstrates the improved cumulative affordability of the Preferred Way Forward over BAU. It represents the difference between the cumulative I&E position for BAU and PWF.

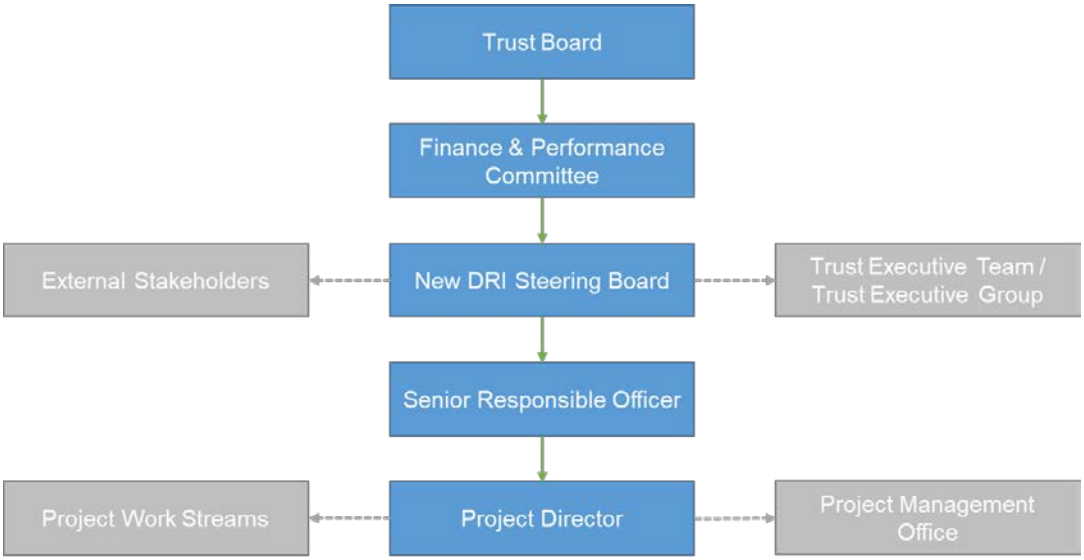


72. In Year 10 the cumulative Preferred Way Forward I&E position includes the revenue impact of disposal of the Doncaster Royal Infirmary Site and impairment of the new hospital on the Basin site to its Modern Equivalent Value (MEV). The MEV impairment is a technical accounting treatment which reflects the difference between the cost of building the new hospital and its value in use. Despite this adjustment, the underlying revenue benefits of the Preferred Way Forward over Business as Usual recover this impact and go on to improve the I&E position in future years.

Management Case

73. The Management Case provides an overview of the governance and management arrangements the Trust has put in place for the New DRI project and includes details of the key personnel, including the SRO, and projected budgets. It also outlines the strategies that will be put in place to ensure that the expected benefits will be realised and that the identified risks will be managed/mitigated effectively.

74. The next stages of the New DRI Project require a strong governance structure which reflects the scale and complexity of activities at OBC stage and the need to work collaboratively with system partners. At SOC stage key decision making and approvals were undertaken by the Finance & Performance Committee. At OBC these arrangements will be replaced by the introduction of a Steering Board reporting to Trust Board through the Finance & Performance Committee. The key components of the OBC governance structure are set out below:



75. The Project Work Streams are set out below. Each Work Stream will be allocated an appropriate Senior Trust Leader who will be responsible for coordinating the activities required, reporting progress and managing risk for their area. Work Streams will be responsible for coordinating their own meeting structures in line with the Project Plan and the varying intensity of work required in their area. Work Stream Leaders will meet regularly with the Senior Responsible Officer and Project Director to ensure that activities between areas are carried out in a collaborative, efficient and effective manner.

Project Work Streams	Team Composition	
Project Management Office	Trust Staff/External PMO Support	Professional Advisers including expertise in: • Health Planning • Architectural • Capital Costing • Engineering • Net Zero Carbon • Modern Methods of Construction • Health Economist • IT & Digital • Town Planning
Clinical Design	Clinical Specialties (Clinicians/Patient Reps)	
Digital & IT	Trust Digital, Information and Estates leads	
Commercial & Estates	Trust Procurement and Estates leads	
Workforce	Trust Organisational design leads	
Finance	Trust Finance leads	
Communications & Engagement	Trust Communications leads	

76. The following table sets out the key milestones from approval of the Strategic Outline Case through to commissioning and opening of the New DRI. The timeline is predicated on either success in the DHSC Expression of Interest process for a place on the New Hospitals Programme or some other, as yet undefined route, through NHSE/I locally.

Milestone	Realistic		Accelerated	
	Start Date	End Date	Start Date	End Date
Approval of Strategic Outline Case/Confirmation of NHP Place		31/07/22		31/07/22
Appointment of Outline Business Case Team	01/06/22	30/06/22	01/02/22	28/02/22
Consultation and planning permission processes	01/06/22	31/05/23	01/03/22	28/02/23
Submission of Outline Business Case (Risk associated with consultation)		30/06/23		31/03/23
Approval of Outline Business Case	01/07/23	30/09/23	01/04/23	30/04/23
Early Remediation Enabling Works Start	01/10/23		01/05/23	
Submission of Full Business Case		30/06/24		28/02/24
Approval of Full Business Case	01/07/24	30/09/24	01/03/24	31/03/24
Completion of Early Remediation Enabling Works		30/09/24		30/04/24
Submission of Orders for Off-site Construction	01/10/24		01/05/24	
Start on site (4 ½ year / 4 year construction programme)	01/10/24		01/05/24	
Completion of Construction Programme		31/03/29		31/03/28
Building Commissioning	01/04/29	30/06/29	01/04/28	30/06/28
Service Transfer to New DRI	01/07/29	31/08/29	01/07/28	31/08/28
New DRI Live	01/09/29		01/09/28	

77. The 'Realistic' timeline is predicated on current best practice and assumes 3 months of approvals following each business case submission and a 4 ½ year construction programme with construction of the new hospital complete by 31/03/29.

78. The 'Accelerated' timeline is predicated on faster approvals, assuming greater NHSEI/NHP involvement in staged sign off and a 4 year construction programme based on optimisation of Modern Methods of Construction and learning from earlier waves of new hospital builds.

79. The ongoing risk management strategy for the programme will incorporate the following activities:

- Risk identification and reporting
- Evaluation of proximity, probability and impact of the risk occurring
- Allocation of risk owner
- Development of risk responses including prevention, reduction, transference, acceptance of reduction
- Identification of escalation procedures
- Planning and resourcing of responses to risks; and
- Monitoring and reporting of risk status.

80. The Risk Register will be continuously updated and reviewed throughout the course of the programme. It will be monitored on a regular basis by the programme team and Steering Board and risk scores will be reviewed and updated as required. Where necessary, New DRI project risks will be escalated through the Trust's risk management governance structure as required.

81. A draft Benefits Realisation Plan has been prepared by the Project Team. This plan describes the benefits expected to accrue from the delivery of the project, aligns them against each of the Investment Objectives and describes how each will be delivered.

82. Key benefits identified at this stage of development include:

- Provision of a safe healthcare environment through elimination of backlog maintenance and critical infrastructure risk
- Improved productivity and efficiency for clinical operations through better infrastructure which provides appropriate space for the volume of work being undertaken, co-located to allow flows of work between key clinical functions and designed to respond to surge pressures and growth in demand
- Improved outcomes for patients through a new Model of Care exploiting digital technology ensuring the right care is provided in the right place at the right time through optimised people & process coordination
- Improved staff satisfaction, recruitment and retention and training and education through a better, safer environment, digitally enabled and designed to support delivery of modern care
- Greater energy efficiency through the development of a 100% electric hospital which meets Net Zero Carbon targets and through smart technology improves logistics and estates management and
- Achieving wider socio-economic benefits through synergistic working across Doncaster to support delivery of a modernised and vitalised town centre.

83. Benefits will be continually re-examined throughout the development of the business case process with further updates and more detailed evaluation carried out at Outline Business Case stage through detailed analysis at specialty and functional levels within the organisation.

84. During the OBC stage a change management plan (or plans) will be produced, that will cover the following three elements

- (1) Preparing for Change
- (2) Managing the Change
- (3) Sustaining the Change

85. A designated Change Manager will be appointed with overall responsibility for the implementation of the plan, preparing the organisation and its staff for transition to new ways of working, and managing the overall transition. Individual actions within the plan may also be assigned to additional individuals who are best placed to deliver that specific action. The plan will also link to the benefits realisation plan, in terms of how changes associated with specific benefits will be defined and measured.

Glossary

Abbreviation	Definition
BAU	Business as Usual
BCCG	Bassetlaw CCG
BCCG	Bassetlaw Clinical Commissioning Group
BIM	Building Information Modelling
BREAAM	Building Research Establishment Environmental Assessment Method
CCG	Clinical Commissioning Group
CCQ	Civic and Cultural Quarte
CDEL	Capital Delegated Expenditure Limit
CDU	Clinical Decisions Unit
CIA	Comprehensive Investment Appraisal
CIAM	Comprehensive Investment Appraisal Model
CIC	Community Interest Company
CIP	Customer Identification Program
CIP	Cost Improvement Program
CIR	Critical Infrastructure Risk
CQC	Care Quality Commission
CRC	Carbon Reduction Commitment
CSF	Critical Success Factors
DBTH	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
DCCG	Doncaster CCG
DCCG	Doncaster Clinical Commissioning Group
DHSC	Department of Health and Social Care
DMBC	Decision Making Business Case
DMBC	Doncaster Metropolitan Borough Council
DQI	Design Quality Indicator
DRI	Doncaster Royal Infirmary
ED	Emergency Department
EIR	Employers Information Requirements
EOI	Expression of Interest
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Returns Information Collection

EWB	East Ward Block
FBC	Full Business Case
FM	Facilities Management
GIA	Gross Internal Area
GMP	Guaranteed Maximum Price
GSL	Government Soft Landings
HBN	Health Building Note
HIP	Health Infrastructure Plan
HPCG	Health Premise Cost Guidance
HTM	Health Technical Memoranda
ICS	Integrated Care Scheme
ICU	Intensive Care Unit
IT	Information Technology
LTFM	Long Term Financial Model
MEAM	Making Every Adult Matter
MH	Mental Health
MHRS	Mental Health Response Service
MMC	Modern Methods of Construction
MoU	Memorandum of Understanding
NHP	National Hospitals Programme
NHSI	NHS Improvement
NHSX	NHS User Experience
NPSV	Net Present Social Value
NZC	Net Zero Carbon
O&M	Operating & Maintenance
OBC	Outline Business Case
OJEU	Official Journal of the European Union
ONS	Office for National Statistics
PAM	Premises Assurance Model
PCBC	Pre-consultation Business Case
PIFU	Patient Initiated Follow Up
PLACE	Patient-Led Assessment of the Care Environment
PLICS	Patient Level Costing Systems
PMV	Potential Pre-manufactured Value
PSC	Public Sector Comparator
PSCP	Principal Supply Chain Partner

PSF	Provider Sustainability Funding
PWF	Preferred Way Forward
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrence Regulations
SABRE	Security Assurance by BRE
SDU	Sustainable Development Unit
SOA	Schedule of Accommodation
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Partnerships
SYB	South Yorkshire & Bassetlaw
SYBICS	South Yorkshire & Bassetlaw Integrated Care System
The Trust	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
TUPE	Transfer of Undertakings (Protection of Employment)

DRAFT

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 21 December 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 – Acting 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 Neil Rhodes - Non-Executive Director and Deputy Chair Jon Sargeant – Interim Director of Recovery, Innovation & Transformation	
In attendance:	Simon Chiva - Senior Solutions Engineer, Inenco (agenda item D1) Fiona Dunn - Deputy Director Corporate Governance/Company Secretary Kirsty Edmondson-Jones - Director of Estates & Facilities Lois Mellor - Director of Midwifery Angela O'Mara - PA to Chair & Chief Executive (Minutes) Marie Purdue - Director of Strategy & Improvement Emma Shaheen - Head of Communications & Engagement	
Public in attendance:	Peter Abell - Public Governor Bassetlaw Dennis Atkin - Public Governor Doncaster Hazel Brand - Public Governor Bassetlaw Mark Bright - Public Governor Doncaster Lynne Logan - Public Governor Doncaster Mick Muddiman - Public Governor Doncaster Mandy Tyrrell – Staff Governor Sheila Walsh - Public Governor Bassetlaw	
Apologies:	Kath Smart - Non-Executive Director	
P21/12/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, via the audience functionality. The above apologies were noted. No declarations of interest were noted, pursuant to Section 30 of the Standing Orders.	

P21/12/A2	**Actions from Previous Meetings (Enclosure A2)**	
	Action 1 - Diagnostic Framework Self-Assessment – Board Leadership – action not yet due Action 2 - Safeguarding Information to Board – action not yet due, to be included in the Chief Nurse Update in January 2022 and quarterly thereafter Action 3 - Civility Training – action closed Action 4 - Nursing Budgets and Establishments - action closed	
	The Board: - ***Noted the updates.***	
P21/12/B1	**Maternity Update (Enclosure B1)**	
	Perinatal Mortality Dashboard The Chief Nurse summarised the content of the paper, including the outcomes of the perinatal mortality review; the findings of which were rated AA or AB, which indicated the provision of appropriate care, with no identified learning. No Healthcare Safety Investigation Branch reports had been received since the last Board report. In respect of PROMPT compliance rates for SPR/SHOs, the Chief Nurse confirmed that consideration had been given to alternative approaches, however, certain elements required face to face training, which had proved to be more challenging. In response to a question from Pat Drake, the Chief Nurse advised that safety huddles and consultant led walkarounds were evidenced on K2. ***Ockenden Update*** The action plan and associated updates were received and noted; the Chief Nurse reported positive feedback had been received from the Local Maternity and Neonatal System. In respect of the reference to consultant midwives and at the request of the Chair, the Chief Nurse confirmed that consultant midwives were independent practitioners with clinical expertise. They would be required to manage an identified cohort of women, devote approximately one third of their time to work with the University on education and training and the remaining third on research matters. The posts were developed in the late 1990s/early 2000s and were attractive posts for senior midwives. In response to questions from Sheena McDonnell, the Chief Nurse confirmed that a resource had now been identified to address action 7, relating to the trust website and informed consent. This action was being monitored through the Quality & Effectiveness Committee. It was clarified that the RAG rating of amber/red in relations to audits, indicated the need to undertake the audit, rather than the audit outcome.	

	The Chief Nurse advised that Ockenden 2 was expected late January 2022 and there was an assumption that the relevant funding would continue. ***Continuity of Carer*** In accordance with national guidance the Board received a quarterly update, the NHS ambition in England was that continuity of carer be offered to all pregnant women, as the default model for maternity services. The Trust's plan would be developed over a series of five waves and for a total of eleven teams. However, progress was currently paused due to the impact of the Covid Pandemic and the number of vacancies and was unlikely to be recommenced until the number of WTE vacancies was 10 or less. Continuity of Carer would be prioritised for roll out to Black, Asian, or Mixed ethnicity populations, who were identified as those likely to experience adverse outcomes first. Pat Drake acknowledged the positive feedback from pregnant women in respect of continuity of carer provision, noting an improved service, communication and receipt of information. It was also noted that the service was championed by the Royal College of Midwives, however, it was acknowledged that the staffing of the service was a challenge and the impact on midwives, including on-call demands was significant. In response to a question from Sheena McDonnell, the Chief Nurse confirmed that the necessary data to identify those BAME, low income/deprived areas was readily available and would be the primary focus when the service was able to be reintroduced. ***Maternity Self-Assessment*** The Board received the updated maternity self-assessment action plan, the self-assessment tool had formed part of the maternity safety discussions with the Chief Midwifery Officer and her team in November 2021. The Chief Nurse confirmed that work on the strategy would commence in the New Year, as responsible officer he would be supported by an external resource.	
P21/12/C1	**<u>Ambulance Handovers (Enclosure C1)</u>**	
	The Chief Operating Officer presented to Board the latest position in respect of actions to improve the number of patients waiting more than 15 minutes from arrival to handover. Currently 42% of handovers were completed in less than 15 minutes. An improved position was reported for November but ongoing work was required. The supporting plan provided an overview of actions in four key themes, pre-hospital/front door issues, through the hospital, operational grip and escalation and accuracy of handovers. Following recent discussions at an extra-ordinary meeting of the Finance & Performance Committee, Neil Rhodes, Committee Chair, confirmed he was assured by the quality and detail of the action plan, whilst recognising the need for more work to be done. In respect of the need to improve the accuracy of handovers and improved data Neil Rhodes asked the Chief Operating Officer to explain the scale of the issue; it was confirmed that following a small scale audit discrepancies in reporting were identified, with the actual	

	position better than reported. Yorkshire Ambulance Service had worked collaboratively to address the identified issues. Discussions with NHSE/I confirmed that common issues across providers could be supported via best practice advice from the Emergency Care Improvement Support Team (ECIST). Pat Drake acknowledged the improving position and looked forward to seeing the impact of the medical decision unit. In respect of the length of time patients were waiting in ambulances the Chief Operating Officer confirmed this was included within the longest wait data and was being tracked through the Finance & Performance Committee. The Chief Executive confirmed ambulance handover delays were often an indicator of bed occupancy/flow issues across the site. Ensuring appropriate discharge for those medically fit to leave and with no right to reside was a critical factor, however this was not completely under the control of the Trust and required a system/partnership approach. In response to a question from Mark Bailey it was confirmed that a number of arrangements were in place to support collaborative working, including regular meetings with the ambulance services and primary care through the Health & Care support cell meetings.	
	The Board: - ***Noted and took assurance from the Ambulance Handover Update.***	
P21/12/D1	**<u>The Green Plan (Enclosure D1)</u>**	
	The Director of Estates and Facilities and Senior Solutions Engineer, Simon Chiva of Inenco presented to Board the Trust's Green Plan. Approval was sought for submission to the ICS ahead of the deadline of 14 January 2022. The ICS would then develop a consolidated system-wide green plan by 31 March 2022. Board had previously received an extensive presentation as part of the Board workshop on 19 October, subsequently considered by the Trust Executive Group in December for further analysis and questioning. The Green Plan was an overarching strategy to achieve net zero status by 2045, the requirements of which were included in section 18 of the NHS standard contract 2021/2022. In response to a question from Neil Rhodes in respect of operationalising the plan, Simon Chiva confirmed the need to translate the Sustainable Development Assessment Tool (SDAT) into meaningful information, supported by the development of a communications and training plan. The overarching strategy would be supported by a series of programmes and task and finish groups to progress the respective actions. Neil Rhodes stressed the importance of ensuring that colleagues could associate with the plan and understand what it meant to them. The Chair shared with members of the Board her ambition to fly a green flag on the Trust sites to indicate compliance with the green plan, an accreditation associated with Keep Britain Tidy where she is Chair.	

	Board granted their approval of the plan, developed in conjunction with Inenco. The objectives of which would now be progressed by the Trust. The Chair shared her appreciation with Simon Chiva and the Director of Estates & Facilities for the extensive work completed to date.	
	The Board: - ***Approved and took assurance from the Green Plan***	
P21/12/E1	**Minutes of the meeting held on 19 October 2021 (Enclosure I1)**	
	The Executive Medical Director sought clarity in respect of minute P21/11/C3, in relation to the Medical Examiner Team's scrutiny of all deaths. Post meeting it was confirmed that no amendment was required.	
	The Board: - ***Approved the minutes of the meeting held on 16 November 2021.***	
P21/12/E2	**Any other business (to be agreed with the Chair prior to the meeting)**	
	In response to a question from Pat Drake it was confirmed that the current number of active Covid-19 patients was 42, the total number of Covid-19 patients stood at 63. Before the onset of the Omicron variant the position was reported to be settled and winter plans were in line with anticipated demand. Omicron had impacted the levels of infection, sickness absence for staff and critical supply chains. The vaccination programme was proving successful and the booster vaccination was expected to significantly increase immunity and reduce hospitalisation. The vaccination target for South Yorkshire was 143k per week until the end of the year – last week 98.5% of the target had been met. It was reported that approximately 80% of critical care occupancy were unvaccinated patients. The North East & Yorkshire region had now faced multiple waves of Covid, plans were currently being reviewed, conversion of wards was being considered and there was a clear focus on managing cover, sickness absence and isolation guidance in order to maximise staffing, whilst ensuring that colleagues were kept safe. Supply chain issues would be raised regionally and nationally, availability of lateral flow kits was likely to be a challenge, colleagues were encouraged to be patient with the gov.uk site as availability changed throughout the day. Partnership working, mutual aid, reinforcing the hands, face, space and ventilation message and the importance of vaccination were all key messages. In respect of Nosocomial standards the Chief Nurse confirmed that Infection, Prevention and Control standards had been maintained and audits had indicated no lapses in preventative measures.	

	Current visiting arrangements had been restricted to one hour pre-arranged for one consistent family member, although flexibility was being exercised in compassionate/end of life cases and in maternity services.	
P21/12/E3	**Governor Questions regarding the business of the meeting (10 minutes) ***	
	The Chair of the Board thanked governors for their continued engagement. In response to a question enquiring if recovery and restoration was achievable and to what extent the non-executive directors were assured of the plans, it was confirmed that Jon Sargeant had been tasked with the delivery of robust recovery plans. Fortnightly focus & delivery group meetings had been put in place, efforts were focused and delivery of plans was joined up and timely. The Chair acknowledged the good working relationships formed with the private sector, supporting clinical priortisation. Neil Rhodes confirmed that the Finance & Performance Committee would continue to receive updates on progress, although services had been impacted by Covid-19, restoration remained a focus. Plans were robust, and the Trust was reported to be well placed from a planning perspective. In closing, the Chair reiterated the need for hands, face space, ventilation and vaccination and shared season's greetings with the Board and those in attendance.	
	The Board: - ***Noted the comments raised.***	
P21/12/E4	**Date and time of next meeting (Verbal)** **Date:** Tuesday 25 January 2022. **Time:** 09:30am **Venue:** StarLeaf Videoconferencing	
P21/12/E5	**Withdrawal of Press and Public (Verbal)**	
	The Board: - ***R****esolved 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.*	
P21/12/F	**Close of meeting (Verbal)**	
	The meeting closed at 11:05	