Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday 27 June 2017 at 8.30am
in the Boardroom, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures
1.	Apologies for absence	(Verbal)
2.	Declarations of Interest	(Verbal)
3.	Actions from the previous meeting	Enclosure A
Presentation		
4.	Red Eye, Red Flags Mr Gerard Jayamanne - Consultant Ophthalmologist	Presentation
Reports for decision		
5.	Corporate Objectives Richard Parker –Chief Executive	Enclosure B
6.	Charitable Funds Policy Jon Sargeant – Director of Finance	Enclosure C
7.	Proposed ERIC submission 16/17 Kirsty Edmondson-Jones – Director of Estates and Facilities	Enclosure D
8.	Review of Board Committees – update Matthew Kane – Trust Board Secretary	Enclosure E
Reports for assurance		
9.	Ophthalmology Post Implementation Review Nick Mawer – Ophthalmology Consultant	Enclosure F
10.	Strategy & Improvement Report & Strategic Direction Update Marie Purdue – Acting Diector of Strategy & Improvement	Enclosure G (to follow)
11.	Finance Report as at 31 May 2017 Jon Sargeant – Director of Finance	Enclosure H
12.	Business Intelligence Report as at 31 May 2017 Led by David Purdue – Chief Operating Officer	Enclosure I
13.	Nursing Workforce Report Moira Hardy – Acting Director of Nursing, Midwifery & Quality	Enclosure J

14. Well Led Action Plan — Enclosure K
Matthew Kane – Trust Board Secretary

15. CQC Inspection Update — Enclosure L
Moira Hardy – Acting Director of Nursing, Midwifery and Quality

Reports for information

16. Chair and NEDs' Report — Enclosure M
Suzy Brain England – Chair

17. Chief Executive's Report — Enclosure N
Richard Parker –Chief Executive

18. Clinical Governance Oversight Committee Annual Report — Enclosure O
Martin McAreavey – Non-Executive Director

19. Minutes of the Finance and Performance Committee held on 22 May 2017 — Enclosure P
Neil Rhodes – Non-Executive Director

20. Minutes of Clinical Governance Oversight Committee on 18 April 2017 — Enclsoure Q
Martin McAreavey – Non-Executive Director

21. **To note:** — Enclosure R
Board of Directors Agenda Calendar
Matthew Kane – Trust Board Secretary

Minutes

22. To approve the minutes of the previous meeting held 23 May 2017 — Enclosure S

23. **Any other business (to be agreed with the Chair prior to the meeting)**

24. **Governor questions regarding the business of the meeting**

25. **Date and time of next meeting**

Date: 25 July 2017
Time: 9.00am
Venue: Boardroom, Doncaster Royal Infirmary

26. **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
Chair of the Board

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Action Notes

Meeting: Board of Directors

Date of meeting: 23 May 2017

Location: Boardroom, DRI

Attendees: SBE, RP, KB, MH, DP, SS, JS, AA, MM, LP, JP, NR, PS

Apologies: None

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**16/10/13**	Ophthalmology Department post-implementation review to be undertaken.	**DP**	**June 2017**	**Complete.** On the agenda – June 2017.
2.	**16/12/107**	An item regarding how governors can get involved in undertaking F&F to be placed on an upcoming Timeout.	**MK**	**June 2017**	**Complete.** This was considered at the Timeout on 26 June.
3.	**17/01/13**	Director of Education to share the Teaching Hospital phase two development plan at a future Board.	**MK**	**September 2017**	Identified as item for future Board strategy work.

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No.	Minute No	Action	Responsibility	Target Date	Update
4.	**17/03/07**	A paper be prepared on how the Trust can assure itself that support is in place concerning changes to NHS Protect.	**JS/KEJ**	**July 2017**	Awaiting response to Trust's letter from NHS Protect.
5.	**17/04/32**	Timetable six month review of CIPs.	**MP**	**November 2017**	Action not yet due.
6.	**17/04/54**	Invite NEDs to future quality summit.	**MH**	**July 2017**	Action not yet due.
7.	**17/04/61**	Bring Learning from Deaths report back to Board in May.	**MK**	**June 2017**	Deferred until July 2017.
8.	**17/05/06**	An issue raised relating to room space within the Research and Development Team would be addressed by the Chief Executive and Director of Estates and Facilities outside the meeting.	**RP/KEJ**	**End of May 2017**	**Complete.**

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No.	Minute No	Action	Responsibility	Target Date	Update
9.	**17/05/30**	Once the Emergency Planning Officer had considered the existing business continuity plans, a presentation would be brought to Board and the plans would be tested by internal audit.	**DP**	**September 2017**	Action not yet due.
10.	**17/05/51**	Work on complaints and the DNA working group would be brought to Board through the Finance and Performance Committee following quarter two.	**DP**	**July 2017**	Action not yet due.

Date of next meeting: 27 June 2017
Action notes prepared by: M Kane
Dated: 1 June 2017
Circulation: SBE, AA, NR, KB, DJ, MH, MM, DP, JS, SS, JP, RP, LP, PS

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Title	**Corporate Objectives**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Richard Parker, Chief Executive**		

Purpose		Tick one as appropriate
	Decision	X
	Assurance	
	Information	

Executive summary containing key messages and issues

In addition to the key operational outcomes and standards which are described in the relevant job descriptions the Executive Directors' draft objectives for 2017/ 2018 set out the actions which will be required to achieve the Trust strategic aims for 2017/ 2018:

- Clinical and operational performance and plans
- Financial stability and improvement
- CQC assessment of Good
- NHSI segment 2 with removal of licence breech
- Completion and delivery of the revised Strategic direction
- Reduction of the key quality, financial, operational and strategic risks

Corporate Objectives will be further reviewed and updated following consideration at the Board of Directors and the outcome of consultation and feedback from Patients, Governors, staff and partners.

Key questions posed by the report

- What is the organisation aiming to achieve and how is it going to achieve it?
- What progress is it making and what are the risks to the objectives?
- Where progress is not as expected, what action will be taken?

How this report contributes to the delivery of the strategic objectives
The actions identified in the attached appendix set out the key actions towards the achievement of the Trust's strategic objectives.
How this report impacts on current risks or highlights new risks
The impact on corporate risks is given in the attached appendix.
Recommendation(s) and next steps
That Board APPROVES the corporate objectives and actions attached as an appendix to this report.

As a *sustainable* Acute *Teaching* Hospitals Trust we will transform services so DBTH can maintain and improve high *quality* integrated care as a crucial, leading *partner* in health and social care across South Yorkshire and Bassetlaw

We always put the patient first
Everyone counts – we treat each other with courtesy, honesty, respect and dignity
Committed to quality and continuously improving patient experience
Always caring and compassionate
Responsible and accountable for our actions – taking pride in our work
Encouraging and valuing our diverse staff and rewarding ability and innovation.

- Work with our staff to develop the skills, values and leadership to provide high quality, efficient and effective care
- Develop and enhance elective care facilities at BDGH and MMH and ensure the appropriate capacity for increasing specialist and emergency care at DRI
- Increasing clinically led partnership working to benefit people and communities
- Supporting the development of enhanced community based services, prevention and self care

Objective	Lead	Supporting Actions	Expected Outcome	Impact on Risks	Expected Outcome at 31/ 03/ 2018	Measurable Milestones	Update on delivery at September 2017	Rating	Update on delivery at December 2017	Rating	Update on Delivery at March 2018	Rating	Actions to be taken forward to 2018/ 2019
Ensure the delivery of the Trusts financial plan and the implementation of an agreed improvement and effectiveness plan with identified work streams and SROs. Delivering service change and savings through achieving agreed targets and milestones	CEO	**Director Strategy and Improvement** Maintain and develop the programme management office, ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.	PMO processes reviewed to meet needs of revised Board sub-committees (Finance and Performance) Milestones and resources required clearly identified for sign off by SRO Up to date position on EEP available monthly Escalations made appropriately to the Transformation Board and F & P Committee	Reduces likelihood of failure to deliver financial plan and Cost Improvement Plans in this financial year	**DS&I -** EEP delivery is in line with forecasts and expectations Progress with delivery of strategic and enabling work streams is documented accurately and all escalations have been appropriately managed	**DS&I -** Review for F&P by July 2017 Up to date accurate information - ongoing							
		Directors Lead agreed improvement work streams as SRO, delivering service change and savings through achieving agreed targets and milestones			Programmes managed to deliver agreed programme outcomes and within agreed timeframes.	Delivery to agreed programme plans							
Work with STP and Place based partners to ensure that the Trust maintains a sustainable future to deliver the needs of the local populations and the legal responsibilities required by NHSI and the CQC	CEO	**Directors** Ensure that the Trust maintains strong and effective partnerships at Place and STP level	**DS&I** - Place plans reflected in Strategic Direction Ongoing involvement in ACP development	Reduces likelihood of failure to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	**DS&I -** Place plans reflected in Strategic Direction Ongoing involvement in ACP development	**DS&I -** Evidenced by joint projects - t.b.c.							
Ensure the completion of the Trusts Strategic Vision to reflect the aims and objectives for the Trust within the STP, Place and legal and regulatory requirements of NHSI and the CQC	CEO	**Director of Strategy and Improvement** Produce a final DBTH Strategic Vision document to the NHSI timescales that is approved by the Board, with input from all appropriate stakeholders	**DS&I –** Completed Strategic Vision document approved by Board Strategic plan with milestones and responsibilities identified Robust evidence of communication and engagement plan being implemented with stakeholders Launch in line with Communications Plan	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	**DS&I -** Progress on strategic milestones as per plan with any escalations being appropriately managed Robust process for escalation where plans are not on track Evidence of functioning governance structure	**DS&I -** Strategic Vision to NHSI by end July 2017 Launch in line with Communications Plan August 2017							
		Executive Directors Lead the refresh of the strategies related to areas of responsibility to ensure the delivery of the Trust's revised Strategic Direction	**DS&I -** Completed QIi Strategy and implementation plan agreed by Board		**DS&I -** Completed QIi Strategy agreed by Board and implementation in line with plan	**DS&I -** Completed QIi Strategy agreed by Board and implementation in line with plan							
Produce a clinical service model for the delivery of safe and sustainable emergency, elective, diagnostic and support services across the Trust	COO Medical Director Director of Nursing Midwifery and Quality	**Directors** Work with the Lead Directors to ensure the delivery of the clinical service model	Publication of a clinically engaged site strategy to deliver improvements in site efficiency and effectiveness	Reduces likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Increased elective capacity on BDGH and MMH. Improved emergency/trauma pathways at DRI	Published strategy July 2017 Service site reorganisations Q2-3							
Maintain Compliance with all NHSI Access Targets and Outcomes Objectives with Sustainability and with Transformation Fund associated Targets (Four Hour Wait and RTT) as a priority.	COO	**Directors** Support the COO to deliver national access and outcome standards in line with the trajectories set by contract or NHSI	Meet/exceed NHSI agreed trajectories	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	DBTHFT is green for governance	Quarterly updates via single oversight framework							
Work with partners to reduce demand on the acute services to ensure that demand equates to available resources		**Directors** Support the COO to deliver a capacity and demand plan to deliver activity plans in line with trajectories set by contract of NHSI	Support CCGs to deliver Quipp and manage demand within existing resources	Reduces the likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Contractual levels of activity are met for patient needs	Quarterly updates via single oversight framework							
Increase elective activity at BDGH and MMH to best utilise available resources and facilities		**Directors** Take the actions necessary to support the COO with transfer of appropriate elective and diagnostic activity to BDGH and MMH	COO - Meet service demands within existing resources DS&I - Contribution by S&I to review of elective activity by site and plan for future outsourcing requirement		**COO -** Service reorganisations are in place to maximise elective capacity **DS&I -** Contribution by S&I to review of elective activity by site and plan for future outsourcing requirement	**COO -** Site strategy milestones identified **DS&I -** Milestones will be contained within the plan							
Work with external partners to review service delivery across the wider STP footprint to ensure services which support place based ambitions and the delivery of high quality and sustainable services		**Directors** Take an active role across the area of responsibility within the STP and Place to ensure services are safe and sustainable and meet the needs of the local population	DBTHFT role in the place and ACS is maximised to deliver sustainable high quality services		DBTHFT place plan clearly identifies the Trust as a key stakeholder in the ACS	Active involvement in ACS work streams to represent DBTH							
Co-ordinate the development of an innovative and sustainable workforce plan across the Trust. Developing and implementing plans to improve leadership, recruitment and retention initiatives	Director of People and Organisational Development	**Executive Directors** Take appropriate actions within areas of responsibility to develop and deliver a sustainable workforce plan using Calderdale framework and alternative professions.	Workforce plan in place which will enable/facilitate the delivery of the Trust's service plans. Commissions in place with HEE/FTEs in order to deliver the workforce models. Reduced vacancy levels and reduced spend on bank and agency staff.	Reduces the likelihood of failing to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Workforce plan developed with clear description of workforce models to be adopted. Clarity as to required commissions through HEE/HEI/FEIs. Recruitment plan in place for each staff group.	Capacity developed for use of Calderdale framework across the trust. Recruitment strategy for hard to recruit to staff groups developed. Recruitment section of website refreshed.							
		Executive Directors Develop the leadership skills within own teams and Care Groups. Identifying and developing talent at all levels to ensure effective succession planning	Leadership teams equipped to deliver the Trust's strategy and supporting strategies. Future talent pool identified together with agreed approach to harness that talent.		Leadership teams are equipped to deliver the Trust's strategic direction and operational plans effectively.	Identification of leadership development requirements. Offering developed ensuring best use of external resource that is available. Approach to identifying future talent in place. Talent pool identified with associated development plan							
Co-ordinate, develop and ensure the implementation, delivery and monitoring of the staff engagement action plan to ensure the delivery of the Trusts values and an improvement in the national staff survey results for 2017/ 18		**Directors** Review the staff survey results relating to areas of responsibility and contribute to the development and delivery of the corporate action plan and the necessary improvements.	Improved staff survey results. Achievement of CQUIN target for health and wellbeing. Well functioning staff experience group.		Improved staff survey results. Improvements in health and wellbeing scores in order to achieve the CQUIN target. Improved involvement of staff in service change.	Staff experience group established. All Care Groups/Directorates to have agreed action plans to improve their survey results. Action plan in place to achieve health and wellbeing CQUIN. Progress against the Trust wide staff survey action plan							
Co-ordinate the production and delivery of Board and Executive Team Development Programmes		**Directors** Take an active role in the delivery of effective Board and Executive Team development days	The Trust will have a Board and Executive Team which works effectively and which is driving forward the Trust's vision, values and strategic direction		Executive Team and Board development plans in place with regular development sessions scheduled. Positive assessment against CQC/NHSI's well led domain. Positive feedback through staff survey results.	Identification of development requirements. Programme developed together with identification of delivery partner. Programme in place.							
To create a stable and motivated finance function, Measured by staff turnover, implementation of restructures, staff survey	Director of Finance	**Directors** Ensure the finance team are integrated into Corporate and Care Group Teams	Fully established finance suitably qualified team, with clear responsibilities providing professional support, and having a reduced reliance on Agency support	Reduces likelihood of failing to achieve compliance with financial performance, delivering accurate financial reporting underpinned by effective financial governance and delivering financial plan. Reduces likelihood of loss of corporate memory.	New strucure implemented with Trainee posts working on a rotational basis. Clear support identified for Care Groups and Corporate Teams.	Structure designed (Apr 17) Structure Agreed with Exec/HR/Staff Side (June 17) Structure implemented (Sep 17) New posts advertised and interviewed (Nov 17)							
To stabilise and embed systems within the organisation and finance function to deliver a strong financial control environment. Measured by delivery of strong financial information, audit reports, understanding of financial performance.		**Directors** Ensure the delivery of the agreed financial plans within the areas of responsibility	Create an industry standard Financial Control environment Implement and stabilise the new ledger system (S4S) Strengthen and embed the Corporate Investment Group Process Set a clear financial plan and maintain a regular financial forecast with recommended corrective actions	Reduces likelihood of failing to achieve compliance with financial performance, delivering accurate financial reporting underpinned by effective financial governance and delivering financial plan. Reduces risks of not hitting the financial targets and sudden changes in financial postion leading to impacts on patient care.	Stronger Financial Control regime and better financial forecasting Stronger Management of Cash position Delivery of agreed financial plans	SBS Go live (Apr 2017) Introduction of Financial Accountability meetings (July 17) Cash Committee (July 2017) Revised SFI's/Standing Orders (Aug 17) Rolling Forecasting (Aug 2017) Half year closed down Oct 2017 Production of Procedure Notes for Fin Function (Dec 2017) Update CCG Contracts 2018/19 (Jan 2018) Budgets 2018/19 (Mar 2018)							
Ensure a robust clinical governance system is maintained and developed across the Trust to deliver the national quality, performance and professional standards applicable to the Trusts services. Taking proactive actions to identify and address any areas of weakness.	Medical Director	**Directors** Ensure that systems and process are in place within the areas f responsibility to support good governance	Sustain and improve care quality and patient safety	Reduces the likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Sustain performance and improve across a range of quality metrics	Maintain care quality metrics within planned trajectory							
Complete the delivery of the action plan following the Royal College Review.		**Directors** Support the delivery of the RCOG action plan.	Deliver all actions to address the Clinical Governance recommendations in the RCOG report		Improved obstetric patient safety, care quality and patient feedback	Delivery of action plan within defined timeline							
Develop a specific programme of work to ensure that the future structure of the Medical Directors office reflects the future needs of the Trust, STP and Place and the composition of the medical workforce		**Directors** Support the development of clinical leadership to maintain the Trusts influence at Place and within the STP	Enhance capacity and capability of the Medical Director's office to meet Trust requirements		Delivery of all Medical Director, Responsible Officer and Caldecott Guardian functions	Progress to delivery of Medical Director objectives							
Implement a Patient and Carer Experience and Engagement Strategy. Implementing national and international best practice in the use of feedback to improve services.	DNMQ	**Directors** Increase experience and engagement in the delivery of services to ensure high quality patient centred services, with tangible measurements, improvement targets and KPI reports to the PEC.	1.Patient experience and engagement strategy completed. 2.Tools and techniques to engage with patients agreed. 3. Increased participation of patients to service improvement work. 4. Metrics for measuring patient experience agreed. 5.Monitoring of patient experience metrics monitored and reported to PEEC monthly. 6.Positive patient experience reported in addition to complaints data.	Reduces likelihood of breakdown of relationship with key partners and stakeholders	Tools and techniques to engage with patients used routinely in clinical areas. Data demonstrates improved patient experience	Timescale for; 1. July 2017 2. September 2017 3. December 2017 4. September 2017 5. September 2017 6. September 2017							
Review the quality assurance tool and quality metrics in line with national quality guidance and launch in May 2017.		**Directors** Ensure that reliable metrics are in plan in all areas to demonstrate the quality of services	1. Review and agree Quality Metrics. 2. Monitor Quality Metrics via QEC / Board 3. Implement Perfect Ward App Trust wide		Metrics demonstrate improved and sustained quality for patients.	Timescale for delivery; 1. May 2017 2. May 2017 3. September 2017							
Oversee the development of a 3 year plan with appropriate milestones to support the implementation of the DBTH Strategic Vision	Director of Strategy and Improvement	**Directors** Ensure that the Director of Strategy and Service Improvements is aware of developments within clinical and support services at local, Place and STP levels	S&I Director is made aware of developments and engaged in discussions about implementation and support required	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	All service developments are made in line with strategy objectives and can evidence S&I discussion	Ongoing - as new developments come online							
Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase QII capacity and capability within DBTH (and potentially with partners)		**Directors** Within the areas of responsibility support the development of capacity and capability in the identification and delivery of quality, efficiency and effectiveness programmes and projects	All capacity and capability issues identified to the PMO and Director of S&I by the SROs of all programmes		All project implementation plans are signed off by SRO and QII training implemented as planned in the QII strategy	Work stream sign off by July 2017 QII plan milestone sin line with strategy currently being agreed							
Maintain a robust and effective Programme Management Office ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.		**Directors** Within the areas of responsibility ensure the identification, delivery and monitoring of efficiency and effectiveness programmes	Ensure current and developing efficiency and effectiveness programmes have robust and measurable programme management arrangement in place.		All programmes have measurable programme management arrangements in place	Arrangements and metrics in place in Quarter 1							

Prepare for and implement the GDPR legislation within the Trust by the end of March 2018	**Chief Information Officer**	**Directors** Take actions necessary to support the delivery of the GDPR	GDPR readiness by April 2018. financial impacts completed for budgeting purposes. SET training undated. DPO annointed.	N/A	GDPR ready to implement for May 18	Plan available by October 17								
Deliver, with available resource, the prioritised IT work plan and associated projects in support of the care group initiatives, the transformation agenda and the CIP activities		**Directors** Take actions necessary to identify the IT needs within the areas of responsibility	Develop portfolio approach to projects. Establish governance group. Deliver regular updates to care groups. Deliver planned work	Reduces the likelihood of failing to deliver Cost Improvement Plans in this financial year	Portfolio governance and communication plan agreed and rolled out. 80% of project delivered - depending on resource and finance at capital level	Governance mechanism agreed October 17								
Deliver the appropriate integration and interoperability technology in support of the Doncaster Place based Intermediate Care Record and if appropriate the STP		**Directors** Take actions necessary to support the delivery of the Intermediate Care Record	Develop the internal DBTH architecture to deliver first stage data to the ICR. Develop technology that supports the internal and external portal. Deliver the clinical viewer for internal use	Reduces likelihood of breakdown of relationship with key partners and stakeholders	Architecture agreed. Contributions to ICDR at Doncaster CCG level. Pilot of clinical viewer complete. Engagement with care groups and consultant community	Architecture draft agreed October 17. Initial pilot presented to clinicians December 17								
Provide appropriate technology support to the Trust for the development of the Single Oversight Framework throughout 2017.		**Directors** Take actions necessary to support the development and delivery of the Single Oversight Framework	Deliver the first stage of the BI framework and 80% of the Single Oversight Framework	Reduces likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	BI framework designed and implemented. Initial build of BI dashboards in ED and one other identified care group. SOF implemented for systems used today - explore options for getting information from non Trust environments e.g. ERS	BI Framework to pilot by Nov 17. SOF first iteration by Aug 17 including alerts and drill down								
Development of a 5 year Estates Strategy, to include a Capital Development Programme linked to Condition Surveys and Corporate Risk Register.	**Director of Estates & Facilities**	**Directors** Take actions necessary to identify the needs of the areas services within the areas of responsibility	The publication of a new 5 year EFM Strategy, linked to a revised Clinical Site Development Strategy	Reduces likelihood of failing to ensure that appropriate estates infrastructure is in place	The availability of an EFM Strategy Document	Draft document available for comment by July 17, ratified by Aug 17								
Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.		**Directors** Contribute to the evaluation of all options for developing the Trusts infrastructure and estate	**DE&F** - The development of capital funding options to support the Trust Strategic Direction		**DE&F** - Opportunities identified and agreed by Board of Directors. **DS&I** - Support business case development with Finance Team Evaluation of DBTH benefits realisation methodology	**DE&F** - Options developed through new Commercial Board monthly meetings **DS&I** - Project implementation reviews to include lessons learned from business case development								

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Title	**Charitable Funds Policy**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Jon Sargeant, Director of Finance**		
Purpose			Tick one as appropriate
	Decision		x
	Assurance		
	Information		

Executive summary containing key messages and issues
As part of the governance issues rectification plan the need for a consolidated charitable funds policy was identified. This draft policy is attached for the consideration and agreement of the Board.
Key questions posed by the report
• Do the new arrangements assure the Board that the Trust has in place a robust system and set of governance arrangements covering charitable funds?
How this report contributes to the delivery of the strategic objectives
The policy sets out the key objectives for the Trust's charitable funds.
How this report impacts on current risks or highlights new risks
This is covered in the policy.
Recommendation(s) and next steps
That the Board: (1) Approves the attached Policy.

(2) Agrees that John Parker will act as Chair of the new Charitable Funds Committee.

(3) Appoints one additional Executive Director having a clinical input e.g. Medical Director, Director of Nursing and Quality, etc to the Charitable Funds Committee.

Doncaster and Bassetlaw Teaching Hospitals
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CHARITABLE FUNDS

May 2017

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

Failure to comply with this policy and related procedures is a disciplinary matter which could result in dismissal.

Name and title of author/reviewer:	Andrew Thomas. Financial Governance lead
Date written/revised:	May 2017
Approved by (Committee/Group):	Board of Directors
Date of approval:	----------
Date issued:	----------
Next review date:	May 2018
Target audience:	Trust-wide

WARNING: Always ensure that you are using the most up to date approved procedural document. If you are unsure, you can check that it is the most up to date version by looking on the Trust Website: www.dbh.nhs.uk under the headings → 'Freedom of Information' → 'Information Classes' → 'Policies and Procedures'

Charitable Funds

Amendment Form

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

Version	Date Issued	Brief Summary of Changes	Author
1.0	___May 2017	• Original Document	Andy Thomas

CONTENTS

1. INTRODUCTION

1.1. GENERAL

1.1.1. This policy covers the governance and operation of the Doncaster & Bassetlaw Teaching Hospitals Charitable Funds.

1.1.2. It should be noted that, whilst this is a free standing arm's length body from the Foundation Trust itself the relevant Trust policies and procedures (including SFIs and SOs) apply unless superseded by the contents of this policy.

1.1.3. Failure to comply with this policy and related procedures is a disciplinary matter which could result in dismissal.

1.2. TERMINOLOGY

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

"the Board"	means the board of directors of the Trust as constituted in accordance with the Trust Constitution;
"Chair"	means the chair of the Charitable Funds committee appointed in accordance with the Trust Constitution;
"Chief Executive"	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Director"	means a director on the Board of Directors of the Trust;
"Director of Finance"	mean the chief finance officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Legal Adviser"	means the properly qualified person appointed by the Trust to provide legal advice;
"the charity"	means Doncaster & Bassetlaw Teaching Hospitals Charitable Fund
"Unrestricted Fund"	Means funds donated for a specific purpose but where, should this purpose be deemed unachievable, the fund may be redirected for other charitable purposes

"Restricted Fund"	Means funds donated to the Trust with a specific purpose for which they must be used
"Designated Fund"	Means monies donated which may be used for any purpose but for which a separate 'fund' has been created for purely legal purposes.
"Charitable Funds Committee"	Means the committee of the Board of Directors set up to govern and administer the Charitable Funds.
"Corporate Trustee"	A Charitable Fund may have one corporate body as a sole Trustee. In this case the Trust is the sole corporate Trustee of the charity.
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

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

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

2. RESPONSIBILITIES & DELEGATION

Trust Board as Corporate Trustee

2.1 Doncaster & Bassetlaw Teaching NHS FT shall be designated the sole corporate Trustee of the Charitable Fund.

2.2 The Board of Directors shall act as this Trustee. Therefore that body is responsible for running the operation of the Charitable Funds and ensuring a good governance structure is maintained.

2.3 The Board of Directors, when acting as the Trustee, needs to demonstrate that the decision making process is:

- Clear – i.e. can be easily understood and recorded as such;
- Open – decisions are made by the Board, acting as corporate Trustee, once all relevant and necessary information is available
- Independent – i.e. the decision making process is independent of any decision making concerning the use of exchequer funds.

2.4 The Trust Board is set up as a corporate Trustee for the Charitable Funds, this means that individuals are not responsible in law for the actions of the charity, however the Trust as a legal entity is. TheTrustee cannot delegate their duties and responsibilities, including major decisions in relation to the management and use of the Charitable Funds. What can however

be delegated is the implementation of Trustee's decisions. To this end the Board shall set up a Charitable Funds Committee which acts for the Corporate Trustee and is responsible for the overall management of the Charitable Fund.

Charitable Funds Committee

2.5 The membership of the Charitable Funds sub-committee shall be as follows :

- NED Chair
- The Chair and all other Non-Executive Directors of the Trust
- Chief Executive
- Director of Finance
- One additional Executive Director having a clinical input e.g. Medical Director, Director of Nursing and Quality, etc.

The Committee may also invite these people to attend;

- A governor observer co-opted by the Board
- Where any specific fund represents greater than £1m of the fund balances (as defined as at the proceeding 31st March) the committee shall offer to co-opt an additional member with a specific knowledge and or interest in that fund. As at 31st March 2017 the only such fund is the Fred and Ann Green Legacy.

2.6 The duties of this committee shall include

- Manage the affairs of the Charitable Fund within the terms of the Trust Deed and appropriate legislation as delegated by the Board of Directors as Corporate Trustee;
- Ensure funding decisions are appropriate, consistent with the Charity and Trust objectives;
- Develop and maintain a strategy for the Charitable Funds. This will include both fundraising and financial elements
- Implement procedures and policies to ensure that the accounting systems are robust, donations are received and accounted for as instructed and that expenditure is correctly recorded.
- Approve the Annual Report and financial statements and ensure all relevant information is disclosed.
- Appoint an appropriate auditor to report on the annual accounts. This would usually be the same auditor as reports on the Foundation Trust's accounts but the Charitable Funds committee has the power, should there be a good reason to do so, to diverge from this arrangement.
- Manage the investment of funds in accordance with the Trustee Act 2000. This will include the appointment of an investment manager/advisor and the regular review of the performance of the funds so invested i.e. at least twice yearly.
- Develop and subsequently review annually an Investments Policy. Key to this will be an assessment of the risk appetite and criteria for investment.
- Develop and subsequently review annually an investment and reserves policy
- Develop, maintain and update a rolling three year forward plan for fundraising, expenditure and investment.

2.7 The Charitable Funds Committee shall establish further sub-committees of itself as required at its discretion. As at May 2017 the only such sub-committee current constituted will be the Fred & Ann Green Advisory Committee.

Fred & Ann Green Advisory Committee

2.8 The Fred & Ann Green Advisory sub-committee shall have the following features and duties:

- Be Chaired by a Non-Executive Director of the Trust
- Comprise Governors and other co-opted members with a particular knowledge/interest of the Fred and Ann Green legacy or Montague hospital.
- Act in a purely advisory capacity for matters relating to the management and usage of the Fred and Ann Green legacy. The Charitable Funds committee shall consider this advice when arriving at its decisions relating to the legacy but in no way be bound by it.
- The Director Of Finance or his deputy will also attend this meeting.

Scheme of Delegation of Expenditure

2.9 The Board, as sole corporate Trustee, shall, upon the recommendation of the Charitable Funds committee set up schemes of delegation for spending the funds. This will allow items, or groups of items, of up to £10,000 to be approved outside of Charitable Funds meetings as follows :

- Initial approval by the designated fund holder.
- Second approval by either the Chief Executive or Director of Finance.

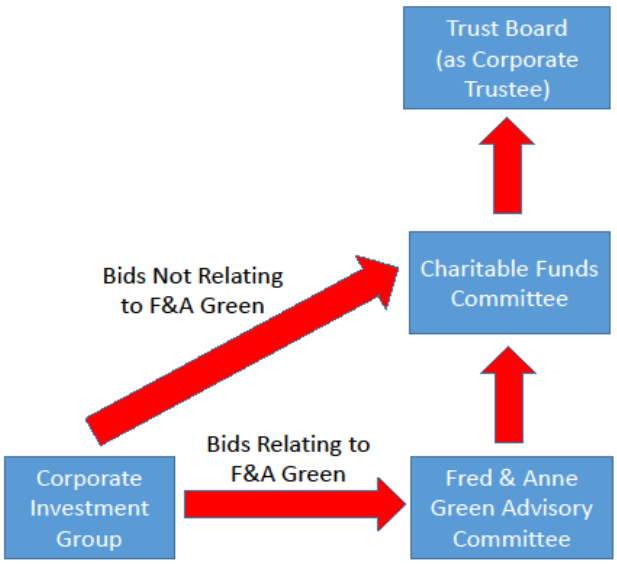
Any commitments will only be made via the Trust's normal processes and must comply with Standing Financial Instructions (SFI's)

2.10 Where an item in excess of these limits is required on an unforeseen, urgent basis and an additional meeting of the Charitable Funds Committee cannot be raised approval may be given outside of a formal meeting by the agreement of all of the members of the committee given in writing by email. Such cases are anticipated to be exceptional and therefore rare.

2.11 All items approved under the delegated powers rules as per 2.9 and 2.10 above shall be reported to the next meeting of the Charitable Funds committee for noting.

2.12 Where a Business Case would be required to be considered by the Trust's Corporate Investment group (CIG) if it was core revenue funded then the same process should apply for Charitable Fund funded items.

GOVERNANCE STRUCTURE



3. AUDIT AND ACCOUNTS

3.1 As outlined in the powers of the Charitable Funds committee in point 2.7 above there is a requirement to prepare and have audited annual accounts.

3.2 Therefore it shall be the responsibility of the Director of Finance to :

- Maintain the necessary financial records to enable the transactions and balances for each fund to be reported.
- Be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trustee to fulfil its statutory responsibilities
- Prepare annual accounts for the consolidated Charitable Funds
- Provide the necessary information and explanations to enable the appointed auditors to complete their work.
- Provide regular reports to the Charitable Funds committee

3.3 Once completed the auditors shall present their report to the Charitable Funds committee for consideration.

3.4 The Charitable Funds committee shall, once they feel able to do so, recommend the adoption of the annual accounts to the Trust Board.

3.5 The Director of Finance shall ensure that the accounts are prepared and audit completed to enable the annual report sand accounts to be submitted to the Charity Commissioners as required. The deadline for this is currently the 31st January of the year following.

4. OPERATIONS OF THE CHARITABLE FUNDS

ALLOCATION TO INDIVIDUAL FUNDS

4.1 Within the over-arching Trust Charity funds held may be split into individual funds to better manage them. Each of these may, for example, represent a ward, department, or specific fundraising appeal, etc. These are called 'Designated Funds'.

4.2 Each sub fund shall, as required by legislation, be categorised in one of the following ways:

- Restricted – such funds must be used for specific purposes only as set out by the donors at the time of the donation or by the terms of a public appeal.
- Unrestricted – funds given to charity without any restrictions imposed by the donor. This would include proceeds from any appeals where the Trustees included a disclaimer to the effect that this is likely should the purpose of the appeal be unachievable.
- Designated – funds given to the hospitals' charity in general free to use at the discretion of the Trustee. In some cases such monies may be placed in a specific discretely defined fund for administrative easy only.

4.3 With the exception of restricted funds as defined above the allocation of monies into individual sub funds is purely for ease of administrative purposes only and has no legal force. The Trustee may, subject to other relevant laws and regulations, merge, split or otherwise amend these funds as seen fit.

4.4 Each fund shall have a number of authorised signatories ranging from one to five. All expenditure for a fund must first be authorised by one of these signatories before then going through the full authorisation process as defined above.

4.5 No fund may go 'overdrawn' i.e. have a negative balance. Any authorised signatories authorising such expenditure may be subject to disciplinary action as per the Trusts SFI's.

PURCHASING

4.6 The authorisation procedures outlined in this document are additional to the applicable purchasing rules of the Trust. i.e. the need to obtain a number of quotes on smaller items, undertake full tender on large expenditures etc.

4.7 In considering the values of items being purchased it is not permissible to segregate sets of or related items to minimise the procurement process.

4.8 All other Trust purchasing policies also apply to the use of Charitable Funds

4.9 In all cases an order shall be raised on the Oracle system for all Charitable Funds purchasing

BANKING

4.10 All receipts and payments will be made via the Trust's bank account. This will be to both ease the

administrative burden and better manage overall cash resources.

4.11 A discrete Charitable Funds bank account will however be maintained to hold any unused cash resources. The level of funds so held will be driven by the Reserves & Investment Policy (see below).

4.12 On a monthly basis the 'inter-company' account between the Trust and Charitable Funds will be reconciled to identify any aggregate sums due from/to the Charitable Funds and a payment/receipt actioned to return this to balance.

CHARGES

4.13 The Trust shall recharge the costs of administering the Charitable Funds to the Fund itself. This cost shall then be distributed proportionately over the various individual funds based on the balances.

4.14 The overall cost to be charged should be in line with the cost of providing the service. This will include, but not necessarily be restricted too:

- The costs of any Charitable FundCharitable Fund accounting systems used
- An appropriate proportion of the costs of other IIT systems used in administering the fund
- The staff time of those in the Finance function and elsewhere delivering the service in support of Charitable FundCharitable Funds
- A reasonable proportion of any other relevant costs

4.15 In some cases Trust members of staff will work on Trust funded projects. Where this is the case a proportionate element of their costs will be recharged.

4.16 It is not permissible for the Trust to either over- or under- charge the Charitable Funds.

4.17 The total of such charges shall be reported to the Charitable Funds Committee on an annual basis.

INVESTMENTS

4.18 One of the powers delegated from the Corporate TTrustee to the Charitable Funds committee is to formulate an investment policy. It should be noted that this is not tied to the requirements of the Trustee Investment Act 1961 to maintain a division between 'narrow' and 'wide' range investments

4.19 The Charitable Funds Committee will be responsible for managing the investment of the Charitable Funds in line with the agreed investment policy in doing so the Charitable Funds committee shall Shall exercise such power with the care of a prudent person

- Shall not make any speculative or hazardous investment
- Shall not engage in trading ventures
- Shall have regard to the need to diversify investments
- Shall undertake to use the services of an investment advisor where this is felt appropriate

4.20 The aims of the charity's investment policy will be to address the needs of the Charity and it's beneficiaries in the short, medium and long term, taking into account the future needs of the Charity in terms of both capital and income.

4.21 The Charitable Funds are made up of a large number (>100) of generally small value designated and restricted funds with often very distinct and diverse objectives. The nature of spend is generally to add to exchequer funded services where recurrent budgets are insufficient to cover the cost of additional 'over and above' items. This means the main requirement for each fund is to maintain a reasonable balance to support the activities of each department, in accordance with the Reserves Policy.

4.22 The exception to this is a Major Fundraising Appeal, which will usually run for around one to four years, followed by a period of about one year when the amount raised will be spent.

4.23 The Trust's proposed current Reserves & Investment policy is shown in appendix A.

INVESTMENT RETURNS

4.24 The Charitable FundCharitable Funds shall invest elements of its resources in line with the investment and reserves policies. This will generate a return from:

- Interest on bank or other deposits
- Share Dividends
- Profit (or loss) on the sale of investments held.

4.25 The aggregate of these investment returns will be added to the overall Charitable Fund balance when received. It is at the absolute discretion of the TTrustee as to how this income is allocated. i.e. it may be allocated proportionately across all funds or retained centrally and credited to the general fund.

4.26 'Unrealised Gains' represent the increased in value of investments held that have not yet been crystallised by sale. Therefore they are still uncertain due to the possibility of these values falling back at some future date. Therefore these are not allocated to specific funds nor should they be included in any planned expenditure.

RESERVES POLICY

4.27 A reserves policy is a product of a charity's strategic planning, budgeting and risk management processes. These processes provide Trustees with the information they need to establish exactly why they might need reserves and to help them quantify the level of this need.

4.28 The Charity Commission expects Trustees to decide, publish, implement and monitor their charity's reserves policy so that they can comply with their legal duties to:

- act in the interests of their charity and its beneficiaries;
- protect and safeguard the assets of their charity;
- act with reasonable care and skill; and
- ensure their charity is accountable.

4.29 In practice, this means that Trustees should develop a reserves policy that:

- fully justifies and clearly explains the rational for keeping or not keeping reserves;
- identifies and plans for the maintenance of essential services for beneficiaries should there be a significant reduction in income;
- publish the reserves policy (even if not required to by law) and ensure it is tailored to the charity's circumstances. It should explain to funders, beneficiaries, the public and the commission exactly what reserves are kept for and when they are to be used;
- make sure that their reserves policy is put in place and operated; and
- regularly monitor and review the effectiveness of the policy in the light of the changing funding and financial climate and other risks.

4.30 The Trust's proposed Investment and Reserves policy is shown in appendix A.

5. FUNDRAISING

5.1 The Trust's Charitable Funds have four main ways of generating additional resources:

- Donations from users, patients, relatives etc.
- Fundraising – either general or for specific purposes
- Bequests included in wills
- Investment income (as outlined above).

5.2 It should be noted that it is not permissible to credit the following to Charitable Funds:

- Fees/salaries for additional work done where the individual earning the monies is in direct control of the fund. e.g. if an individual asks for any overtime or additional payments to be paid tax free into a Charitable Fund where the same individual has direct control over the subsequent expenditure of those sums. In such cases the fees/salaries should be paid to the employee net of tax in the usual manner then the recipient can subsequently donate to the Charitable Fund with the gift aid mechanism being used to maximise the donation.
- Where the income credited to the fund arises from activities undertaken by NHS staff in time paid by the NHS
- Where the income relates to the sale of items purchased at NHS expense.
- Any other income where the expenditure to generate the income was funded by core exchequer funding. If in doubt the advice of the Director of Finance or his/her designated deputy should be sought

5.3 All fundraising activity should first be registered with the Charitable Funds lead in the Trust's finance department. This is to ensure that all fundraising is duly accredited, there are mechanisms in place to ensure that all funds raised are credited to the relevant fund, and that all legal aspects are fully covered.

5.4 When fundraising the general aims of the Foundation Trust should be considered. Whilst all fundraising is encouraged and it is accepted that non-standard activities are often the most successful care should be taken that no activities that could be deemed to bring the Trust into disrepute are undertaken.

5.5 When accounting for fundraising care must be given to the need to ensure that the Trusts Charitable Funds do not become fragmented into a large number of small funds. The establishment of too many 'restricted' funds (see 4.1 above) is likely to lead to a lack of flexibility in not being able to deploy significant resources as and when required

5.6 To avoid the over fragmentation of the funds the following principles should be applied:

- When receiving donations the appropriate form should be used as shown in Appendix B. This clearly states that all donations are made to the Charitable Funds 'General Fund' and as such may be used for any charitable purpose as determined by the Trustee. However there is an additional opportunity for the donor to indicate, in a non legally binding way, the purpose for which he/she would like their donation used. This will enable the Charitable Funds to both attribute the item to a specific designated fund whilst maintaining the opportunity and flexibility to fund large schemes and reallocate donations to where they can be best used.

- Where a specific appeal is being launched for a significant sum the literature should clearly state that, should the funding not be required for the specified purpose, then the Trustee retains the right to use it elsewhere within the general charitable purposes of the Trust. Examples of where this might happen is where insufficient funding is raised, funding in excess of the cost of the item required is raised, due to changes in technology and/or service patterns a different development might now be considered preferable to deliver the original purpose, etc.

- Where a significant bequest is received it may be necessary to set up a 'Restricted' fund (see 4.1 above). In some cases this will be unavoidable. However, where future bequests are being encouraged and/or discussed with the Trust in advance of the donor's death the use of an unrestricted or designated fund should be encouraged.

5.7 The use of gift aid and other such mechanisms to maximise the effects of donations is to be integral to all fundraising.

APPENDIX A – RESERVES & INVESTMENT POLICY

Objectives

The objectives of the investment of the charities funds are as follows:

- Preserve the real value of the capital and provide an income
- Invest over a long term time horizon
- Apply a “medium” risk profile
- Ensure that the charity has the liquid resources available as and when required

Investment Advisor

To best achieve the stated objectives an investment advisor/manager will be retained to manage the fund’s long and medium term capital.

This appointment will be made for an initial period or 3-5 years with an annual review of performance.

The use of such an advisor does not remove any of the duties and responsibilities of the Corporate Trustee or Charitable Funds Committee.

Level of Acceptable Risk

The Charitable Funds committee considers that investment should be restricted to securities listed on a recognised stock exchange and unit Trusts recognised under the Financial Services Act.

Further, the committee will ensure that there is adequate diversity of investment to minimise the risk of individual institutions performing poorly. To deliver this the overall portfolio will consist predominantly of real assets to achieve the necessary growth in income and capital blended with less volatile assets to provide the diversification and dampen volatility.

Where investments are held in non-UK Sterling denominated holdings the current risk should be an additional consideration. Given the scale of the Charitable Funds held it is not anticipated that more than a small proportion of the total holdings by value would be exposed to this direct current risk.

Ethical Investment

In general terms the interests of the Charitable Funds beneficiaries are best served by the investment strategy seeking to obtain the best financial return from the Charity’s investments, consistently and with commercial prudence. Indeed Charity Commission guidance is that decisions to decline to invest in a particular company should only be considered if its activities are directly contrary to the charitable purposes.

Therefore, given the overarching health based nature of the charity, the following sectors will not be invested in:

- Tobacco and related products
- Alcohol
- Arms and munitions

These restrictions will not apply where any involvement in these sectors is peripheral to the overall business.

The Balance of Long and Short/Medium Term Investment

The Corporate Trustee considers that the available funds should be split between long term and short term investments. This will be monitored at each Committee meeting to ensure that the split is appropriate to the future expenditure requirements. The emphasis will always be on making sure that funds will be available when required.

Given the generally long term nature of the fund's spend profile the Trust shall generally maintain the majority of its funds' investments in longer term items. However this will be reduced should the three year plan identify the need for significant cash funding on a shorter term basis.

The core driver in the fund's liquidity policy will to maintain between 6 – 12 months forecast expenditure in the form of cash invested on the Money Markets in line with the Trust's treasury policy. This forecast will be as shown in the Charitys' rolling three year plan.

Inevitably this figure will vary from time to time based on the charity's expenditure plans. In particular there will be a need to maintain significantly more funds in the form of cash when a large expenditure project is approaching commencement or underway.

Reporting and Monitoring Investment Performance

The performance of the charity's investments will be reported to each meeting of the Charitable Funds committee with a more detailed review twice a year.

Reserves

The charity holds a reserve amongst its investments for a number of reasons:

- Should there be a significant drop off of charitable receipts it may not always be possible to cease expenditure as quickly.
- At any time the charity will have on going commitments not yet charged to funds. e.g. staff agreed to be funded over an extended period.
- There may be a marked down turn in the value of investments held.

The Trustee considers it prudent that reserves should be sufficient:

- To ensure stability of funding for ongoing projects;
- To cover one year administration, fund-raising and support costs;
- To avoid the need to sell investments held for the longer term at short notice therefore possibly minimising the return.

Therefore the Trustee considers it prudent that the minimum level of unrestricted reserves held is sufficient to cover the aggregate of:

- Sufficient funds to cover all forward expenditure commitments
- The estimated likely costs of ceasing operations and closing the charity
- An additional £250k 'buffer'

The aggregate reserves value to be maintained will be recalculated annually based on the financial positions at 31st March.

Monitoring Compliance with the Reserves Policy

On an annual basis, the funds held by the charity will be examined to ensure compliance with this reserves policy. If a designated fund does not have plans to spend its reserves within a reasonable time of receiving them and if, in the Trustee's opinion, the need for a particular designated fund no longer exists, those funds will be redirected to the general fund.

APPENDIX B – RECEIPT OF DONATIONS DOCUMENTATION

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Charitable Funds Donation Form

Please insert your name & address

Name:

Address:

I give to Doncaster & Bassetlaw Teaching Hospitals NHS FT as the Trustee of the Doncaster & Bassetlaw Teaching Hospitals Charitable Fund, Registered Charity 1057917, the sum of
£ _____ for the general purposes of that Charity.
Without imposing any trust, I desire they use such sums to :

If your donation is for a specific purpose, please say so here e.g. to provide extra comforts for the **patients of ward X**

Gift Aid - Tax Free Giving

If you are a tax payer, please tick the box below so that we can claim back 25p for every £1 you give, at no extra cost to you.

Please tick if you wish for your donation to be treated as Gift Aid

☐ Yes please, I want Doncaster & Bassetlaw Teaching Hospitals Charitable Fund to reclaim tax on the enclosed donation.

I confirm I have paid or will pay an amount of Income Tax and/or Capital Gains Tax for the current tax year (6 April to 5 April) that is at least equal to the amount of tax that all the charities and Community Amateur Sports Clubs (CASCs) that I donate to will reclaim on my gifts for the current tax year.
I understand that other taxes such as VAT and Council Tax do not qualify.

Please sign and date

Donor's signature & Date

the form

For Trust use only

RECEIVED WITH THANKS the sum of £ _____ for
and on behalf of Doncaster & Bassetlaw Teaching Hospitals Charitable Funds.

Signature _____ Date _____

APPENDIX C – CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE (ToR)

Charitable Funds Committee
Terms of Reference

Name	**Charitable Funds Committee (CFC)**
Purpose	To oversee and manage the Trust's Charitable Funds i.e. Doncaster & Bassetlaw Teaching hospitals Charitable Funds.
Responsible to	Trust Board (as the Corporate Trustee)
Delegated authority	The committee has the following delegated authority: • To authorise expenditure from the Charitable Funds as laid down in the Trust's Scheme of Delegation. • To manage the affairs of the Charitable Fund within the terms of the Trust Deed. • To develop and implement a fund raising plan. • To invest the available fund monies as appropriate. • Oversee the management and monitoring of the Trust's Charitable Funds • Ensure that policies and procedures are in place such that all decisions regarding fund expenditure is appropriate and consistent with the objectives of both the Charity and Trust. • Develop and maintain a rolling three year expenditure strategy for the Charitable Funds. • Approve the annual report and accounts of the Charitable Fund. • Appoint an appropriate auditor to report on the annual accounts. • Manage the investment of funds as laid down by both statute and the charity's investment and reserves policy. • Authorise all Charitable Fund expenditure in line with the approved scheme of delegation.
Chair	• Designated No-executive Director
Membership	• All Non-Executive Directors of the Trust • Trust Chief Executive • Trust Director of Finance • One additional Trust executive director having a clinical input i.e. either medical or nursing director. • A governor representative may observe the meeting

	• A co-opted representative from and funds with a balance greater than £1m
In attendance	As required by the business to be discussed
Secretary	Trust Board Secretary
Quorum	3 (Inc. at least 1 Executive Director AND at least 2 Non-Executive Directors)
Voting	Each member has one vote, with the chair of the meeting having the casting vote in the event of a tie.
Decision making	The committee may make decisions and approve proposals both in and outside of meetings where the issue is considered urgent. Any such decisions will then be brought to the next meeting for inclusion in the minutes.
Attendance requirements	Committee members must attend at least 75% of meetings, and all members are expected to nominate alternates when they are unable to attend.
Frequency of meetings	Quarterly, generally subsequent to the Board of Directors.
Papers	Papers will be distributed at least 5 days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	• Fred & Anne Green Advisory Committee • Other sub-committees for specific significant appeals set up from time to time
Circulation of minutes	Members and responsible committees.
Date approved by the committee:	_____ 2017
Date approved by Board of Directors:	_____ 2017
Review date:	_____ 2017

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Estates Return Information Collection (ERIC) 2016/17**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Kirsty Edmondson-Jones, Director of Estates and Facilities**		
Purpose			Tick one as appropriate
	Decision		x
	Assurance		
	Information		

Executive summary containing key messages and issues

This Estates Return Information Collection (ERIC) forms the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31st March. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and also supports work to improve efficiency. It is therefore critical that the data provided is of the highest quality in terms of its accuracy as well as being consistent with other trusts.

The ERIC return for 2016/2017 has received approval from the Standardisation Committee for Care Information (SCCI) and is a mandatory requirement to ensure compliance under the terms of section 259 of the Health and Social Care Act 2012. In addition, the Standard Contract requires the data to be collected in accordance with specific reporting criteria at Trust and Site level to ensure information provided is meaningful, usable and transparent.

ERIC collects information relating to the costs of providing, maintaining and servicing the NHS estate used in the delivery of patient care. This includes the costs of providing certain patient-focused services such as food, laundry and cleaning. In addition, the collection includes a number of non-financial aspects of the operation of buildings, such as information relating to fire safety and an organisation's progress in meeting carbon reduction targets.

Lord Carters final report (February 2016) raised concerns about the quality of some Trusts' returns to the ERIC database as not being as accurate as they could be, leading to a recommendation for improved governance and assurance of the data return and approval by the Trust Board and Director of Finance prior to submission. Attached is the proposed ERIC return report for 2016/17 that must be submitted by 30th June 17.

Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The report contributes to the Trusts' strategic objectives, particularly around the ability to provide the safest most effective care possible whilst controlling and reducing the cost of healthcare provision, and the provision of a suitable infrastructure. The data collected through ERIC enables the Trust to benchmark against other trusts to determine our relative levels of efficiency, safety and quality. In addition, the ERIC data is used for local investment planning, contract negotiation and service management, enabling the Trust to provide efficient and cost effective services, ensuring the delivery of better value healthcare and quality patient services.
How this report impacts on current risks or highlights new risks
The report provides accurate data for the Trusts' functional space and quality of buildings highlighting costs for current risks: • Cost to eradicate high risk backlog • Cost to eradicate significant risk backlog • Cost to eradicate moderate risk backlog • Cost to eradicate low risk backlog • Cost to eradicate Safety related Critical Infrastructure Risk (CIR) • Cost to eradicate Non-compliance related Critical Infrastructure Risk (CIR) • Cost to eradicate Continuity related Critical Infrastructure Risk (CIR)
Recommendation(s) and next steps
That the Board Approve and Note the information enclosed on the ERIC 2016/17 submission will be committed through EFM Information, HSCIC (NHS DIGITAL) on 30/06/2017 and released into the public domain in October 2017. That the Director of Finance is assured through internal audit that data provided is complete, accurate and up-to-date.

Trust Name	DONCASTER AND BASSETLAW TEACHING
Trust Code	RP5
Trust Type	ACUTE - LARGE
Region	NORTH OF ENGLAND COMMISSIONING REGION
Reporting Year	2016/2017
Trust Data Report	

Trust Profile	Unit	Value
Number of sites - General acute hospital	No.	3
Number of sites - Specialist hospital (acute only)	No.	0
Number of sites - Mixed service hospital	No.	0
Number of sites - Mental Health (including Specialist services)	No.	0
Number of sites - Learning Disabilities	No.	0
Number of sites - Mental Health and Learning Disabilities	No.	0
Number of sites - Community hospital (with inpatient beds)	No.	0
Number of sites - Other inpatient	No.	1
Number of sites - Non inpatient	No.	0
Number of sites - Support facilities	No.	0
Number of sites - Unreported sites	No.	0
Number of sites leased from NHS Property Services	No.	1

Strategies and Policies	Unit	Value
Estates Development Strategy	Yes/No	No
Healthy transport plan	Yes/No	No
Board approved Adaptation Plan	Yes/No	No
Sustainable Development Management Plan/Carbon Reduction Management Plan	Yes/No	No
Carbon reduction target	Select	4. No Sustainable Development Management Plan or Carbon reduction Plan
NHS Premises and Facilities Assurance - Assessment/Approval	Select	3. Assessed but not approved by the organisation's board
NHS Premises and Facilities Assurance - action plan	Select	3. Action plan produced but not approved by the organisations board

Finance	Unit	Value
Capital investment for new build	£	0
Capital investment for improving existing buildings	£	2,287,475
Capital investment for equipment	£	271,740
Private Sector investment	£	0
Investment to reduce backlog maintenance	£	1,681,574
Cost to meet NHS Premises and Facilities Assurance action plan	£	112,203
Estates and Facilities savings from Cost Improvement Plans	£	1,626,214
Estates and Facilities planned savings from Cost Improvement Plans	£	1,384,977
Income from services provided to other organisations - catering	£	289,455

Income from services provided to other organisations - laundry and linen	£	29,466
Income from services provided to other organisations - other	£	836,572

Safety	Unit	Value
RIDDOR incidents	No.	33
Estates and facilities related incidents	No.	8
Clinical service incidents caused by estates and infrastructure failure	No.	4
Overheating occurrences triggering a risk assessment	No.	8
Percentage of clinical space monitored for temperatures	%	59.20

Fire Safety	Unit	Value
Fires recorded	No.	0
False alarms - No call out	No.	5
False alarms - Call out	No.	4.00
Number of deaths resulting from fire(s)	No.	0
Number of people injured resulting from fire(s)	No.	0
Number of patients sustaining injuries during evacuation	No.	0

Site Name	Site Code
AGGREGATE SITE	AGGRE
BASSETLAW DISTRICT GENERAL HOSPITAL	RP5BA
DONCASTER ROYAL INFIRMARY	RP5DR
MONTAGU HOSPITAL	RP5MM

Facilities Management (FM) Services	Unit	AGGRE	RP5BA	RP5DR	RP5MM
Estates and facilities finance costs	£	163,562	2,044,833	5,026,185	663,127
Estates and property maintenance	£	46,612	846,745	716,133	243,349
Grounds and gardens maintenance	£	3,648	17,654	73,493	6,896
Electro Bio Medical Equipment maintenance cost	£	0	184,185	1,120,028	35,000
Other Hard FM (Estates) costs	£	0	1,377,853	3,629,624	479,273
Other Soft FM (Hotel Services) costs	£	16,387	1,672,974	4,407,047	581,927

Income Generation	Unit	AGGRE	RP5BA	RP5DR	RP5MM
Income received for area leased out for retail sales	£	0	0	83,060	0
Area leased out for retail sales	m²	0	0	126	0

Areas	Unit	AGGRE	RP5BA	RP5DR	RP5MM
Gross internal floor area	m²	1,569	38,131	107,058	14,268
Occupied floor area	m²	1,569	37,132	107,058	13,879
NHS estate occupied floor area	%	0.00	100.00	100.00	100.00
Site heated volume	m³	4,397	113,001	274,991	36,478
Land area owned	Hectares	0.00	10.70	11.24	3.59
Land area not delivering services	Hectares	0.00	1.60	0.23	0.76
Clinical space	m²	1,569	24,964	68,370	9,650
Non-clinical space	m²	0	12,167	38,688	4,229

Function and Space	Unit	AGGRE	RP5BA	RP5DR	RP5MM
Not functionally suitable - occupied floor area	%	0.00	28.00	41.00	28.00

Not functionally suitable - patient occupied floor area	%	0.00	32.00	43.00	30.00
Floor area - empty	%	0.00	0.00	0.00	0.00
Floor area - under used	%	0.00	11.00	2.00	6.00
Single bedrooms for patients with en-suite facilities	No.	0	26	115	23
Single bedrooms for patients without en-suite facilities	No.	0	23	92	6
Isolation rooms	No.	0	0	6	0

Age Profile	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Age profile - 2015 to 2024	%	0.00	0.00	0.00	0.00
Age profile - 2005 to 2014	%	0.00	6.60	0.20	11.70
Age profile - 1995 to 2004	%	0.00	14.40	2.10	28.00
Age profile - 1985 to 1994	%	0.00	38.90	9.60	24.70
Age profile - 1975 to 1984	%	0.00	24.80	0.00	0.00
Age profile - 1965 to 1974	%	83.60	3.10	50.70	17.20
Age profile - 1955 to 1964	%	0.00	1.90	24.00	3.30
Age profile - 1948 to 1954	%	0.00	0.00	0.00	0.00
Age profile - pre 1948	%	16.40	10.30	13.40	15.10
Age profile - total (must equal 100%)	%	100.00	100.00	100.00	100.00

Quality of Buildings	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Cost to eradicate high risk backlog	£	0	497,377	11,744,122	259,011
Cost to eradicate significant risk backlog	£	0	1,609,355	28,045,878	505,591
Cost to eradicate moderate risk backlog	£	0	1,266,578	4,919,850	192,435
Cost to eradicate low risk backlog	£	0	477,542	1,848,516	57,347
Cost to eradicate Safety related Critical Infrastructure Risk	£	0	918,873	22,973,116	365,479
Cost to eradicate non-compliance related Critical Infrastructure Risk	£	0	405,791	12,384,499	149,550
Cost to eradicate continuity related Critical Infrastructure Risk	£	0	782,068	4,432,385	251,573

CHP	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
CHP units operated on the site	No.	0	0	1	1
CHP unit/s size	Watts	0	0	1,150,000	110,000
CHP unit/s efficiency	%	0	0	76	81
Fossil energy input to CHP system/s	kWh	0	0	30,794	1,692,898
Thermal energy output of CHP system/s	kWh	0	0	13,599	859,451
Electrical energy output of CHP system/s	kWh	0	0	9,854	514,641
Exported electricity	kWh	0	0	0	0
Exported thermal energy	kWh	0	0	0	0

Energy	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Energy costs (all energy supplies)	£	22,135	824,264	2,134,199	250,826
Electricity consumed	kWh	74,949	606,099	13,189,423	1,085,147
Gas consumed	kWh	212,821	218,165	3,591,807	5,256,448
Oil consumed	kWh	0	0	0	0
Coal consumed	kWh	0	0	0	0
Steam consumed	kWh	0	0	0	0
Hot water consumed	kWh	0	0	0	0
Electricity consumed - green energy tariff	kWh	0	0	0	0
Electricity consumed - third party owned renewable	kWh	0	0	0	0
Non-fossil fuel consumed - renewable	kWh	0	0	0	0
Electrical energy output of owned onsite renewables	kWh	0	0	0	0

Peak electrical load	MW	0.00	0.87	2.60	0.36
Maximum electrical load	MW	0.00	0.90	2.12	0.29

Water Services	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Water cost	£	6,280	129,656	208,607	29,076
Sewage cost	£	0	81,157	225,275	29,562
Water volume (including borehole)	m³	1,086	34,538	194,819	18,450

Waste	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Landfill disposal cost	£	0	12,362	30,563	3,926
Landfill disposal volume	Tonnes	0.00	63.00	257.00	24.47
Incineration disposal cost	£	1,621	11,911	42,843	1,902
Incineration disposal volume	Tonnes	1.00	21.25	83.00	4.00
Waste reycling cost	£	0	12,362	91,083	9,160
Waste reycling volume	Tonnes	0.00	209.50	772.00	56.86
Other recovery cost	£	988	49,742	296,776	15,934
Other recovery volume	Tonnes	5.40	175.42	700.00	23.36

Car Parking	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Parking spaces available	No.	0	766	1,165	338
Designated disabled parking spaces	No.	0	39	55	34
Average fee charged per hour for patient/visitor parking	£	0.00	1.37	1.37	1.37
Average fee charged per hour for staff parking	£	0.00	0.25	0.25	0.25
Is there a charge for disabled parking	Yes/No/None	No	No	No	No

Cleanliness	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Cleaning service cost	£	20,000	1,394,235	4,022,239	581,910
Cleaning staff	WTE	1.00	56.66	154.00	24.97
Routine cleaning method/s - Traditional wet-mopping (disposable)	Yes/No		Yes	Yes	Yes
Routine cleaning method/s - Traditional wet-mopping (reusable)	Yes/No		No	No	No
Routine cleaning method/s - Microfibre (disposable)	Yes/No		No	No	No
Routine cleaning method/s - Microfibre (reusable)	Yes/No		No	No	No
Routine cleaning method/s - Disposable wipes	Yes/No		No	No	No
Routine cleaning method/s - Other	Yes/No		No	No	No
Enhanced cleaning method/s - Steam Cleaning	Yes/No		Yes	Yes	Yes
Enhanced cleaning method/s - Hydrogen peroxide fogging	Yes/No		Yes	Yes	Yes
Enhanced cleaning method/s - UV Light	Yes/No		No	No	No
Enhanced cleaning method/s - Chlorine-releasing cleaner	Yes/No		No	No	No
Enhanced cleaning method/s - Sporicidal cleaner	Yes/No		Yes	Yes	Yes
Enhanced cleaning method/s - Other	Yes/No		No	No	No
Cleaning audit processes - Visual audits based on the National Specification for Cleanliness or Publically Available Specification	Yes/No		Yes	Yes	Yes

Cleaning audit processes - Visual audits based on an alternative Specification to the National Specification for Cleanliness or Publically Available Specification	Yes/No		No	No	No
Cleaning audit processes - ATP swab testing	Yes/No		No	No	No
Cleaning audit processes - UV light testing	Yes/No		No	No	No
Cleaning audit processes - Microbiological swab testing	Yes/No		No	No	No
Cleaning audit processes - Other	Yes/No		Yes	Yes	Yes
Cost of cleaning occupied floor area assessed as Red/Very High Risk	£		209,135	402,238	87,286
Occupied floor area assessed as Red/Very High Risk	%		15	10	15
Required standard for occupied floor area assessed as Red/Very High Risk	%		95	95	95
Achieved standard for occupied floor area identified as Red/Very High Risk	%		95	95	95
Cost of cleaning occupied floor area assessed as Amber/High and Significant Risk	£		975,964	2,815,567	378,241
Occupied floor area assessed as Amber/High and Significant Risk	%		50	70	65
Required standard for occupied floor area assessed as Amber/High and Significant Risk	%		92	92	92
Achieved standard for occupied floor area identified as Amber/High and Significant Risk	%		92	92	92
Cost of cleaning occupied floor area assessed as Green/Low Risk	£		209,136	804,447	116,382
Occupied floor area assessed as Green/Low Risk	%		35	20	20
Required standard for occupied floor area assessed as Green/Low Risk	%		75	75	75
Achieved standard for occupied floor area identified as Green/Low Risk	%		0	0	0
Cost of cleaning the occupied floor area not requiring regular cleaning	£		0	0	0
Occupied floor area not requiring regular cleaning	%		0	0	0

Inpatient Food Services	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Inpatient food service cost	£	0	963,020	2,209,490	263,332
Inpatient main meals requested	No.	0	227,579	664,664	69,485
Cost of feeding one inpatient per day (inpatient meal day)	£	0.00	11.09	9.40	11.83

Laundry & Linen	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Laundry and linen service cost	£	0	195,065	780,260	51,333
Pieces per annum	No.	0	828,388	2,415,123	228,980
Laundry and linen service used	Select	0. No Service	1. Full Service – Contracted	1. Full Service – Contracted	1. Full Service – Contracted

Portering Services	**Unit**	**AGGRE**	**RP5BA**	**RP5DR**	**RP5MM**
Portering service cost	£	0	435,480	2,312,103	121,918
Portering staff	WTE	0.00	18.62	70.00	5.00

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Review of Committees – update**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Matthew Kane, Trust Board Secretary**		

Purpose		Tick one as appropriate
	Decision	x
	Assurance	
	Information	

Executive summary containing key messages and issues

The purpose of the report is to amend a decision made at the meeting on 23 May in connection with the review of board committees.

Background

Corporate governance within foundation trusts is guided by English Law (namely, the NHS Act 2006 and Health and Social Care Act 2012) and NHSI's Code of Corporate Governance. The Code is best practice guidance and does not prescribe what governance systems and processes should look like or set rigid rules.

The provisions of the Code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not a breach of NHS Foundation Trust Condition 4 of the NHS Provider Licence. However, reasons for non-compliance should be explained to illustrate how actual practices are consistent with the principle to which the particular provision relates.

Issue

The Board wished to redesign its committee structure around the Single Oversight Framework and new strategic direction. In shaping the new structure the Board recognised the requirement for the new committees, occasionally, to make decisions as well as to obtain assurance. For example, the current ANCR being responsible for signing off the internal audit plan and approving this year's accounts.

This resulted in a proposal to include relevant executives as well as non-executive directors on

the committees and, in the case of ANCR, this was the Director of Finance. It was still intended that the committee be chaired by a NED with recent and relevant financial experience and include two other NEDs.

In production of the Board report, the Code was checked and there was no impediment to inclusion of executive directors within the membership of the Finance and Performance and Quality and Effectiveness Committees.

In respect of ANCR, the latest version of the Code states that while it considers that all members of the audit committee should be independent "the option to 'explain' non-compliance is available for trusts that have valid reasons." The reasons for non-compliance might be as mentioned above: (1) to align the ANCR's composition with the other Board committees and (2) to acknowledge the decision-making responsibilities that occasionally fall to be decided by the committee. It is worth pointing out that, at the end of each section of the Code, the relevant statutory provisions relating to the section are spelt out. In the audit committee section no relevant statutory provisions are cited.

The Board made a decision to approve the revised terms of reference for the three Board committees on 23 May and included within that was the intention to include the Executive Director for Finance within the membership of ANCR. However, upon subsequent review of the 2006 Act legislation it became clear that the provision relating to audit committees within public service corporations (of which an NHS foundation trust is one) is mandatory rather than discretionary.

Proposed Resolution

The Board may amend the general substance of a resolution passed in the last six months by a notice of motion containing the signatures of any five directors. In the meantime the original resolution will not have any actual effect as ANCR is not due to meet under the refreshed structure until 20 July.

Key questions posed by the report

N/A

How this report contributes to the delivery of the strategic objectives

The report is procedural and does not specifically relate to the strategic aims.

How this report impacts on current risks or highlights new risks

N/A

Recommendation(s) and next steps

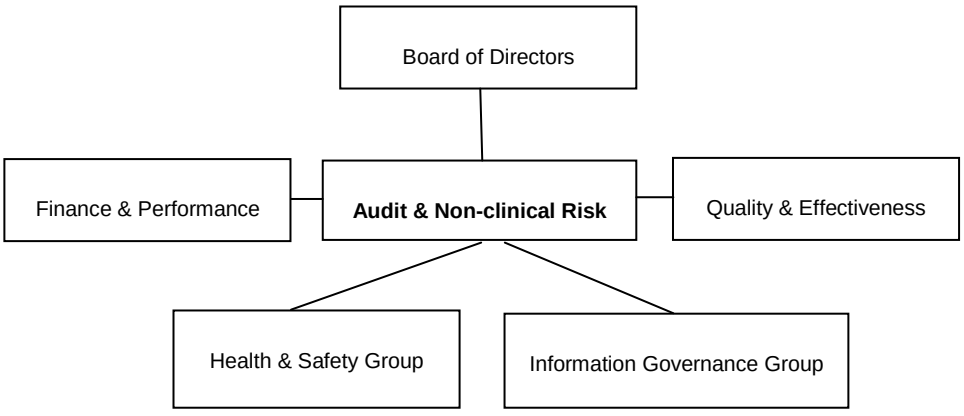
Board is asked to approve an amendment to resolution (2) from the item 'Review of Board Committees', substituting the words:

(2) Establish the new committee structure as set out in the attached report with the terms of reference attached as Appendix A, with effect from 1 June 2017.

With the words:

(2) Establish the new committee structure as set out in the report to the Board of Directors of 23 May 2017, including the terms of reference for F&P and QEC, but omitting the Director of Finance as a member of ANCR and replacing the terms of reference for ANCR with those hereby attached.

Audit and Non-clinical Risk Committee
Terms of Reference

Name	Audit and Non-clinical Risk Committee ("the committee")
Purpose	To provide the Board of Directors ("the Board") with a means of independent and objective review of internal controls and risk management arrangements relating to: • Financial systems • The financial information used by the Trust • Non clinical controls and assurance systems, including information to governors • Non clinical risk management arrangements • Compliance with law, guidance and codes of conduct • Counter fraud activity
Responsible to	Board of Directors. The Chair of the committee is responsible for reporting assurance to the Board on those assurance matters covered by these Terms of Reference. The minutes of the committee shall be submitted to the Board of Directors. The Chair of the committee will report to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board of Governors, or require executive action. The committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Delegated authority	The committee is a non-executive committee and holds no executive powers other than those specifically delegated in these Terms of Reference.  The committee is authorised to investigate any activity within its Terms of Reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the committee.

	The committee is authorised by the Board to secure legal or independent professional advice, or to request the attendance of external advisers with relevant experience and expertise if it considers this necessary.
Duties and work programme	1 <u>Integrated Governance, Risk Management and Control</u> 1.1 The committee shall review the effectiveness of the system of integrated governance, risk management and internal controls, to satisfy the Board that its approach to integrated governance remains effective. For the avoidance of doubt the committee will <u>not</u> review specific clinical governance, clinical risk management or clinical controls - this is the role of the Clinical Governance Oversight Committee. 1.2 Determine the actions, controls and audits/reviews required to provide non-executives and the Board with robust assurance regarding the reported financial position going forward; and to maintain the confidence of governors, regulators and the public. Undertake ongoing review of the implementation and effectiveness of these. 1.3 The committee will review the adequacy of: i. all non clinical risk and control related disclosure statements (in particular the Annual Governance Statement and Declarations of Compliance made to Monitor) together with any accompanying Head of Internal Audit statement, external audit opinions or other appropriate independent assurance, prior to endorsement by the Board; ii. the underlying assurance processes that include the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of related disclosure statements; iii. the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and iv. the policies and procedures for all work related to fraud and corruption (but shall not be responsible for the conduct of individual investigations); and v. The operating of, and proposed changes to, the Board of Directors standing orders, standing financial instructions, the constitution, codes of conduct, scheme of delegation and standards of business conduct. 1.4 In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurance from executive directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

2 Internal Audit

2.1 The committee shall monitor the effectiveness of the internal audit function established by management that meets mandatory *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the committee, Chief Executive and Board. This will be achieved by:

i. consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
ii. review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
iii. consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
iv. oversee the effective implementation of internal and external audit recommendations;
v. ensuring that the Internal Audit function is adequately resourced and have appropriate standing within the organisation; and
vi. annual review of the effectiveness of Internal Audit.

3 External Audit

3.1 The committee shall review the work and findings of the External Auditor appointed by the Board of Governors and consider the implications of and management's responses to their work. This will be achieved by:

i. consideration of the appointment and performance of the External Auditor in accordance with the Trust specification for an External Audit Service, informed by Monitor's Audit Code for NHS Foundation Trusts;

ii. discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan ensuring co-ordination, as appropriate, with other External Auditors in the local health economy;

iii. discussion with the External Auditors of their local evaluation of audit risk and assessment of the Trust and associated impact on the audit fee;

iv. review of all External Audit reports, including agreement of the annual audit letter, before submission to the Board and review of any work carried outside the annual audit plan, together with the appropriateness of management responses; and

v. review of the annual audit letter and the audit representation letter before consideration by the Board.

4 Other Assurance Functions

4.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider their implications to the governance of the organisation. These will include, but will not be limited to: any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Health and Safety etc.); professional bodies with responsibility for the performance of staff; or functions (e.g. accreditation bodies, etc.) relevant to the Terms of Reference of this committee.

4.2 In addition, the committee will review the work of the other committees within the organisation whose work can provide relevant assurance to the committee's own scope of work.

5 Management

5.1 The committee shall request and review reports and assurance from directors and managers on the overall arrangements for non clinical governance, risk management and internal control.

5.2 They may also request reports from individual functions from within the organisation as appropriate.

6 Financial Reporting

6.1 The committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
ii. changes in, and compliance with, accounting policies and practices;
iii. unadjusted mis-statements in the financial statements;
iv. major judgemental areas;
v. significant adjustments resulting from the audit;
vi. the clarity of disclosures; and
vii. the going concern assumption

6.2 The committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7 Other areas of work

7.1 Information Governance:- The committee shall receive reports and review assurance from directors and managers on the overall arrangement for compliance with Information Governance Standards.

7.2 Health and safety, fire and security:- The committee shall receive reports from relevant directors and officers, including the Local Security Management Specialist, on the arrangements for compliance with relevant health and safety, fire and security standards.

7.3 Counter fraud:- The committee shall receive quarterly reports from the Local Counter Fraud Specialist on counter fraud arrangements, cases, policies and plans.

7.4 Whistleblowing: responsibilities for ensuring that robust systems and processes are in place to raise concerns throughout the organisation.

8 Special Assignments

8.1 The committee shall commission and review the findings of any special assignments required by the Board.

9 Performance

9.1 The committee shall request and review reports and assurance from directors and managers on the overall arrangements for reporting compliance with:

i. the Trust's non clinical corporate objectives;
ii. Monitor's governance standards and declarations, including the review of areas of non-compliance in the context of Monitor's "comply or explain" philosophy; and
iii. key non clinical performance objectives.

10 Risk Register

10.1 The committee shall request and review reports and assurance from directors and managers on effects of arrangements to identify and monitor risk. The Board will retain the responsibility for routinely reviewing specific risks.

11 Workplan

11.1 The committee's annual workplan is an appendix to these Terms of Reference, and is subject to annual review by the committee.

Policy approval	The Committee has responsibility for approving the following policies: - Fraud, Bribery & Corruption Policy and Response Plan - Standards of Business Conduct and Employees Declarations of Interest Policy
Chair	A Non-executive Director, appointed by the Board of Directors.
Membership	Three non-executive directors. • One of the non-executives shall have recent and relevant financial experience. • Each non-executive shall normally not serve more than three years as a committee member, unless the requirement for one of the members to have recent and relevant financial experience is compromised.
In attendance	• Director of Finance • Deputy Director of Finance • Trust Board Secretary • Local Counter Fraud Specialist • Appropriate internal and external audit representatives • Security Management Specialist • Other trust staff as appropriate / requested The Chief Executive, executive directors or other officers will be required to attend at the request of the committee, for issues relevant to their areas of responsibilities. Two public governors, nominated by the Board of Governors, will be invited to attend the committee, as observers.
Secretary	Trust Board Secretary
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.
Quorum	Two members.
Attendance requirements	Committee members must attend at least 50% of meetings.
Frequency of meetings	No less than quarterly and more frequently as required. At least once per year, the Committee should meet with the external and internal auditors, without management being present, to discuss matters relating to its responsibilities and issues arising from the audit. The External Auditor and Head of Internal Audit may request a private meeting if they consider that one is necessary. They will also have direct access to the Chair of the committee.

Papers	Papers will be distributed a minimum of five clear working days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	Health and Safety Committee Information Governance Steering Group
Circulation of minutes and other reporting requirements	The Governor observers shall report to the Board of Governors on a quarterly basis regarding the work of the committee, any matters needing action or improvement and the corrective actions to be taken. The committee shall report to the Board of Governors and seek its approval regarding the appointment, reappointment, termination of appointment and fees of the External Auditors.

Date approved by the committee:	
Date approved by the Board of Directors:	
Review date:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Post Implementation Review Ophthalmology**		
Report to	**Board of Directors**	**Date**	**27.06.2017**
Author	**Nick Mawer, Ophthalmology Consultant** **Laura Freeman, Business Manager, Surgical care Group**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	X

Executive summary containing key messages and issues
The paper identifies the main objectives for the investment in the Fred and Ann Green Ophthalmology Unit and explores if these have been achieved. Main objectives To deliver contracted activity To reduce/eliminate additional sessions Redesign patient pathway by increasing specialist clinics Improve administration functions to support RTT/income delivery Build new department to increase capacity and provide quality service in an appropriate environment
Key questions posed by the report
Does the Ophthalmology Unit deliver the expected outcomes from the investment in the service?
How this report contributes to the delivery of the strategic objectives
By identifying that the outcomes have benefitted patients and the investment in the service has returned value.
How this report impacts on current risks or highlights new risks
The 2 main risks identified are the ability of the service to maintain National Performance Targets and the additional costs associated with medical staff agency.
Recommendation(s) and next steps
For the Board to be assured that the actions identified will improve the outcomes for compliance and patient outcomes.

Project Implementation Review

Title of Project:	Ophthalmology department new build
Project Lead:	Nick Mawer
Date of Completion:	13 June 2017
Evaluated by:	Laura Freeman, Business Manager

1. Background

The business case set out the investment needed within the Ophthalmology Department to enable the delivery of the Contracted activity in a safe and sustainable manner.

The Ophthalmology department had had a lack of investment over a number of years which had led to an under resourced clinical and administration.

The build enabled the department to deliver safe and appropriate care to patients attending for a wide range of outpatient appoints and treatments.

Main objectives

To deliver contracted activity

To reduce/eliminate additional sessions

Redesign patient pathway by increasing specialist clinics

Improve administration functions to support RTT/income delivery

Build new department to increase capacity and provide quality service in an appropriate environment

2. Assessment of Costs

Capital Costs

Initial Project Costs:	£1,358,183	**Actual Project Costs:**	£1,443,002

Variance: £84,819

Explanation of variation in costs:

There were issues at the beginning of the project with the windows in the old clinic environment which resulted in additional spend on the project. Estates would be able to give further explanation on the increased costs

Ophthalmology Income 2017/18

Ophthalmology contract income is £194k behind plan at the end of Month 2 2017/18. The service currently has 4 Consultant vacancies.

	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
130 - Ophthalmology	**9,603**	**9,229**	**-374**	**1,177,695**	**983,411**	**-194,284**
CPC	223	243	20	26,040	30,054	4,014
Daycase	524	391	-133	395,341	297,395	-97,946
Drugs	0	0	0	665	0	-665
Elective	6	0	-6	5,722	0	-5,722
Emergency	16	8	-8	16,563	11,591	-4,972
Outpatient CAP	0	0	0	0	-49,535	-49,535
Outpatient Procedures	2,097	2,235	138	203,695	216,687	12,992
Outpatients First	1,775	1,432	-343	255,772	206,288	-49,484
Outpatients Follow Up	4,961	4,918	-43	272,648	270,179	-2,470
Readmissions	1	1	0	1,248	1,113	-136
Readmissions - Income Adj.	0	0	0	0	-361	-361

3. Assessment of Deliverables

New department fit for purpose of seeing Ophthalmology patients

The new department was built in two phases, in phase one a new area was built creating new clinics rooms, in phase 2 the Ophthalmology department moved into the new area, whilst the old area was redesigned and in phase 3 the intravit rooms were upgraded.

The new area included the creation of a new main waiting area, separate from OPD1, and a further sub waiting areas within the department. A waiting area has also been created outside the department to accommodate the intrevit patients. There is also a dedicated paediatric waiting area, within the main waiting area. These new waiting areas have helped to reduce patient queues, which were a major concern and area of complaint, and have also helped with patient flow, allowing patients to flow through the department and decreasing blockages. The different waiting areas have provided an entry reception and a separate exit reception, which again has helped with patient flow.

The department now has

10 clinic rooms (previously 7)

7 Vision rooms (previously 4)

2 Dedicated paediatric rooms (previously 1)

2 laser rooms (previously 1)

2 Intravit rooms (previously 1)

Each room has been built to a bigger size allowing for patients with mobility problems and for wheelchairs and are each equipped with the right Ophthalmology equipment.

Main objectives

To deliver contracted activity

Although the department has had an increase in rooms the Ophthalmology Consultant team is not up to full establishment due to issues with recruitment. We have advertised for a number of roles and unfortunately due to a national shortage we have been unable to recruit into to the current vacancies.

To reduce/eliminate additional sessions

The increases in the number of rooms and layout of the department has enabled to department to bring some of the additional weekend work in to the week and as such decreased the additional costs of running weekend clinics.

Redesign patient pathway by increasing specialist clinics

We have been able to increase the number of specialist clinics as we now have the supporting staff and equipment to run them successfully. Patients now have a clear investigative pathway on arriving at the clinic which is smoother and more efficient, both in terms of visual testing and diagnostic procedures which are provided in the department. Access to vision rooms and photography imaging has greatly improved, enhancing the pre consultation patient experience.

Redesign of pathways during the rebuild process including AMD, Glaucoma and Emergency clinics has enhanced patient experience of the clinical environment and also provided dedicated specialist staff to support the delivery. This has included incorporating specialist nurse led / allied health professional clinics across these specialist services.

Improve administration functions to support RTT/income delivery

Increases in the admin team have impacted positively on the RTT position as now the validation of patient pathways is monitored on a daily basis. The increase in waiting areas has required the appointment of receptionists which has enable the timely out coming of all patient following clinic and has enabled patients to leave the department with a f/up appointment or pre-op as required. Timely out coming of patient clinics is also essential to ensure we receive the correct income. Booking in kiosk's are also rolling out across the Ophthalmology service, which will further compliment the provision of a dedicated Ophthalmology reception team at the entrance to the clinic.

Build new department to increase capacity and provide quality service in an appropriate environment

Overall the new department has been able to provide the capacity to reduce additional weekend sessions and increase the number of general and specialist clinics that are able to run. The patient experience has greatly improved with patients being able to comfortably wait in designated waiting

areas, without queues and be seen in a purpose built department that suits the needs of the patients it holds.

The additional rooms have also greatly help with the training of staff in new techniques. Again the layout and increase in rooms has greatly helped with patient flow and as such improved the patient experience and increased staff morale.

Also, are there any outstanding elements of the project and what action plan has been created to address these actions (please attach).

Due to national issues the Trust has struggled to recruit to the Consultant vacancies and although we have appointed to some vacancies, further vacancies have arisen from retirements.

The Ophthalmology team are looking at alternative ways to deliver the service including:

1. Further expansion of Nurse led / Allied Healthcare Professional facilitated services within macular pathway and emergency clinics, which release further Medical Staff time to dedicate to specialist complex pathway patients. Following networking with Ophthalmology Consultant Nurse at STH and Moorfields Eye Hospital, a Business Case has been developed to support recruitment of additional nursing / AHP workforce to support this. The initial advert will be aiming to recruit experienced and skilled Ophthalmology practitioners, in addition to the in house training being provided to our existing non-medical Ophthalmology practitioners.
2. Outsourcing to an alternative provider to increase activity & income

Was the project delivered on time?

Yes

4. Assessment of Benefits

Main benefits

Increase in specialist clinic rooms

Increase in Visions rooms

Better patient flow due to increase in waiting areas and sub waiting areas

Enhanced patient experience across pathway's

Conducive patient environment – both in clinical rooms and waiting areas.

Enhanced paediatric experience both in clinical room and waiting areas.

Increased staff morale

Reduction in additional weekend sessions

Reduction in the number of complaints about the environment

Workforce review providing role development from apprentice level through Bands 1 to 4.

Extended opportunities for career pathways for Nursing & AHP workforce.

5. Assessment of Risks

The risks of the project were

Being unable to recruit to positions – unfortunately Consultant recruitment has been difficult and continue to cause a problem for the department.

Reduction in additional expenditure – additional weekend sessions has reduced but due to the inability to recruit to Consultant posts some additional work has continued

Non- achievement of RTT – Due to inability to recruit the current team does not have capacity to undertake required activity which is impacting on RTT

Future Growth – There is still room for growth and development within the department which will be recognised with the recruitment of further Consultants

6. Assessment of duties

Weekly building meetings were held to manage the project involving dedicated staff from Estates, Procurement, Department Clinical lead, Lead nurse, IT, Communications and Project Manager. This worked well. It was also very helpful to have a dedicated clicnia lead as part of the project team to ensure clinical engagement form the beginning.

7. Skills Transfer

The increase in clinic rooms has allowed for increased training of all staff in dedicated clinic rooms, with the required equipment.

Development of apprentice scheme, trainee assistant practitioner and across the Bands 1 – 4 range, enabling effective utilisation of the right staff with the right skills at the right time. The medical, nursing and AHP teams have been very supportive in developing the range of new roles at Bands 1 to 4, providing practical and theoretical support to facilitate the skill mix change.

The next phase of skills transfer relates to development of the nurse led / ahp led macular services, which will build on existing skills and knowledge and be supported in house and by accessing support from the team at STH, who are sharing skills packages and can provide clinical supervision if required. We anticipate the development will be completed in house, however support from the STH Nurse Consultant will be accessed as required.

8. Assessment of Project Management Arrangements

There was change in Project management lead part way through the project which could have impacted on the project, but the team worked hard to solve any issues and as such the project was delivered on time and achieved the main objectives

9. Assessment of Economic/Commercial Impact

The new build has improved staff morale and the patient experience and as such the reputation of the department dramatically. The new department has improved patient flows and as such the experience they have in the department and as such has reduced the complaints associated with the department.

10. Conclusion and Recommendations

Conclusion

The project was a success as a new department has been created that is fit for purpose and provides a safe and calm environment for Ophthalmology patients with decreased waiting times and better patient flows. The project has increased the number of rooms in all areas allowing the department to grow and expand and to increase the number of patients that flow through the department increasing the ability to achieve the contracted activity. The staff within the department work within a better environment, with fewer complaints from patients and as such this has improved staff morale dramatically.

The clinic Sister, Lead AHP and matron are now progressing with development and roll out of twice yearly open events for service users and further development of service users forums.

Recommendations

1. That the care group continue to advertise for the replacement/new consultants and SAS posts
2. Continue to explore possibilities of working together with another partner on ophthalmology provision
3. That the Care Group proceed to recruitment for experienced Nursing / AHP practitioners to support the nurse led macular injection service.

Lessons Learnt	Action Required	Lead
Not to assume all aspects of plan delivered without detailed checks	Need to revisit original plan for waiting area set up as not complete	L Marshall/E foxon-wise
Involvement of admin staff in project as issue with notes /administration processes	Need to review current admin working practices	V redhall

Further Evaluation Dates

Further project evaluation dates arranged:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Strategy & Improvement Update**		
Report to	**Board of Directors**	**Date**	**27rd June 2017**
Author	**Marie Purdue, Acting Director of Strategy & Improvement**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		

Executive summary containing key messages and issues
This paper seeks to provide:- a) Progress on 17/18 Efficiency & Effectiveness workstreams - paragraph 2 b) Update on development of new schemes in year – paragraph 3 c) Strategic Direction Update – paragraph 4 d) Quality Improvement & Innovation – paragraph 5
Key questions posed by the report
Is progress with the efficiency and effectiveness workstreams sufficient to address the efficiency requirement in the financial plan? Does the approach taken to developing the Strategic Direction and Quality Improvement & Innovation Strategy assure Board that we will comply with best practice and our undertakings to NHSI?
How this report contributes to the delivery of the strategic objectives
Reduce and control the cost of healthcare – this report identifies progress to date on efficiency and effectiveness workstreams
How this report impacts on current risks or highlights new risks
The main risk of not progressing existing workstreams and identifying new projects is that we will not have a credible and supported plan to deliver the savings necessary to reduce the financial deficit of the Trust. As a subset of this our key stakeholders and partners may lose faith in our ability to manage our own response to this issue and will take more direct ownership and control.
Recommendation(s) and next steps
The committee is asked to **note** the information contained within this report.

1 Introduction

1.1. This paper seeks to provide:

a) Progress on 17/18 Efficiency & Effectiveness workstreams - paragraph 2
b) Update on development of new schemes in year – paragraph 3
c) Strategic Planning Process – paragraph 4

2 Progress on 17/18 Efficiency & Effectiveness workstreams - Month 2 and cumulative delivery to year end

2.1 Month 2 – May 2017 *Annex 1*

- The planned delivery for the Improvement Programme for FY17/18 is £14.5m, with a reported actual delivery at M2 of £435k against a forecast delivery of £985k (see Annexe 1)
- Mirroring some of the issues identified last month, this is behind plan by £550k mainly as a result of underperformance in the procurement, clinical administration & outpatients and local work streams and a lower than anticipated level of budget slippage (previously grip & control).
    - The procurement performance is linked to locum agency costs and has been impacted by changes to IR35. There have also been changes to the original phasing of the plan and it is anticipated that much of this will recover in year with the inclusion of new schemes.
    - An improvement in income had been assumed as a result of the work undertaken around Standard Operating Procedures for clinic change and procedure coding. It has proved difficult to tease out actual and overall the income position does not show any signs of improvement. Further benchmarking and deep dives into areas where this opportunity should be greatest are planned in July.
    - The local workstream contains efficiency plans identified as “in the pipeline” but these are not yet implemented – the PMO are actively following these up.
    - The actions to address the level of budget slippage are contained within the Finance Report.
- Given the changes to the procurement projections in light of the locum contract the workstream has been escalated to the Finance & Performance Committee with a focus on how additional schemes might be used to bridge the gap
- A medical productivity workstream update has also been requested by the Finance & performance Committee at the June meeting.

2.2 Governance and Accountability

- Workstream presentations to the Finance & performance Committee on progress, issues and risks have been timetabled based on perceived level of risk. Given the need for potential escalation of issues, slots have been retained to allocate on an as required basis.
- A standard template for presentation has been shared with SROs and workstream leads

3 Update on development of new schemes in year

3.1 Ideas Generation

- Care Group and corporate department meetings have taken place with the PMO and Finance to sign off implementation of identified schemes and discuss any new ideas. Any new ideas generated have been added to the pipeline and are being scoped to determine feasibility.
- As part of the strategic direction development, postcards and electronic surveys have been circulated to engage with a wider range of staff to gather improvement ideas. Feedback has been asked on:

    - Bright Ideas: ideas about how we can work better together, improve patient care, simplify processes and become more efficient
    - Bug Bears: top 3 bugbears which, if fixed, would make staff's working day better and improve patient care

3.2 Reducing the gap

- In May £8.252m of the £14.5m target remained unidentified, although there was an expectation that there will be £2.5m of non-recurrent grip and control savings. Further benchmarking and analysis has been undertaken with the Executive team to hypothesise further potential efficiency savings and this will be presented at this Finance & Performance meeting. Initial work suggests the following opportunities.

	TARGET	PID Forecast (Mth 2)		PIPELINE Opportunities		TOTAL	
Workstream / SRO	**2017/18 £000**	**2017/18 £000**	**Recurrent £000**	**2017/18 £000**	**Recurrent £000**	**2017/18 £000**	**Recurrent £000**
Theatres	500	500	1,000	69	92	569	1,092
Medical Productivity	461	261	823	558	400	819	1,223
Non Medical Productivity	68	51	68	313	257	364	325
Management & Corporate Services Review	727	994	1,067	232	320	1,226	1,387
Clinical Service Pathways	873	873	1,310	441	882	1,314	2,192
Procurement	1,858	1,422	1,573	80	80	1,502	1,653
Clinical Admin & Outpatients	790	750	1,095	0	0	750	1,095
Infrastructure	396	261	790	150	300	411	1,090
Commercial	0	300	375	200	360	500	735
LOCAL - Care Group GM's / Corporate Managers	575	287	306	96	150	383	456
Unidentified	5,752	0	0	0	0	0	0
SUB TOTAL	**12,000**	**5,699**	**8,407**	**2,139**	**2,841**	**7,838**	**11,248**
Target						**14,500**	**14,500**
GAP						**-6,662**	**-3,252**
Run Rate Efficiencies	2,500	2,292	0	0	0	2,292	0
TOTAL	**14,500**	**7,991**	**8,407**	**2,139**	**2,841**	**10,130**	**11,248**
Target						**14,500**	**14,500**
GAP						**-4,370**	**-3,252**
Sensitivity GAP Analysis	**10% Over Achievement**					**-3933**	**-2927**
Sensitivity GAP Analysis	**10% Under Achievement**					**-4807**	**-3577**

- This will be finalised following the Finance & Performance meeting with more detailed plans being presented at the July Finance & Performance and Board meetings.
- Delivery of this target will be a challenge and will take continued focus and commitment.

4 Strategic Planning Process

4.1 Engagement on the draft strategic vision continues with electronic surveys, postcards and attendances at meetings within and outside the Trust.

4.2 Work on enabling strategies continues to enable further development of a three year plan to support the vision. Timescales for completion have been agreed with the various stakeholders.

4.3 The recent Management Board focussed on the Clinical Services Strategy with input from all care groups and corporate departments, testing the strategic objectives and developing more detailed implementation plans.

4.4 The final is on track to be completed by July 2017 as agreed with NHSI. The draft will be shared at a Board timeout in June with circulation of a final prior to Board agreement for submission at the July meeting.

5 Quality Improvement & Innovation

5.1 Work is continuing on the development of the Quality Improvement & Innovation (Qii) strategy and its associated action plan, with organisational wide actions identified for the next 3 years which will be led by Strategy & Improvement and the Qii team.

5.2 Engagement with all Care Groups and Corporate teams is almost complete which is identifying key priority areas for Qii focus for 2017/18, as well as identifying high impact Qii workstreams to support the efficiency and effectiveness work. This will ensure Qii principles are embedded into all transformation work going forward. In addition, as part of the engagement on the new Trust strategy, we have been asking staff for their ideas which will then be used to prioritise with staff a small number of ideas to start with using an engaging Qii approach to take forward and action these.

5.3 A new role of Lead Consultant Qii has been developed and is currently being recruited to, which will be the lead medical champion for Qii across the organisation working for 2 PAs per week, initially for a 12 month period to support the implementation of the Qii Strategy. This post will be a key Qii champion with an instrumental role in engaging with medical colleagues on Qii to develop a culture of continuous improvement that achieves sustained change for the benefit of patients.

5.4 Arrangements are being made to share and discuss the draft Qii strategy with Board to shape its detail. Regular updates will be provided to Board and relevant sub-committees on implementation and outcomes on an on-going basis.

5.5 The strategy is on track to be completed by July 2017 as agreed with NHSI. The draft will be shared at a Board timeout in June with circulation of a final prior to Board agreement for submission at the July meeting.

6 Summary

6.1 Identification of the required amount of effectiveness and efficiency saving for 17/18 continues to present a significant challenge but work continues and will be shared at this meeting.

Efficiency & Effectiveness Programme Forecast 2017/18 – M2 position

		Plan 2017/18 £'000	Plan in Month £'000	Actual in Month £'000	Variance to Plan in Month £'000	Plan YTD £'000	Actual YTD £'000	Variance to Plan YTD £'000	Forecast 2017/18 £'000	Forecast Recurrent £'000	Financial RAG YTD	Milestone RAG YTD
Efficiency & Effectiveness Plans												
1	Theatres	500	0	0	0	0	0	0	500	1,000	3	3
2	Medical Productivity & Agency Reduction	461	0	5	5	0	8	8	261	823	3	1
3	Non-Medical Productivity	68	6	0	-6	11	0	-11	51	68	1	3
4	Administration & Outpatients	790	16	0	-16	24	0	-24	750	1,095	1	1
5	Management & Corporate Review	727	59	76	17	118	153	35	994	1,067	4	2
6	Clinical Pathways	873	0	0	0	0	0	0	873	1,310	3	3
7	Procurement	1,858	154	20	-134	308	33	-275	1,422	1,573	1	2
8	Infrastructure	396	6	0	-6	12	0	-12	261	790	1	2
9	Local	575	48	17	-31	96	33	-63	288	306	1	n/a
10	Commercial	0	0	0	0	0	0	0	300	375	3	3
11	Unidentified	5,752	0	0	0	0	0	0	0	0	1	n/a
11	Unidentified - Slippage	2,500	208	0	-208	417	208	-209	2,292	0	1	n/a
		14,500	496	118	-378	985	435	-550	7,991	8,407	1	2

Financial RAG

1	Red Risk, over -10% behind plan
2	Caution/Amber, 0 to -10% behind plan
3	Good, 0 to +10% ahead of plan
4	Excellent, over +10% ahead of plan

Milestone RAG

1	Red Risk, over -10% behind plan
2	Caution/Amber, 0 to -10% behind plan
3	Good, 0 to +10% ahead of plan

Position at Month 2 – June 2017

The planned delivery for the Improvement Programme for FY17/18 is £14.5m, (including 2.5m of slippage).
Scoping of additional opportunities is still underway

Actual delivery in M2 was £435, behind plan in month by £550k
YTD Forecast £7.991m

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – May 2017**		
Report to:	**Board of Directors**	Date:	**27th June 2017**
Author:	**Jon Sargeant - Director of Finance**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

To update the Board on the financial position for the month of May 2017.

Recommendation(s)

The Board is asked to NOTE that the reported financial position is a deficit of £6.5m, which is £346k behind the year to date plan.

Delivering the Values – We Care

- Not applicable

Related Strategic Objectives

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Focus on innovation for improvement
- Develop responsibly, delivering the right services with the right staff

Analysis of risks

- Due to the deficit the Trust is in breach of its license with Monitor

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P2 May 2017

27th June 2017

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE SCORECARD MAY 2017

1. Income and Expenditure vs. Forecast

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000		YTD Performance Actual £'000	YTD Performance Variance £'000		Annual Plan £'000	Forecast £'000
I&E Perf Exc Impairments	2,569	385	A	6,469	346	A	16,489	16,489
Income	(31,603)	(1,182)	F	(59,882)	(974)	F	(361,214)	(361,214)
STF Incentive	(577)	0	F	(1,154)	0	F	(11,547)	(11,547)
Expenditure	33,672	1,521	A	65,349	1,220	A	376,414	376,414
Pay	22,144	980	A	43,279	1,392	A	251,339	251,339
Non Pay	11,527	541	A	22,070	(172)	F	125,075	125,075

F = Favourable A = Adverse

Financial Sustainability Risk Rating	Plan	Actual
UOR	4	3
CoSRR	1	2

2. CIPs

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000		YTD Performance Actual £'000	YTD Performance Variance £'000		Annual Plan £'000	Forecast £'000
Employee Expenses	92	(252)	A	389	(291)	A	11,675	
Drugs	0	0	F	0	0	A	65	
Clinical Supplies	11	(76)	A	17	(159)	A	1,156	
Non Clinical Supplies	0	0	A	0	0	A	10	
Non Pay Operating Expenses	15	(19)	A	29	(39)	A	1,224	
Income	0	(31)	A	0	(62)	A	369	
Total	**118**	**(379)**	**A**	**435**	**(550)**	**A**	**14,500**	

3. Statement of Financial Position

All figures £m	Opening Balance 01.04.17	Current Balance 30.04.17	Movement in year
Non Current Assets	**196,907**	**195,756**	**(1,151)**
Current Assets	33,612	69,359	35,747
Current Liabilities	(31,967)	(76,724)	(44,757)
Non Current liabilities	(79,348)	(75,655)	3,693
Total Assets Employed	**119,204**	**112,736**	**(6,468)**
Total Tax Payers Equity	**119,204**	**112,736**	**(6,468)**

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000	Forecast £'000
Cash Balance	1,900	6,184	1,900	6,184	1,900	1,900
Capital Expenditure	412	316	412	316	6,481	6,481

5. Workforce

	Funded WTE	Actual WTE		Bank WTE	Agency WTE		Total in Post WTE	Under / (over)
Current Month	6,049	5,333		137	124		5,595	454
Previous Month	6,049	5,301		194	60		5,555	494
Movement	0	(32)	0	57	(64)	0	(40)	(40)

1. Context/Background

The month 2 position for 2017/18 is a deficit of £6,469k, which is £346k behind the planned deficit of £6,124k. Income levels have recovered significantly from the low levels seen in month 1, but high medical staffing spend in a number of specialities, along with lower than planned delivery of planned CIP savings have meant that the Trust has not achieved it's financial plan in May.

2. Executive Summary

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Income	-30,998	-32,180	-1,182	-60,061	-61,036	-974	-61,307	-61,419	-111	-372,761	-372,761
2. Costs	32,151	33,672	1,521	64,129	65,349	1,220	64,360	63,970	-390	376,414	376,414
3.Capital Charges	1,031	1,077	47	2,056	2,156	100	2,340	2,312	-28	12,836	12,836
Total Position Before Impairments	**2,184**	**2,569**	**385**	**6,124**	**6,469**	**346**	**5,392**	**4,863**	**-529**	**16,489**	**16,489**
4.Impairments	0	0	0	0	0	0	0	0	0	0	0
Total Position After Impairments	**2,184**	**2,569**	**385**	**6,124**	**6,469**	**346**	**5,392**	**4,863**	**-529**	**16,489**	**16,489**

I&E position	In Month Plan	In Month Actual	In Month Variance	2017/18 Plan
Position before STF	2,761	3,146	385	28,036
STF funding	-577	-577	0	-11,547
Reported position	2,184	2,569	385	16,489

During May, income has been £1,181k better than expected, largely driven by an over-performance on Non PbR Drugs, Maternity tariff and some improvements in casemix following the completion of month 1 coding. During May, Care Group expenditure was £2.2m higher than budgeted levels. Within this figure is an overspend of £380k relating to non PBR drugs, £931k of overspend on pay budgets (£596k of which can be offset by agency premium funding held in reserves) and £379k of unachieved CIP savings.

The cumulative income position at the end of Month 2 is £974k favourable.

	Monthly Position			Cumulative Position			Annual Plan
Income Group	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	
Patient Income from CCGs	-25,644	-26,433	-789	-49,300	-49,980	-680	-302,252
Drugs	-1,745	-2,111	-366	-3,543	-3,992	-449	-22,574
STF	-577	-577	0	-1,154	-1,154	0	-11,547
Trading Income	-3,032	-3,059	-26	-6,064	-5,910	155	-36,387
Grand Total	**-30,998**	**-32,180**	**-1,181**	**-60,061**	**-61,036**	**-974**	**-372,761**

The expenditure position in May was £1,521k worse than budgeted levels.

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Pay	21,165	22,144	980	41,886	43,279	1,392	42,515	41,956	-558	251,339	251,339
2. Non-Pay	9,806	11,130	1,324	19,580	20,899	1,319	19,481	19,979	498	110,931	110,931
3. Reserves	1,180	397	-783	2,663	1,171	-1,491	2,365	2,085	-280	14,144	14,144
Total Expenditure Position	**32,151**	**33,672**	**1,521**	**64,129**	**65,349**	**1,220**	**64,360**	**64,020**	**-341**	**376,414**	**376,414**

3. Conclusion

High Medical Agency spend and unachieved CIP savings compared to plan have led to a deficit £346k bigger than plan, despite income levels being significantly higher than plan in Month 2.

4. Structure Update

The new structure for Management Accounts has now been finalised and agreed with HR, Staff Side representatives and Executive Directors. The structure was shared with the team on the 19th June and the process of staffing slotting in or expressing preferences for roles will now begin.

5. Additional 2016/17 Income

On the 15th June 2017 the Trust received notification that NHS Improvement have changed the Trust's final audited accounts for 2016/17 to include an additional £419k of STF funding. We are asked to adjust for this value in our 2017/18 accounts as an immaterial prior year amount. This gives a total STF fund for 2016/17 of £22,743k.

6. Recommendations

The Board is asked to note the month 2 2017/18 financial position of £6.5million deficit, £346k behind plan. The Finance and Performance Committee has tasked the Executive to produce a recovery plan for the CIP programme to bring the financial performance into line with the agreed plan.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

Performance - May 2017 - (Month 2)

Sewa Singh	Medical Director
Moira Hardy	Interim Director of Nursing
David Purdue	Chief Operating Officer
Jon Sargeant	Director Of Finance
Karen Barnard	Director of People and Organisational Development

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Business Intelligence Report**		
Report to:	**Board of Directors**	Date:	**27/06/2017**
Author	**Karen Barnard, Director of People and OD** **Moira Hardy, Director of Nursing, Midwifery and Quality** **David Purdue, Chief Operating Officer** **Sewa Singh, Medical Director**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The Business intelligence report highlights the key performance and quality targets required by the Trust to maintain Monitor compliance.
The report focuses on the 4 main performance area for Monitor Compliance
- Cancer, measured on average quarterly performance
- 4hr Access, measured on average quarterly performance
- 18 weeks including Diagnostic waits, measured quarterly but on monthly performance against active waiters, performance measured on the worst performing month in the quarter
- Infection control against CDiff annual trajectory

The quality report focuses on the key indicators of mortality and gives specific focus into best practice tariffs, complaints and serious incidents.

The report is triangulated against staffing levels for the Trust with a focus on sickness/ absence and staff turnover.

The report reviews the actions being taken to address for all performance and quality indicators.

Recommendation

To note

Delivering the Values - We Care (how the values are exemplified by the work in this paper)

We always put the patient first
- *By ensuring the correct capacity and pathways are in place to allow for treatment in the right place, first time. To ensure quality care is at the centre of all we do to provide the most efficient service.*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity
- *By ensuring that all parties have contributed to the planning and delivery of services*

Committed to quality and continuously improving patient experience
- *By delivering new ways of working across health and social care to ensure compliance with all quality indicators*

Always caring and compassionate
- *By ensuring staff are committed to working with partners to improve services.*

Responsible and accountable for our actions – taking pride in our work
- *By being accountable for delivery of the efficient and effective services*

Encouraging and valuing our diverse staff and rewarding ability and innovation
- *Engaging with staff to encourage their ideas and working with them to change practice*

Related Strategic Objectives

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Focus on innovation for improvement
- Develop responsibly, delivering the right services with the right staff

Analysis of Risk

- Resource – Key financial issues related to additional funding streams to support planning for surge capacity.
- Governance – The Trust needs to maintain compliance framework with monitor
- Equality and Diversity – No known issues or risks.
- PR and Communications – Need for continued appropriate communication to ensure ongoing performance
- Patient, Public and Member Involvement – Public attendance at System Resilience Groups
- Risk Assessment – The risks to the Trust's performance are very high 2016/17, at this stage especially in relation to 4hr access
- NHS Constitution - Rights and Pledges – No known issues or risks.

Board Assurance Framework

1	Failure to achieve performance and compliance targets and processes	4 X 3 = 12
2	Failure to match capacity with demand, particularly during winter	4 X 4 = 16
3	Failure to maintain appropriate organisational corporate governance systems	5 X 4 = 20

Executive summary - Performance - May 2017

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The performance report is against operational delivery in March , April and May 2017

Provide the safest, most effective care possible
Monitor governance compliance is rated against 3 National targets, 4hr Access, Referral to Treatment, which includes diagnostic waits and Cancer Targets. The targets are all monitored quarterly, both 4hr access and cancer are averaged over the quarter but referral to treatment is monitored each month of the quarter and must be achieved each month.
The business intelligence report also highlights key National and local targets which ensure care is being provided effectively and safely by the Trust.

4hr Access
The target is based on the number of patients who are treated within 4hrs of arrival into the emergency department and set at 95% and reported quarterly as an average figure. This target is for all urgent care provided by the Trust for any patient who walks in. We have 2 type 1 facilities, ED at BDGH and DRI and 1 type 3 facility at MMH.

May Performance

Trust 91.39%, Including GP attendances 92.49%, total 14391 pts, 1175 more than April
The Trust has now received additional National monies to improve front door streaming services for both DRI and BDGH

The Trust maintained the planned trajectory for quarter 1; Key bed pressures were seen at DRI after the May Day bank holiday , a system wide response was initiated which allowed flow to be maintained . A proactive plan was put in place to support the DRI site for the spring Bank holiday but flow through the system worked effectively. Medical workforce gaps remained the predominant cause of breaches.

Doncaster achieved **88.92**%. Total attendances 10426

1042 patients failed to be treated within 4hrs, 83 more than April.
720 patients were delayed due to internal ED waits, 83 more than April. 104 were delayed due to bed waits, 34 more than April, 157 required to wait in the department due to their condition.
12.3% of patients were transferred to the urgent care centre.

Bassetlaw achieved **95.06**%. Total attendances 3965

196 patients failed to be treated within 4hrs, 118 less than April
125 patients were delayed due to internal ED waits, 124 less than April. 14 were delayed due to bed waits, 4 less than April and 25 patients were required to wait in the department due to their condition.

The Urgent Care Network, are reviewing the actions for 4hr access across the STP footprint with each stakeholder leading on system wide improvement
System wide perfect week planned for the 5th of September being supported by ECIP.

Referral to Treatment

The target is now measured against incomplete pathways only at 92**%.**

May 90.6%

The focus of the data quality team is now on education within care groups to ensure the access policy is adhered to.
There are 5 specialities not compliant in May compared to 8 in April
The key specialities which are adversely affecting the Trust position are all within the Surgical Care Group and enhanced performance monitoring is being undertaken

Diagnostic performance 98.5%

Key issue again relates to audiology capacity, locums are now in place but performance in this area is the only 1 of the 13 diagnostic tests not achieving the 99% target. Medical imaging achieved 99.3%

Cancer Performance

April 62 day performance 82.6%

April 2 week wait 86.7%

A detailed action plan is in place with the CCGs to address the performance shortfall against the 2 week wait target.

A 10 high impact intervention plan has been completed nationally to address the national performance shortfall against 62 day target. This plan is complete and the Trust is compliant with all elements of the plan.

Stroke Performance

There was an unusually high number of discharges in the month (64) compared to a monthly average for the year of 48; only 3 patients were outside of NHS Doncaster and NHS Bassetlaw.
There were significant pathway issues, with the usual Bassetlaw to DRI transfers but also patients being delayed in A&E and late referrals from other receiving wards. There were bed delays as some of this cohort of patients were admitted in months where the Trust was under pressure for beds. There was an increase in the number of 0-1 hour admissions compared to February but also some long delays in the>10 hours band., where the patients symptoms were not suggestive of a stroke. All patients who do not meet the direct access in 4hrs are all reviewed by the service.

SNAPP results remain the best in South Yorkshire for patient outcomes.

David Purdue Chief Operating Officer June 2017

At a Glance -May 2017 (Month 2)

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
4-5	Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.0%	M	Apr-17	100.0%	
		31 day wait for second or subsequent treatment: anti cancer drug treatments	98.0%	M		100.0%	
		31 day wait for second or subsequent treatment: radiotherapy	94.0%	M		100.0%	
		62 day wait for first treatment from urgent GP referral to treatment	85.0%	M		82.6%	
		62 day wait for first treatment from consultant screening service referral	90.0%	M		100.0%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		98.6%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		86.7%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		90.1%	
6-7		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	May-17	91..4%	
8-9		Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	May-17	90.6%	
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		98.5%	
6-7	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	May-17	05:20	
		A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		07:57	
		A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		04:00	
		A&E: Time to treatment decision (median) HH:MM	01:00	N		00:54:00	
		A&E unplanned re-attendance rate %	5.0%	N		0.3%	
		A&E: Left without being seen %	5.0%	N		3.0%	
		Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		N	Apr-17	654	
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes		N		69	
		Ambulance Handovers Breaches -Number waited over 60 Minutes		N		21	
10-12	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	N	Mar-17	43.8%	
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	N		53.1%	
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	90.0%	N		100.0%	
		Proportion of applicable patients receiving a joint health and social care plan on discharge (Trust)	90.0%	N		85.2%	
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N		71.9%	
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N		80.7%	
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	N	May-17	57.6%	
13	Theatres & Outpatients	Cancelled Operations	0.8%	N	May-17	1.1%	
		Cancelled Operations-28 Day Standard	0	N		1	
		Out Patients: DNA Rate		L		9.3%	
		Out Patients: Hospital Cancellation Rate		L		5.1%	
				L			
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		L	Mar-17	6.2%	

Page		Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
17	Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	May-17	54.0%	41.2%	81.3%	
		Best Practice Criteria					
		36 hours to surgery Performance		64.0%	52.9%	87.5%	
		72 hours to geriatrician assessment Performance		86.0%	85.3%	87.5%	
		% of patients who underwent a falls assessment		100.0%	100.0%	100.0%	
		% of patients receiving a bone protection medication assessment		100.0%	100.0%	100.0%	
		Mortality-Deaths within 30 days of procedure		2.00%	0.00%	6.25%	

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
19	Safe	Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	May-17	2	
		Infection Control MRSA	0	L		0	
16		HSMR (rolling 12 Months)	100	N	Mar-17	92.63	
		Never Events	0	L	May-17	0	
		VTE	95.0%	N	Apr-17	95.0%	
19		Pressure Ulcers	12 Per Month 144 full Year	L	May-17	6	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		0	
		Catheter UTI	Snap shot audit			1.12%	

Page		Indicator	Current Month	Month Actual	Data Quality RAG Rating
20	Complaints & Claims	Complaints received (12 Month Rolling)	May-17	Data not availiable	
		Concerns Received (12 Month Rolling)		Data not availiable	
		Complaints Performance		39.0%	
		Clinical Negligence Scheme for Trusts (CNST)		Data not availiable	
		Liabilities to Third Parties Scheme (LTPS)		Data not availiable	
		Claims per 1000 occupied bed days		Data not availiable	

Page		Indicator	Current Month	Month Actual	YTD (Cumulative)	Data Quality RAG Rating
23	Workforce	Sickness	May-17	3.3%	3.6%	
24		Appraisals			58.5%	
25		SET Training			68.4%	

Monitor Compliance Framework: Cancer - April 2017 (Month 1)

Context

Cancer targets are reported quarterly as an average position. Guidance for 62 day pathways has been published which clarifies internal transfer as day 38 for classic 62 day pathways. Performance measures are reported a month behind due to validation and National uploads.

Reasons for Success/Failure

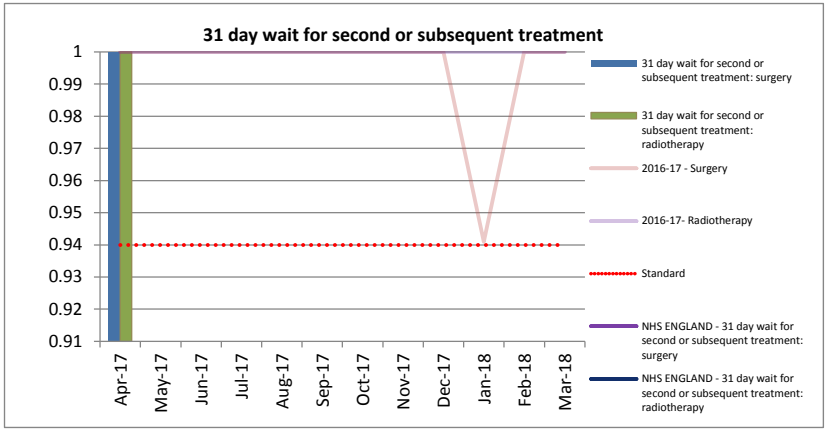
2 week wait failed to achieve the target for both CCGs as a consequence, of reduced capacity in urology and dermatology, main cause of breach remains patient choice. Action plan being shared with CCGs
62 day classic performance achieved at 82.6% mainly due to capacity issues within the urology service.

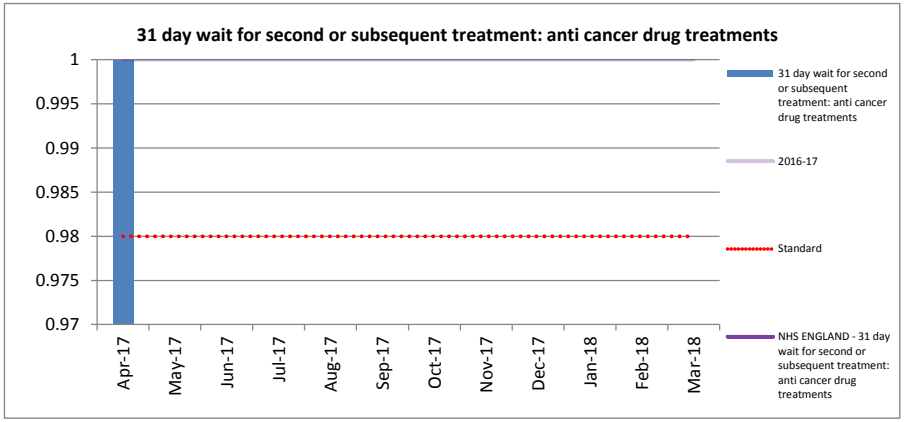
Actions being taken to address any issues

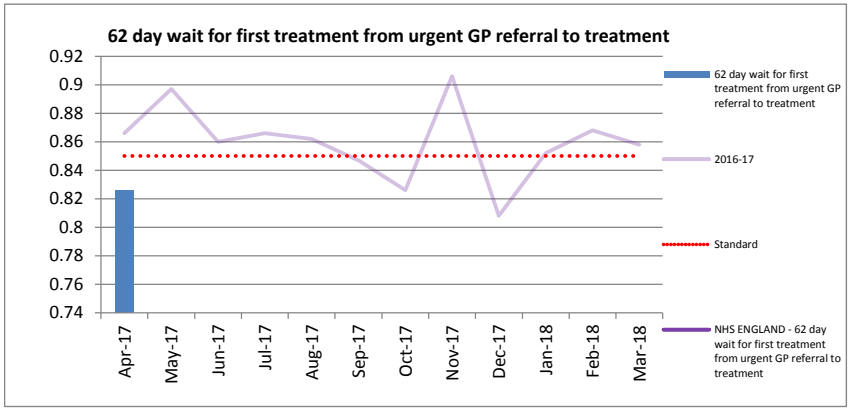
The Trust reports weekly at the PTL all 62 day target performance
Electronic system flags delays within the cancer team to raise at key timing points in patient pathways
Individual breach reports are discussed with the MDTs to ensure learning is in place
10 high impact intervention action plan completed
Improved access to diagnostics, KPIs set against a 7 day turnaround plan, new processes for flagging 62 day pathways being launched in Q1 2017/18
Changes to referral systems being reviewed in line with E referral pathways which need to be embedded by April 2018
Process mapping carried out on two week wait administration pathways. Key areas of work continue around capacity on sites.
Central 2 week wait team to be relocated with the boking team to improve communication.

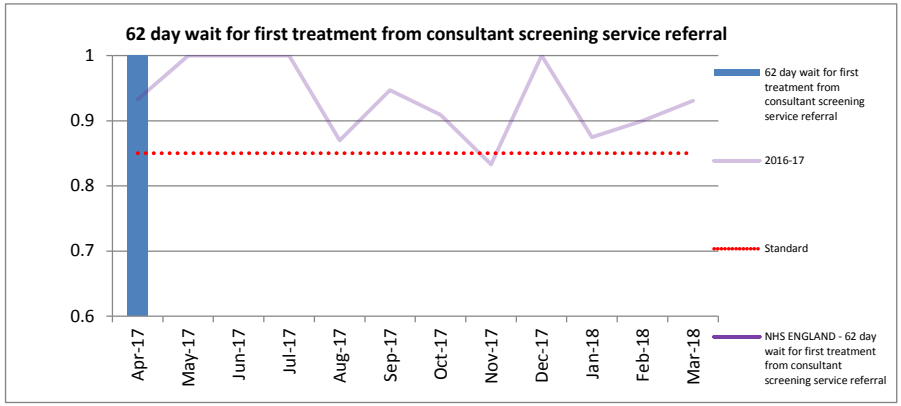
Indicator		Standard	Apr-16	QTR 4 2016-17	Feb-17	Mar-17	Apr-17
31 day wait for second or subsequent treatment: surgery		94.0%	100.0%	97.7%	100.0%	100.0%	100.0%
31 day wait for second or subsequent treatment: anti cancer drug treatments		98.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day wait for second or subsequent treatment: radiotherapy		94.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 day wait for first treatment from urgent GP referral to treatment	Tumour Type	85.0%					
	Breast		100.0%	100.0%	100.0%	100.0%	100.0%
	Gynaecological		100.0%	85.3%	81.8%	37.5%	100.0%
	Haematological		100.0%	85.4%	100.0%	80.0%	100.0%
	Head & Neck		33.3%	53.7%	77.8%		0.0%
	Lower Gastrointestinal		60.0%	75.5%	90.9%	90.9%	94.4%
	Lung		87.5%	73.8%	100.0%	87.5%	100.0%
	Other		100.0%	95.2%	100.0%		100.0%
	Sarcoma			66.7%	100.0%	0.0%	100.0%
	Skin		90.9%	97.4%	100.0%	96.4%	90.5%
	Upper Gastrointestinal		100.0%	87.6%	85.7%	80.0%	100.0%
	Urological		76.3%	74.2%	65.5%	82.8%	52.9%
	All Cancers		86.6%	85.5%	86.8%	85.8%	82.6%
62 day wait for first treatment from consultant screening service referral	Tumour Type	90.0%					
	Breast		100.0%	98.6%	90.0%	100.0%	100.0%
	Gynaecological			88.9%		100.0%	
	Haematological			100.0%		100.0%	
	Head & Neck						
	Lower Gastrointestinal		50.0%	68.2%		0.0%	100.0%
	Lung						
	Other						
	Sarcoma						
	Skin						
	Upper Gastrointestinal						
	Urological						
	All Cancers		93.3%	94.3%	90.0%	93.1%	100.0%
31 day wait for diagnosis to first treatment- all cancers		96.0%	99.3%	99.3%	100.0%	98.7%	98.6%
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)		93.0%	93.1%	89.0%	86.5%	88.5%	86.7%
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)		93.0%	93.4%	93.3%	93.8%	93.1%	90.1%

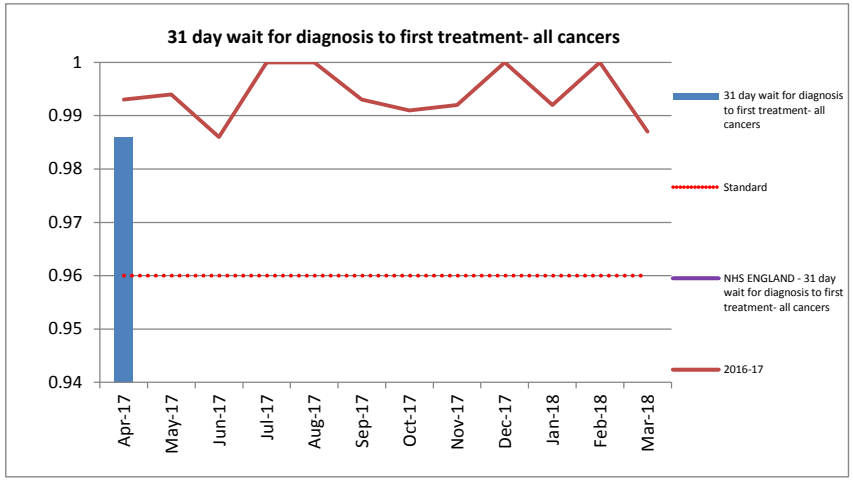
Monitor Compliance Framework: Cancer - Graphs - April 2017 (Month 1)

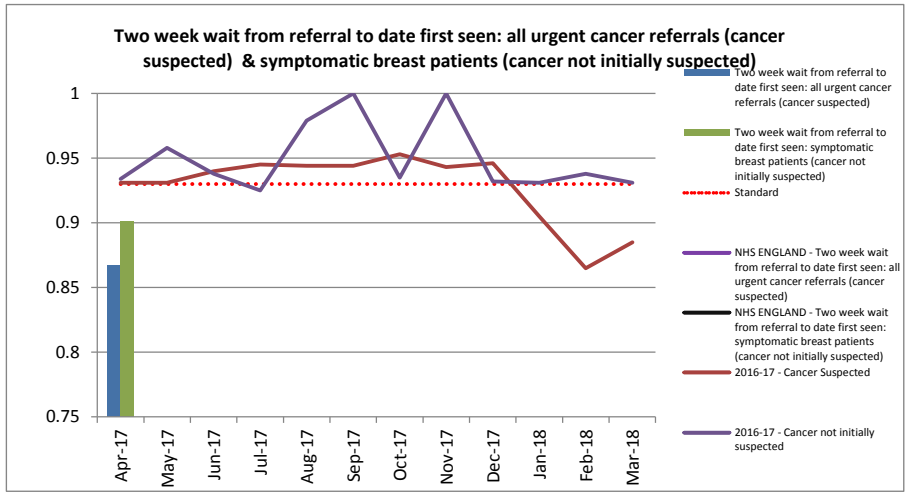












Monitor Compliance Framework: A&E - May 2017 (Month 2)

Context

4hr access is measured against all patients attending an urgent care facility. DBTH has 3 departments, 2 type 1 and 1 type 3. No GP patients are currently incorporated into the figures as they attend directly to Ambulatory units. GP patients are currently being collected in shadow form to assess the impacts on performance.

Reasons for Success/Failure

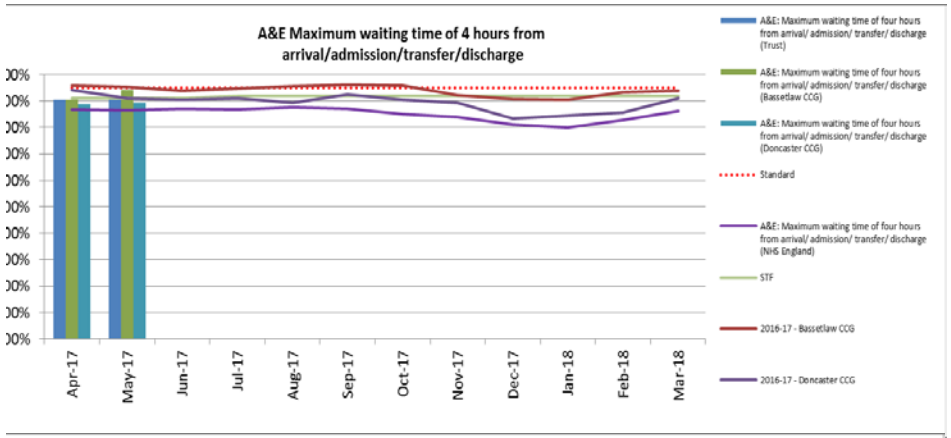
May Performance 91.39%
With GP urgent referrals 92.48%
Remain within top quartile of Trusts
Key issues related to internal ED doctor waits on both sites
Escalation systems worked effectively to improve flow following May Day bank holiday

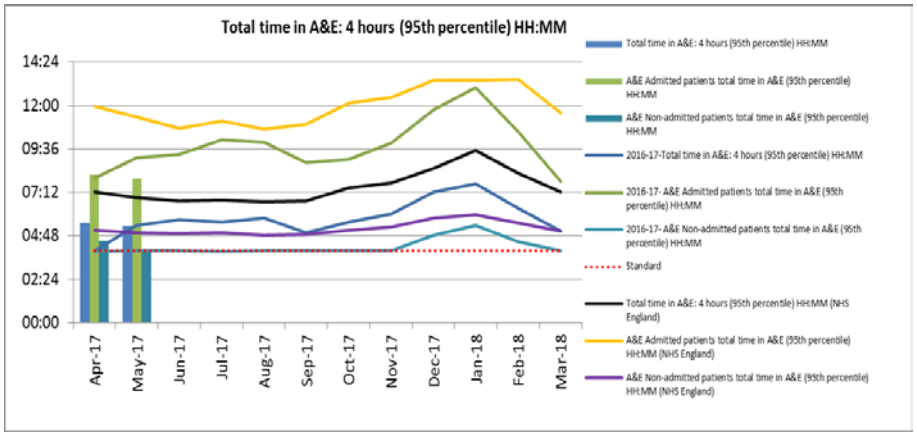
Actions being taken to address any issues

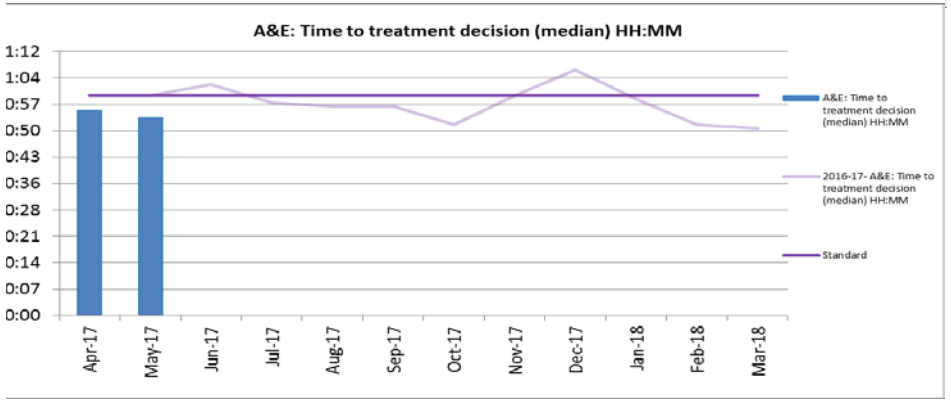
FDASS reviewed at DRI, awaiting CCG decision on staffing model. Continue to review ability to increase percentage streamed to alternatives currently 12.5% against a benchmark of 15%
Streaming model being agreed at BDGH following award of National monies for streaming.
Reviewing Urgent and Emergency Care as part of Bassetlaw Place Plan.
Workforce reviews being undertaking to assess the potential impact of IR35 regulation changes
DTOC work reviewed for transfer to assess pathways at Bassetlaw and Doncaster. DTOC workshops conducted to agree consistent counting.
Weekend working being reviewed to assess the effectiveness of consultant ward rounds on both main sites and the infrastructure available to support decision making

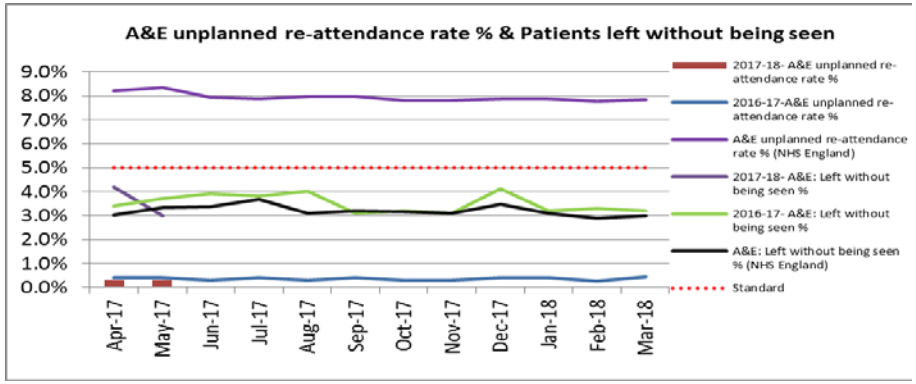
Indicator	Standard	May-16	Qtr 4 2016-17	Mar-17	Apr-17	May-17
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Trust)**	95.0%	93.1%	88.9%	92.6%	90.4%	91.4%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Bassetlaw CCG)**		95.4%	92.5%	93.9%	90.5%	94.2%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Doncaster CCG)**		91.1%	86.9%	91.0%	88.9%	89.2%
Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	04:00	06:20	05:05	05:30	05:20
A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	09:07	10:55	07:50	08:11	07:57
A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	03:58	04:37	03:59	04:31	04:00
A&E: Time to treatment decision (median) MM	01:00	01:00	00:53	00:51	00:56	00:54
A&E unplanned re-attendance rate %	5.0%	0.4%	0.3%	0.4%	0.3%	0.3%
A&E: Left without being seen %	5.0%	3.7%	3.0%	3.2%	4.2%	3.0%
Indicator	**Standard**	**Apr-16**	**Qtr 4 2016-17**	**Feb-17**	**Mar-17**	**Apr-17**
Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		680	2062	727	612	654
Ambulance Handovers Breaches -Number waited over 30 & under 60 Minutes		75	311	108	73	69
Ambulance Handovers Breaches -Number waited over 60 Minutes		11	195	13	10	21

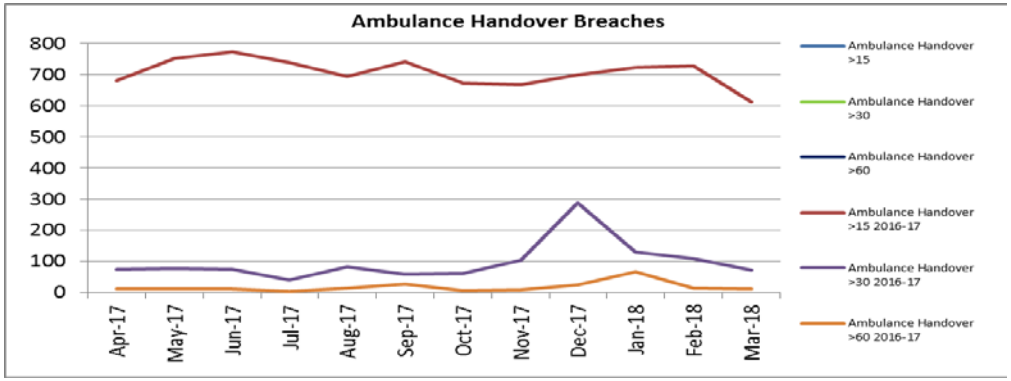
Monitor Compliance Framework: A&E - Graphs - May (Month 2)











Monitor Compliance Framework: 18 Weeks & Diagnostics -May 2017 (Month 2)

Context

The Trust has changed the way the incomplete pathways snapshot is monitored.
• Late Entered Referrals are included
• All amendments made to pathways since the end of September will have been reflected in the data. Previously only those flagged on the DQ system with earlier stops would have been removed.
• The removal of any late entered clock stops prior to the end of September. Previously only those in the month or flagged on the DQ system would have been removed.
• Correction on weeks waiting calculation for incomplete pathways as the calculation previously reported one day extra on each pathway,
• Inclusion of ASIs.
Please note: From March 2017 a change has been made to exclude pathways which were for 'planned' procedures but CaMIS was incorrectly starting a Referral to Treatment Clock. For March 2017, this change has resulted in the removal of around: 350 Incomplete Pathways and Incomplete Pathways with a decision to admit for treatment, 200 Admitted Clock Stops and 250 New RTT Periods. The affected specialties are Pain Management and Medical Ophthalmology (which fall into 'Others' when reported to Unify). In March this affected RTT performance negatively by 0.1%.

Reasons for Failure (if applicable)

Incomplete pathways for May ended at 90.6%.
There was one 52wk breach reported in May and this pathway is ongoing due to further diagnostics.
Specialties failed to meet 92% in April:
- General Surgery
- Urology
- ENT
- Ophthalmology
- Trauma and Orthopaedics

Key issues
- Workforce
- Theatre capacity and utilisation
- Cancellations at a specialty level
- Patient Administration - validation, right first time, tracking / management
- Anaesthetic workforce
- Managing demand

Diagnostic performance for April: 98.52%
Key issues:
- Audiology, back log of patients due to staff sickness and vacancies

Actions being taken to address any issues

Weekly PTL meetings take place with Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT. In response to the current RTT position Recovery Plans are regularly reviewed and challenged with each Care Group. Performance is also discussed at the Care Group Accountability Meeting. Main areas of concern; Ophthalmology, General Surgery, ENT and Pain Management. Due to ongoing failure to deliver performance, the Surgical Care Group has been placed in Advanced Monitoring. Diagnostics: Audiology and Endoscopy long term sustainability plan.

Improvements
- Dermatology has increased performance from 85% to +95%
- Orthopaedics continues to increase performance from 88% back to almost 91%
- Waiting list management across sites and communication
- Respiratory remains at +93% May

Actions
18 week pathways
- Advanced Monitoring for RTT with Surgical Care Group. Bi-weekly meetings chaired by COO.
    - Outsourcing action plans agreed with care group for; ENT and Ophthalmology
    - Internal action plans agreed with care group for; Pain Management and GI
- Collaboration with CCG on referral management and support in managing demand: Planned Care Programme Board and SDIP
- Paused validating below 15 weeks to focus on patient administration quality improvement.
- Working Group established focussed on patient administration - improving patient information through focussed training T&E plan
- Theatre Productivity Plans led by Theatre Workstream

Diagnostics
- Audiology, two locums commenced 10/04 and third Locum appointed early April. Trajectory is reduced breaches in May and mitigated by end of June. On track to deliver.
- Endoscopy capacity secured through external supplier to mitigate patient breaches. Provider required up to end of May to manage demand and reduce waiting list.
- Endoscopy business case by surgical care group. CIG in May/June

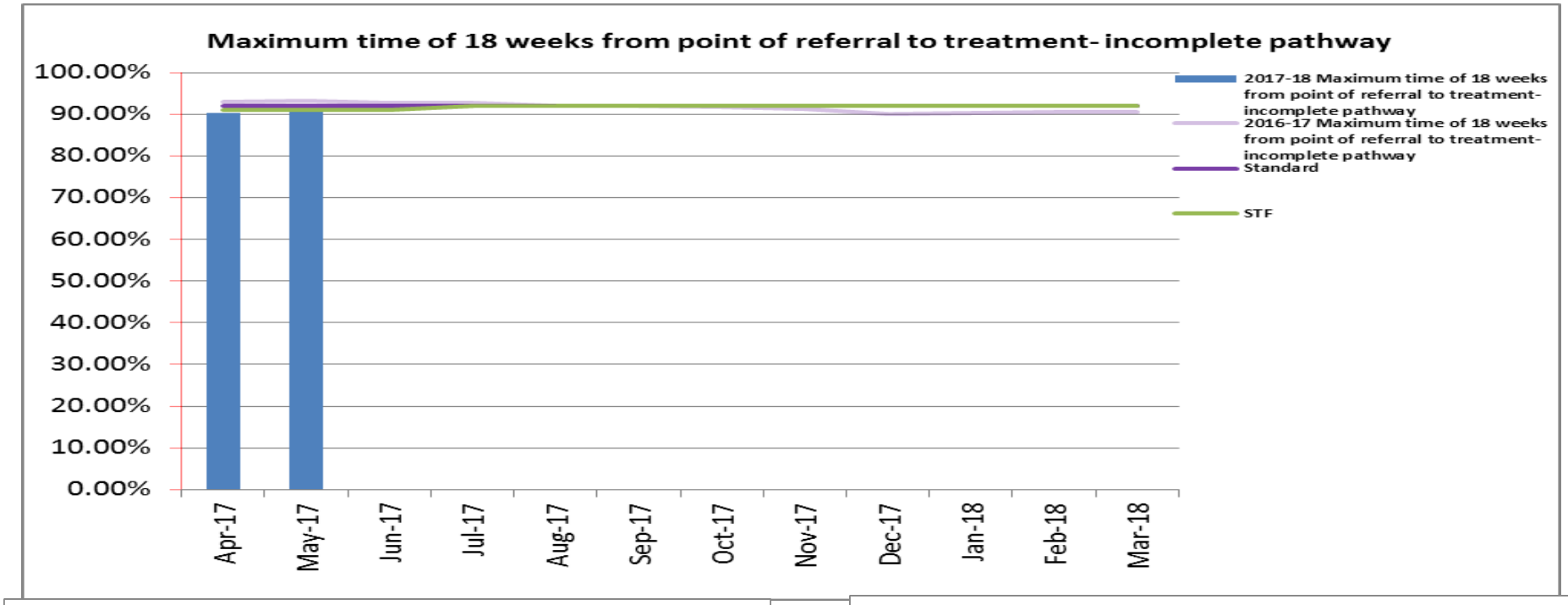
Risks
- Cancellations due to beds
- Completeness of internal additional capacity based on staff availability
- Securing out-sourcing capacity that is cost effective and timely
- Investment in Endoscopy - Business Case
- 52wk breach due to quality of patient information.
- Anaesthetic workforce and recruitment

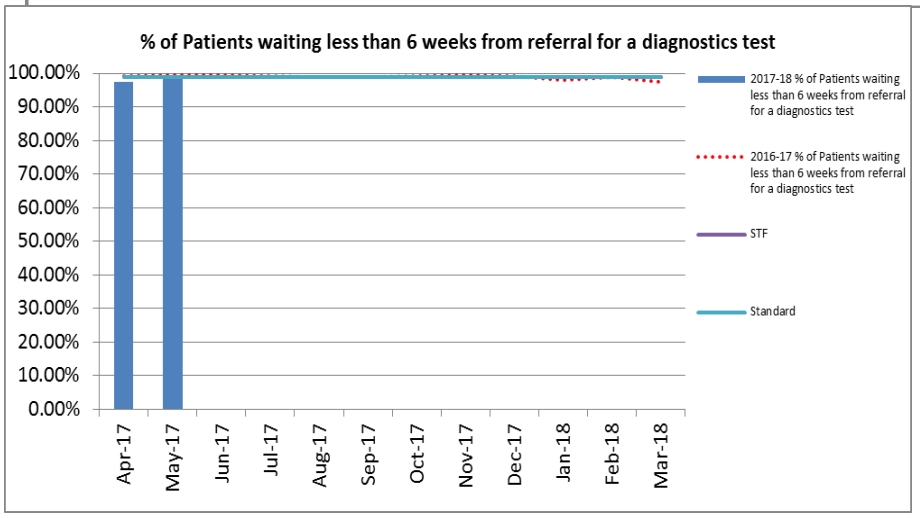
Summary
STF target for May is 91%. The Trust failed this at 90.6%. STF Trajectory for Q1 of 2017/18 is 91%. Q2 onwards 92%. The Trust remains focussed on achieving 92% as soon as possible.

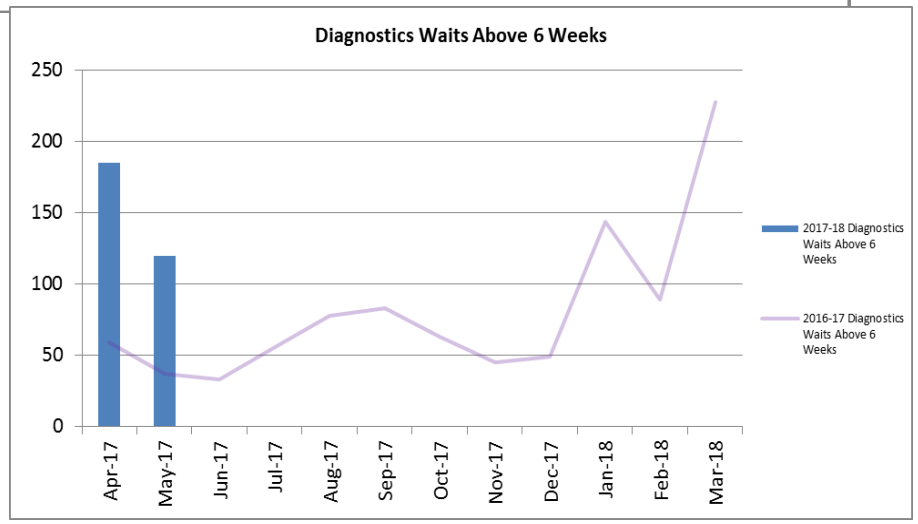
Indicator	Standard	May-16	Qtr. 4 2016-17	Mar-17	Apr-17	May-17	Expected date to meet standard
Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	93.10%	90.4%	90.5%	90.4%	90.6%	

Indicator	Standard	Apr-16		Mar-17	Apr-17	May-17	Expected date to meet standard
% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	99.50%		97.43%	97.54%	98.52%	
Diagnostics Waits		37		228	185	120	

Monitor Compliance Framework: 18 Weeks & Diagnostics - May (Month 2)







Stroke -March 2017 (Month 12)

Context

Stroke Targets are now reported against the SSNAP data, performance at level A/B across all areas

Reasons for Failure (if applicable)

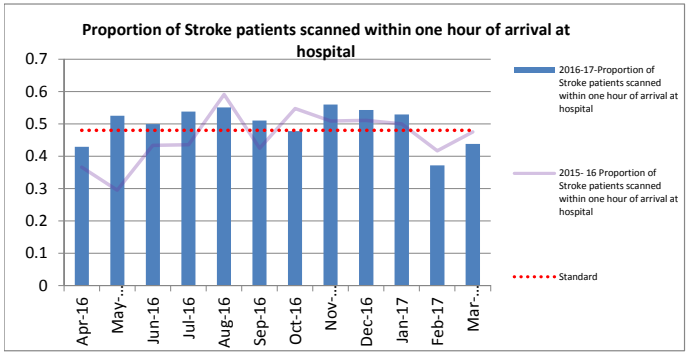
64 patients were discharged in March with a stroke 53% were directly admitted within 4hrs if this was 5hrs the target acheives 78%
11 patients waited over 10hrs to be admitted which is a result of their symptoms not being suggestive of a stroke.

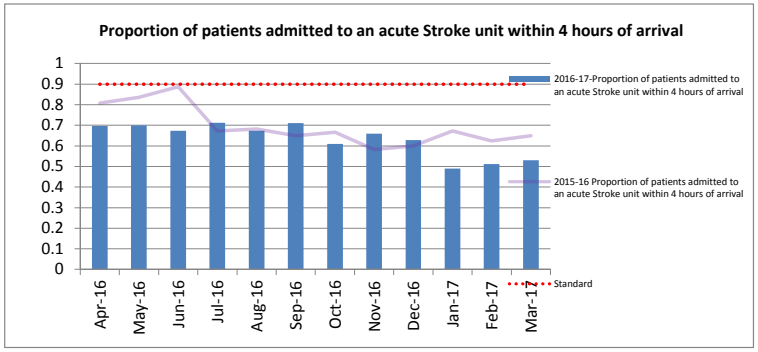
Actions being taken to address any issues

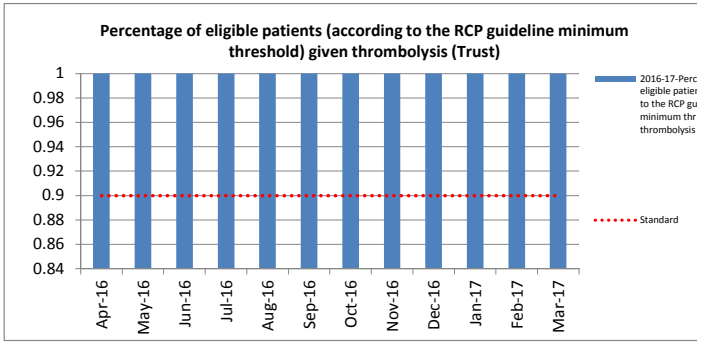
The stroke pathway is being process mapped to look at improvements
Improved working with ED staff to identify patients
The number of direct access beds for hyper acute stroke is being increased across the stroke unit
Working with EMAS to ensure patients are correctly identified to give direct access
Pathways for the stroke service out of the hospital to MMH and early supported discharge are being reviewed to ensure adequate bed capacity

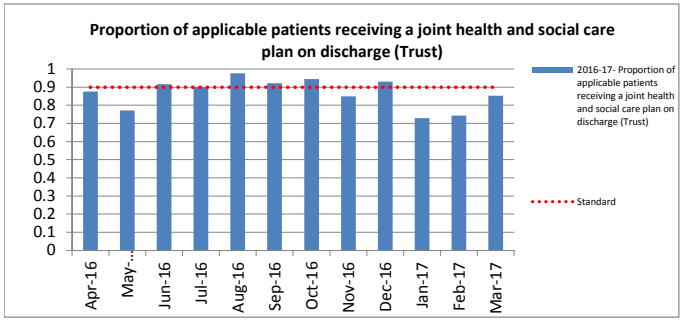
Indicator	Standard	Mar-16	Qtr 4 2016-17	Jan-17	Feb-17	Mar-17
Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	47.5%	44.9%	52.9%	37.2%	43.8%
Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	65.0%	51.3%	49.0%	51.2%	53.1%
Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	90.0%	N/A	100.0%	100.0%	100.0%	100.0%
Proportion of applicable patients receiving a joint health and social care plan on discharge (Trust)	90.0%	N/A	78.5%	73.0%	74.4%	85.2%
Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N/A	65.7%	53.7%	69.2%	71.9%
Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N/A	74.5%	65.9%	74.4%	80.7%
	Standard	**May-16**	**Qtr 4 2016-17**	**Mar-17**	**Apr-17**	**May-17**
Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	60.5%	57.3%	61.5%	58.3%	57.6%

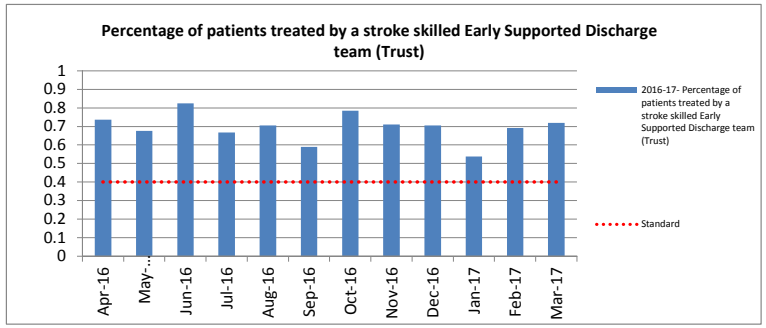
Stroke - Graphs March 2017 (Month 12)

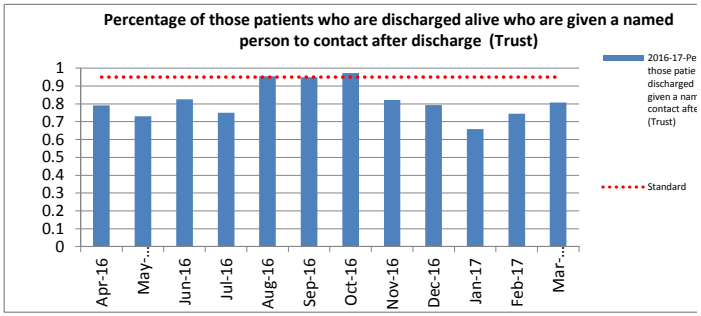


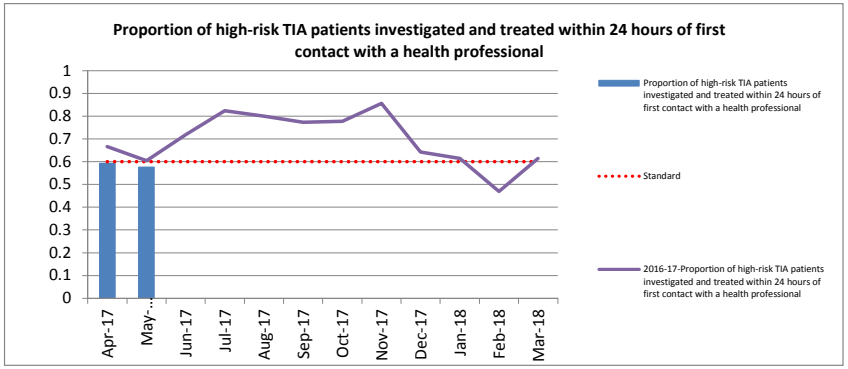




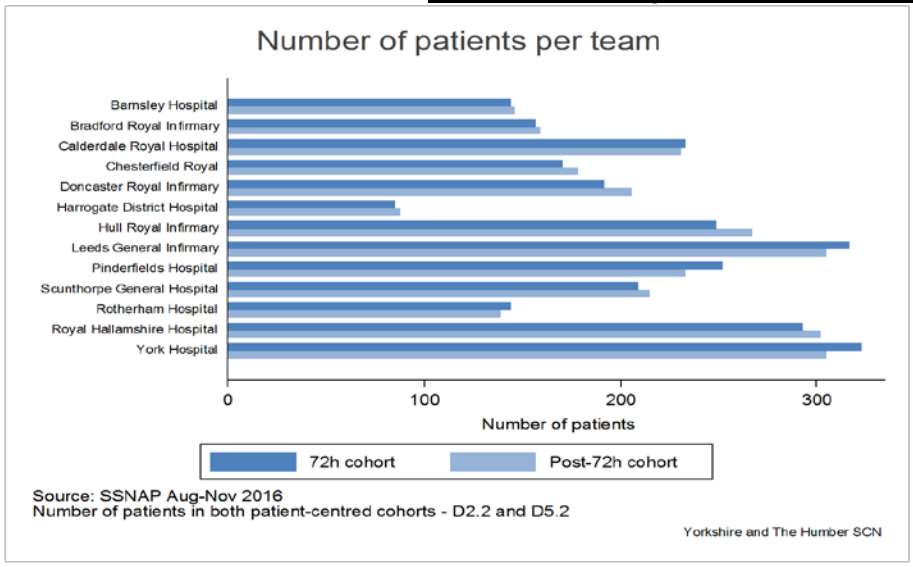


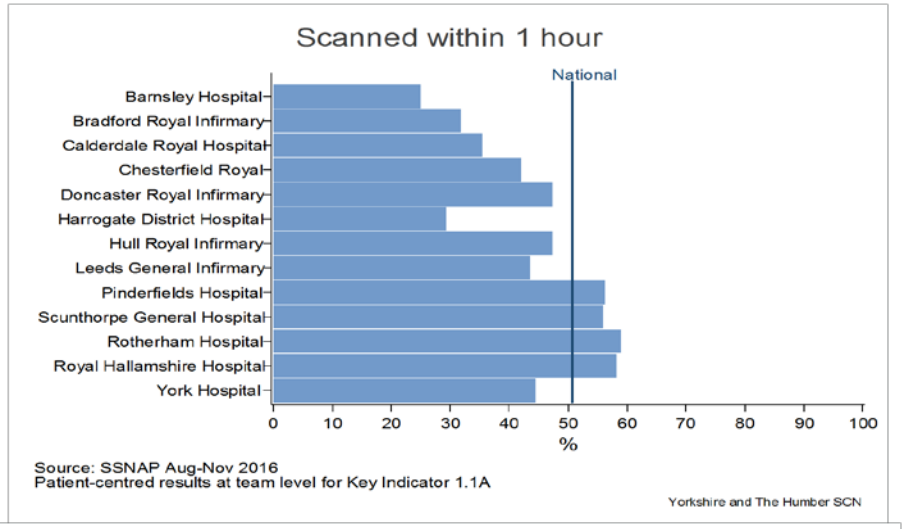


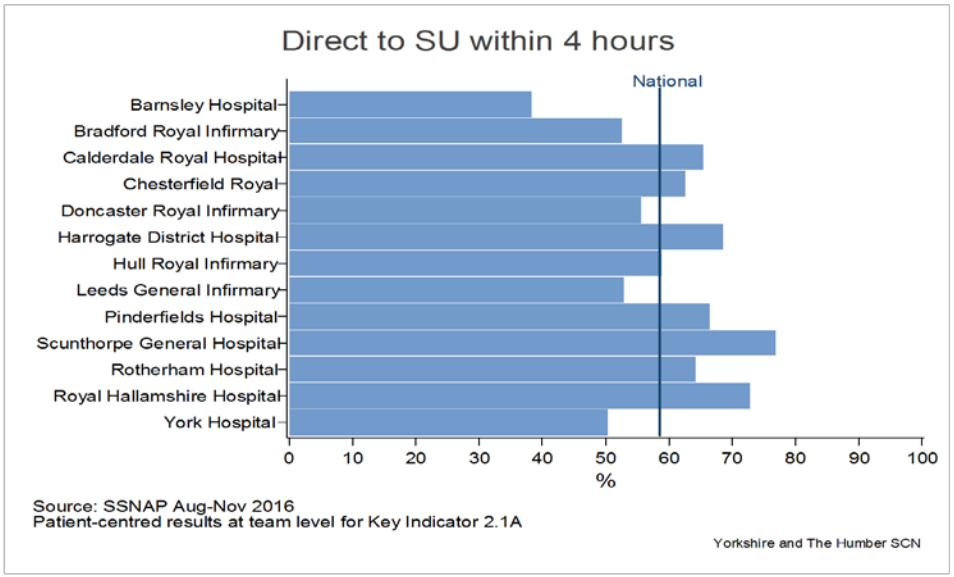


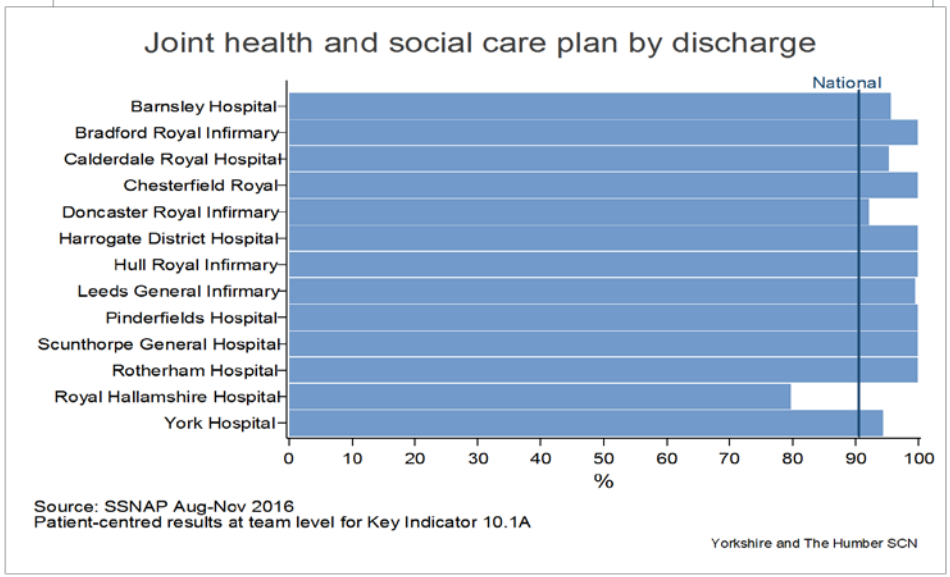


Stroke - Graphs South Yorkshire August - November 2016



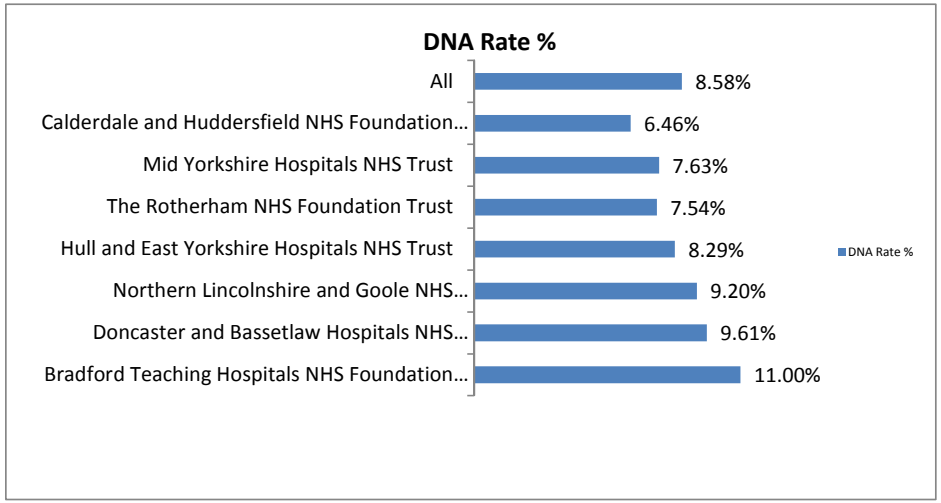






Theatre & Outpatients -May 2017 (Month 2)

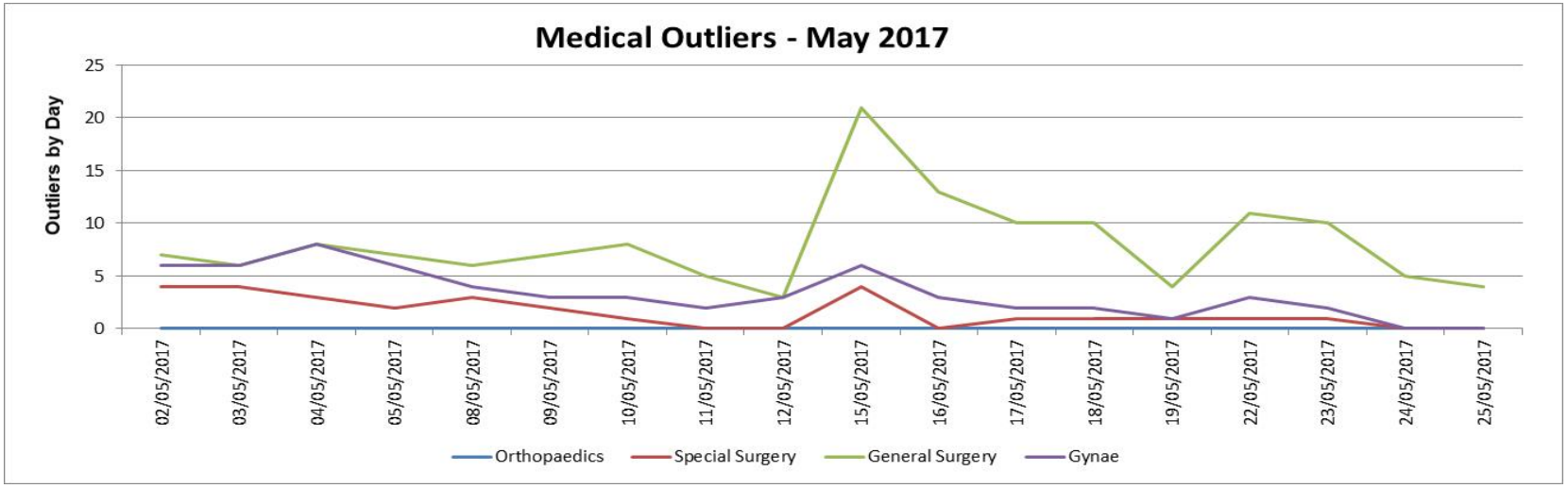
DNA Rate: Benchmarking data taken from Healthcare Evaluation Data (HED) (April 2016 to March 2017)

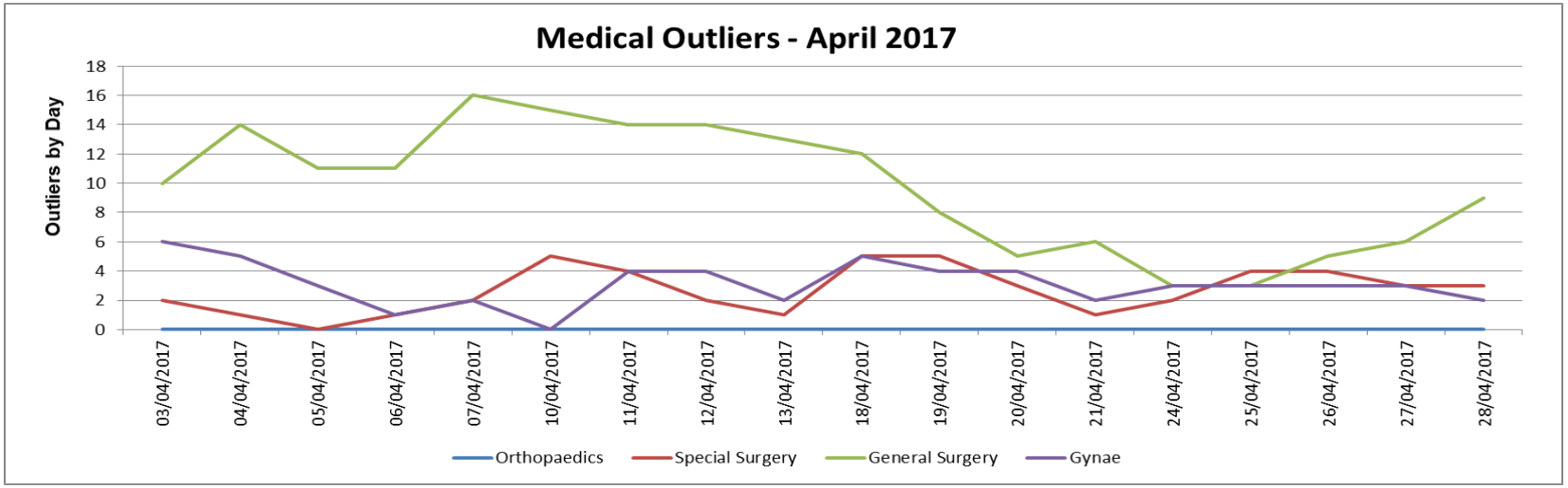


Indicator	Standard	May-16	Qtr 4 2016-17	Mar-17	Apr-17	May-17
Cancelled Operations (Total)	0.8%	1.2%	1.4%	1.0%	1.0%	1.1%
Cancelled Operations (Theatre)		1.0%	1.1%	0.8%	0.7%	0.9%
Cancelled Operations (Non Theatre)		0.2%	0.3%	0.2%	0.3%	0.2%
Cancelled Operations-28 Day Standard	0	0	3	0	0	1
Outpatients: DNA Rate Total (Refreshed Each Month)		9.05%	9.25%	8.81%	9.08%	9.32%
Outpatients: DNA Rate First (Refreshed Each Month)		9.09%	9.52%	9.28%	9.48%	9.94%
Outpatients: DNA Rate Follow Up (Refreshed Each Month)		9.02%	9.12%	8.59%	8.89%	9.02%
Outpatients: Hospital cancellation Rate (Refreshed Each Month)		6.79%	5.90%	5.73%	6.10%	5.14%
Outpatients: Patient cancellation Rate (Refreshed Each Month)		10.26%	10.80%	10.07%	9.55%	10.36%
Outpatients: Patient died cancellation Rate (Refreshed Each Month)		0.00%	0.00%	0.00%	0.00%	0.00%

* Please note cancellation data has changed to reflect cancellations made within 14 days of the appt.

Medical Outliers by Specialty - May 17 (Month 2)





	Daily average	Most Sleepers-out in May 2017	Least Sleepers-out in May 2017
Medicine to Ortho	0	0	0
Medicine to S12	2	4	0
Medicine to Surgery	8	21	3
Medicine to Gynae	3	8	0

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Safety & Quality - May 2017 (Month 2)

HSMR: The Trust's rolling 12 month HSMR remains better than expected at 92.6. HSMR for March was 81.3

Fractured Neck of Femur: A significant improvement in achievement of BPT to 80% in month whilst 12 month rolling relative mortality risk is at 90.

Serious Incidents: SI numbers remain low.

Executive Lead:
Mr S Singh

C.Diff: There has been a reduction in the number of cases of C Diff reported this month compared to the same period last year, however we currently remain above trajectory. A robust IPC plan of action has been put in place which is being monitored.

Fall resulting in significant harm: No falls resulting in significant harm this month, which is the same as this time last year.

Hospital Acquired Pressure Ulcers: Twice as many pressure ulcers have been reported this month compared to the same time period last year. All pressure ulcers are currently being reviewed through an RCA process and therefore this position may change during June.

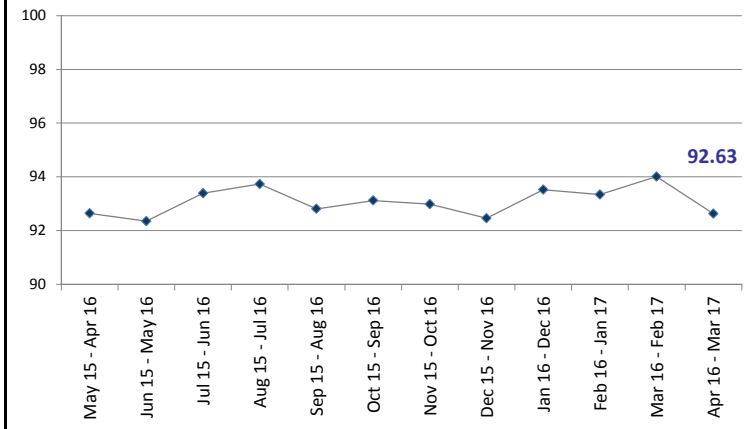
Complaints and concerns: Complaints resolution has improved this month and work to improve this further continues

Friends & Family Test: Response rate in ED continues to be low particularly at the minor injuries unit which is being addressed. Likely to recommend is above or at national average for both Inpatients and ED.

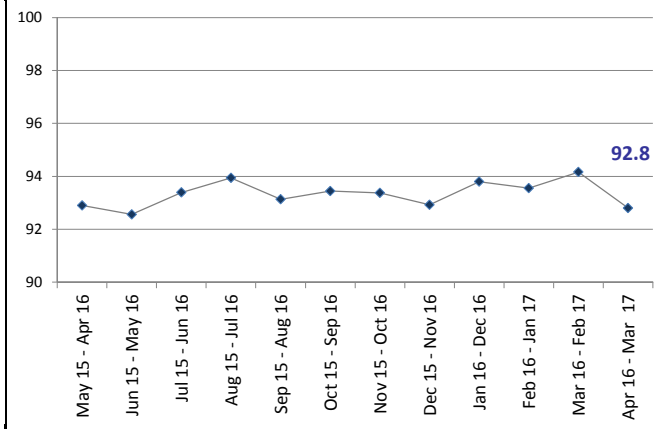
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - March 2017 (Month 12)

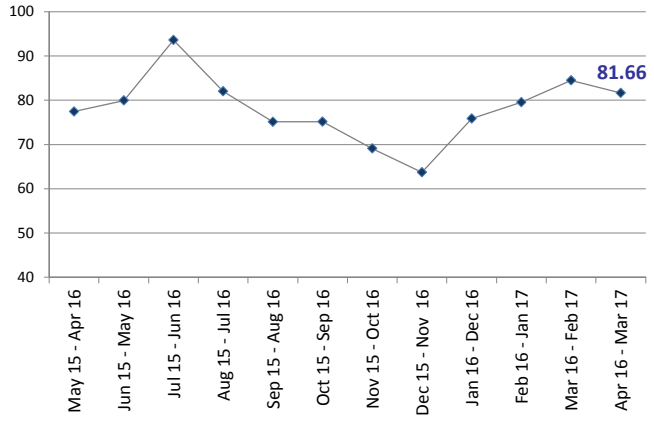
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

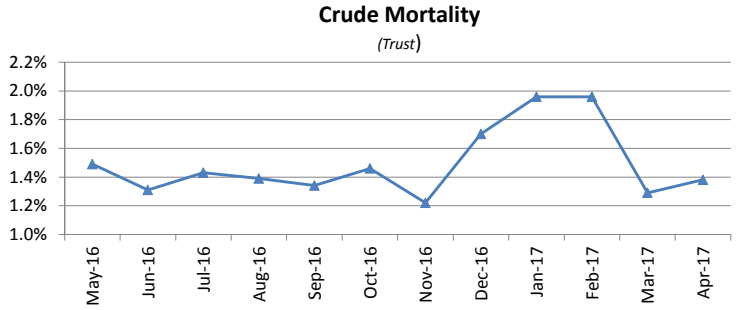


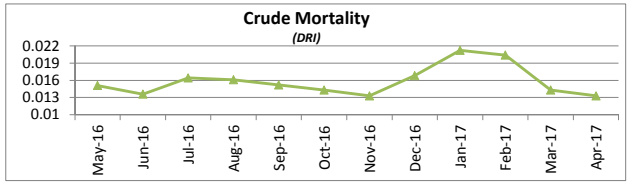
HSMR Trend (monthly)

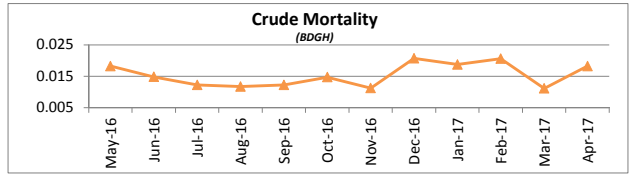
	2014	2015	2016	2017
January	115.45	116.80	99.21	96.81
February	99.11	99.94	97.73	106.45
March	102.91	90.54	97.37	81.34
April	110.49	105.91	88.50	
May	90.93	101.15	96.60	
June	113.74	80.27	92.81	
July	109.94	92.56	96.45	
August	120.18	100.27	87.08	
September	110.10	90.26	94.04	
October	106.58	90.29	88.30	
November	106.84	88.98	82.61	
December	115.87	82.30	93.71	

Crude Mortality (monthly) - May 2017 (Month 2)

(number of deaths/number of patient discharged)



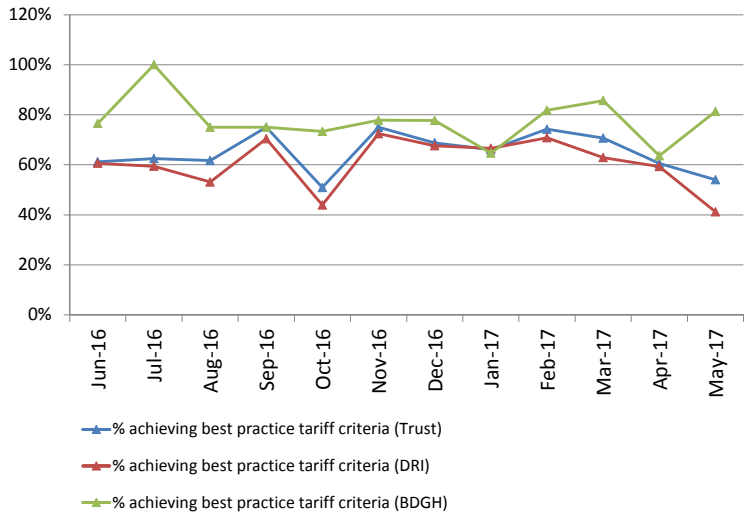




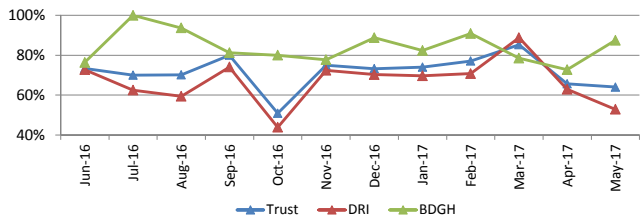
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Trust	**1.32%**	**1.47%**	**1.37%**	1.34%	1.38%	1.22%	1.70%	1.96%	1.96%	1.29%	1.38%	1.17%
Doncaster	1.37%	1.70%	1.59%	1.53%	1.43%	1.33%	1.68%	2.12%	2.04%	1.43%	1.33%	1.08%
Bassetlaw	1.48%	1.22%	1.17%	1.22%	1.47%	1.12%	2.07%	1.87%	2.06%	1.11%	1.82%	1.63%

NHFD Best Practice Pathway Performance - May 2017 (Month 2)

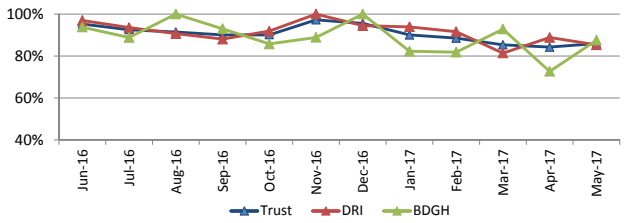
Best Practice Criteria Performance



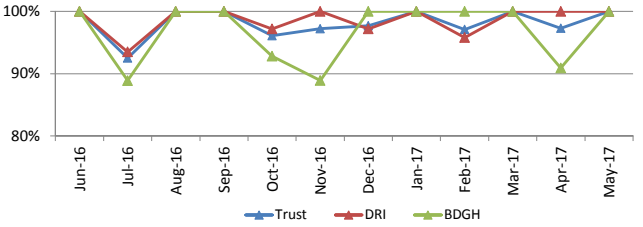
36 Hours to Surgery Performance



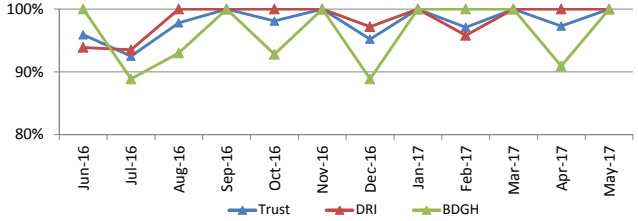
72 hours to Geriatrician Assessment Performance



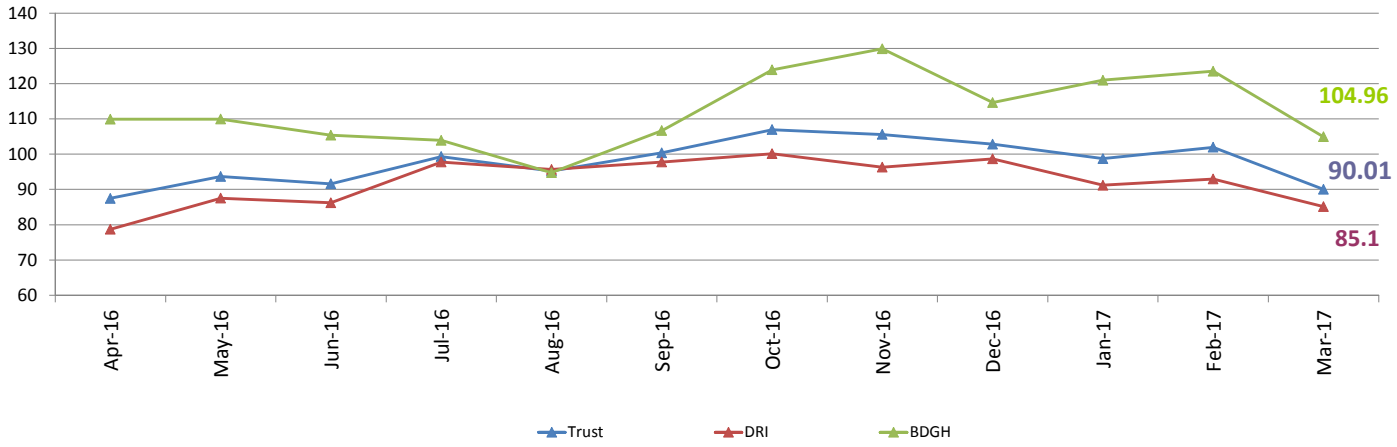
Bone Protection Medication Assessment



Falls Assessment Performance



Relative Risk Mortality (HSMR) - Fractured Neck of Femur
Rolling 12 month



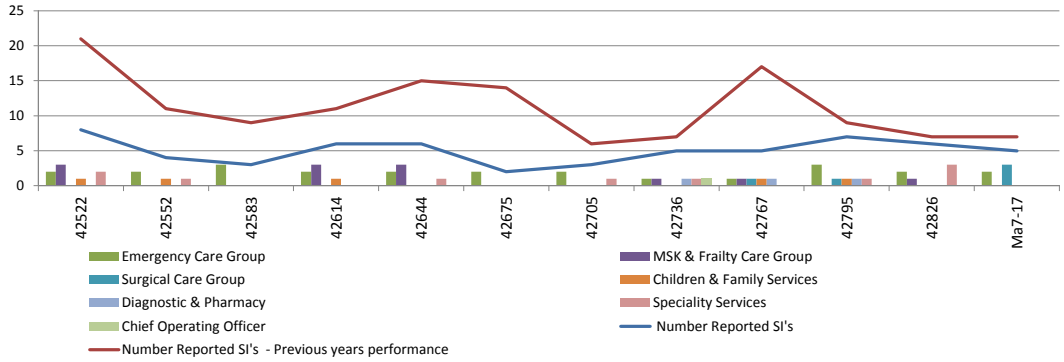
Serious Incidents - May 2017 (Month 2)

(Data accurate as at 14/06/17)

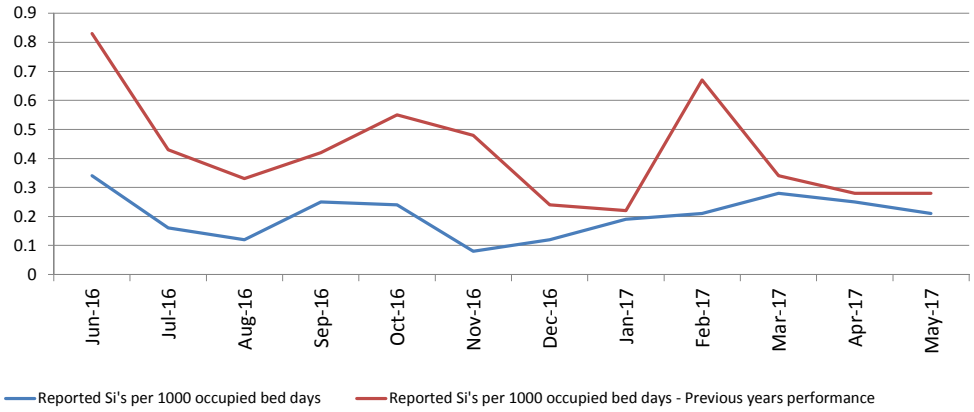
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Care Group)



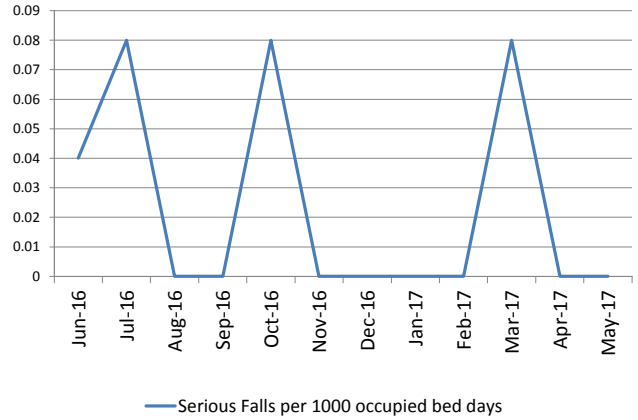
Serious Incidents per 1000 occupied bed days



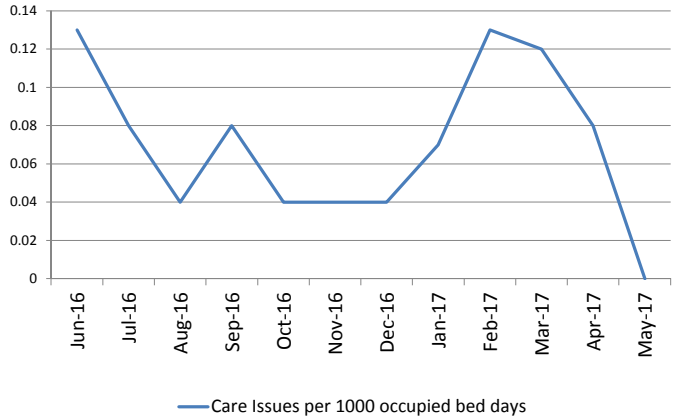
Current YTD reported SI's (Apr 17-May 17)	11	Number reported SI's (Apr 16-May 17)	11
Current YTD delogged SI's (Apr 17-May 17)	3	Number delogged SI's (Apr 16-May 17)	3

Themes

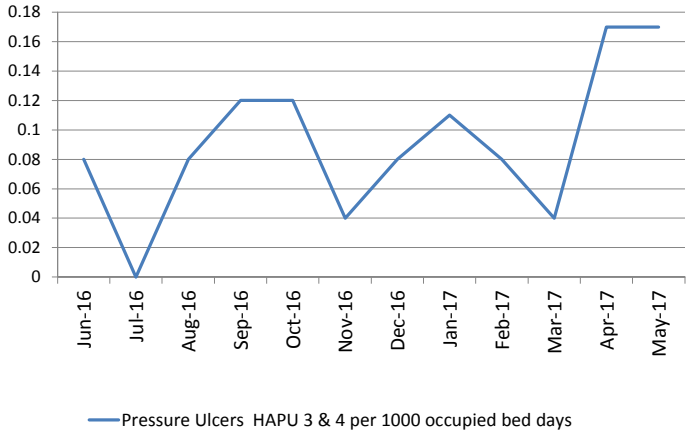
Serious Falls



Care Issues

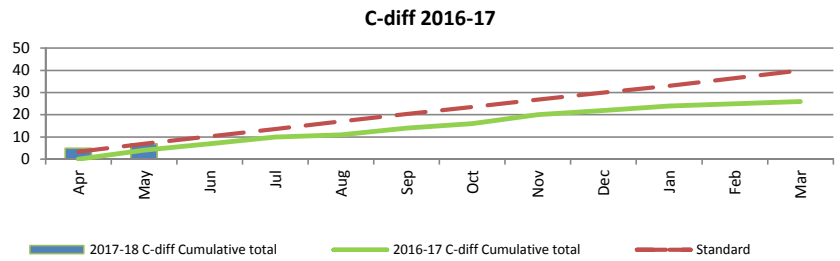


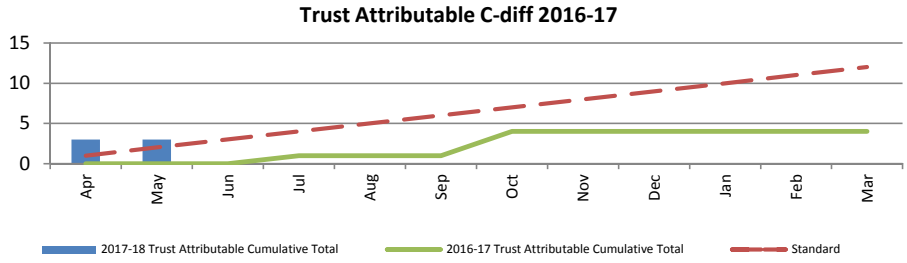
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - May 2017 (Month 2)
(Data accurate as at 14/06/2017)

	Standard	Apr	May	Jun	Q1	YTD
2017-18 Infection Control - C-diff	40 Full Year	5	2			7
2016-17 Infection Control - C-diff	40 Full Year	0	4			4
2017-18 Trust Attributable	12	3	0			3
2016-17 Trust Attributable	12	0	0			0

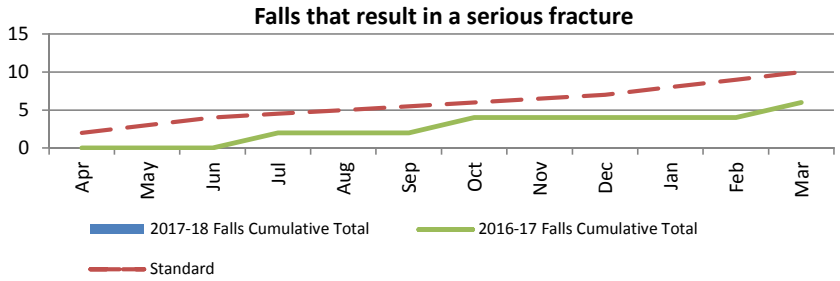




Pressure Ulcers & Falls that result in a serious fracture - May 2017 (Month 2)
(Data accurate as at 14/06/2016)

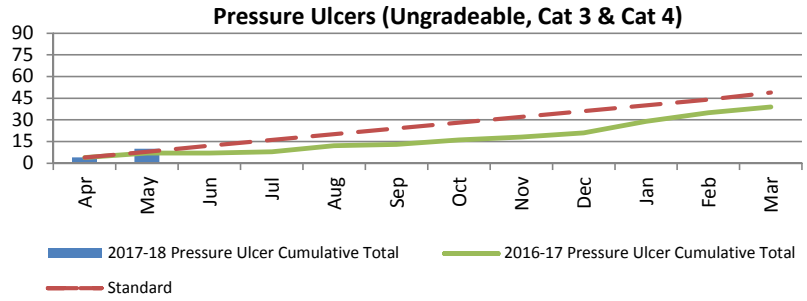
	Standard	Apr	May	Jun	Q1	YTD
2017-18 Serious Falls	10 Full Year	0	0			0
2016-17 Serious Falls	19 Full Year	0	0			0

Please note: At the time of producing this report the number of serious falls reported are prior to the RCA process being completed.



	Standard	Apr	May	Jun	Q1	YTD
2017-18 Pressure Ulcers	34 Full Year	4	6			10
2016-17 Pressure Ulcers	60 Full Year	4	3			7

Please note: At the time of producing this report the number of pressure ulcers reported are prior to the RCA process being completed.

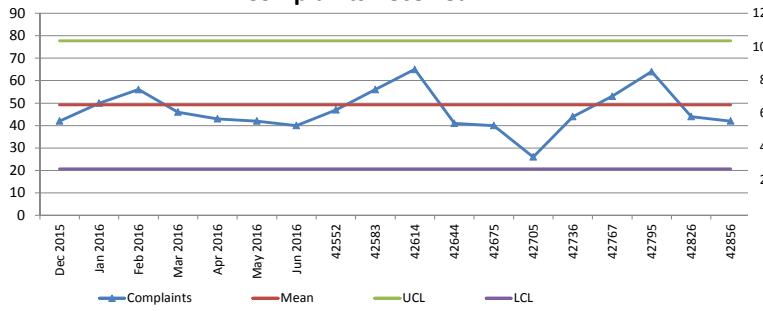


Complaints & Claims - May 2017 (Month 2)

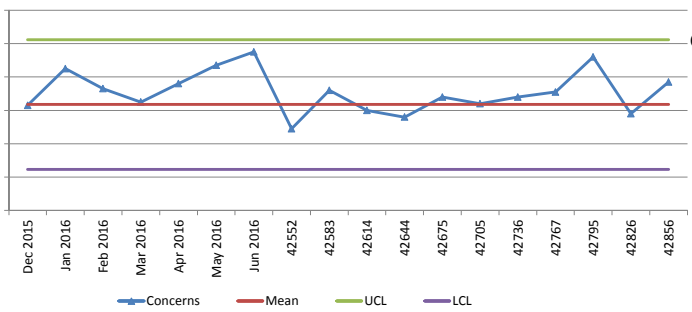
(Data accurate as at 07/06/2017)

Complaints

Complaints Received

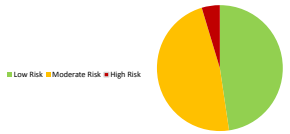


Concerns Received



May 2017 Complaints Recieved Risk Breakdown

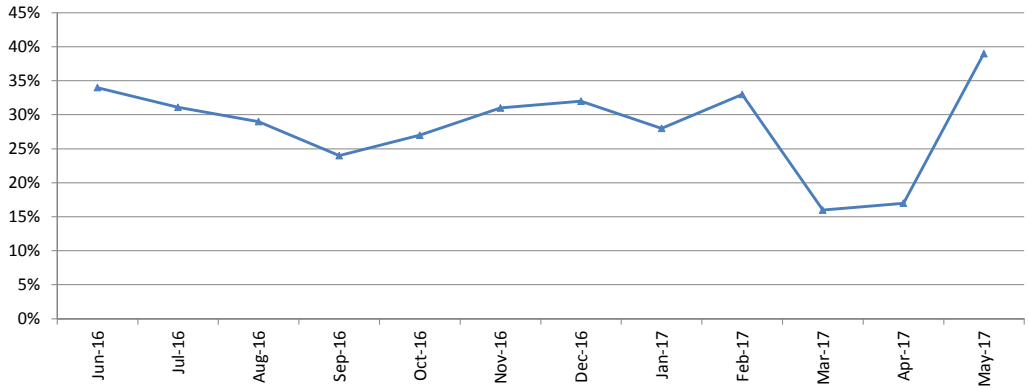
Year to Date Complaints Recieved Risk Breakdown



Complaints - Resolution Perfomance

(% achieved resolution within timescales)

Complaints Resolution Performance



Please note: Performance as a percentage is calculated on the cases replied and overdue, compared to the due date. Any current investigations that have not gone over deadlines are excluded data.

Parliamentary Health Service Ombusdman (PSHO)

Month	Number of cases referred for investigation	Number Currently Oustanding
May	0	9

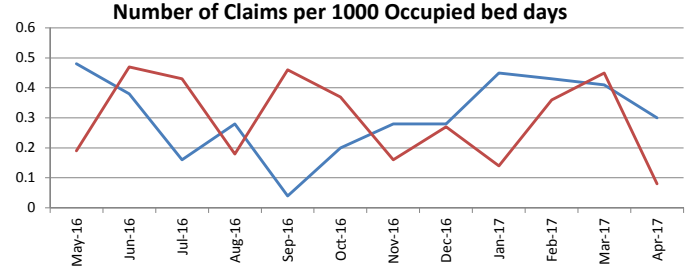
	Number referred for investigation YTD	Outcomes YTD	
2016/17	9	Fully / Partially Upheld	0
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
2017/18	1	Fully / Partially Upheld	
		Not Upheld	
		No further Investigation	
		Case Withdrawn	

Claims

	Current Month	Month Actual	YTD
Clinical Negligence Scheme for Trusts (CNST)	May-16	awaiting data	5
Liabilities to Third Parties Scheme (LTPS)	May-16	awaiting data	2

Please note: At the time of producing this report the number of claims reported are provisional and prior to validation

Number of Claims per 1000 Occupied bed days

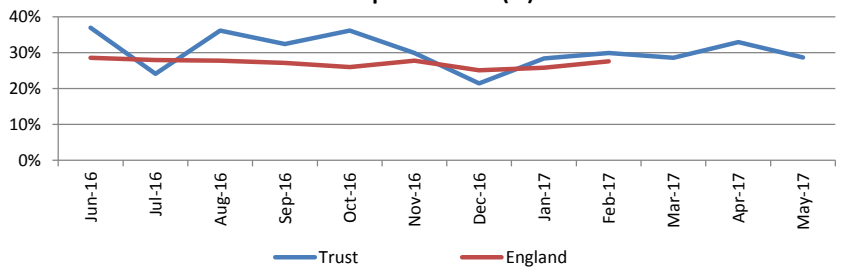


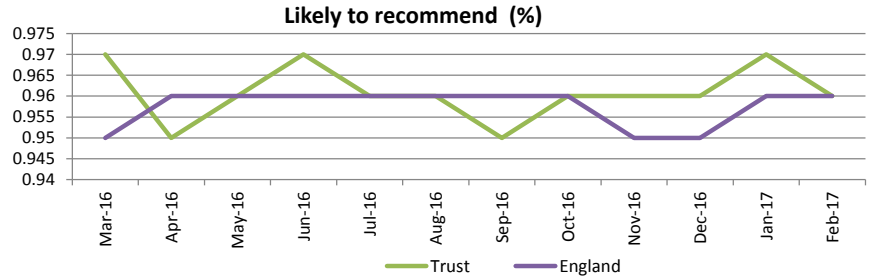
Friends & Family - May 2017 (Month 2)

(Data accurate as at 12/06/2017)

Inpatients

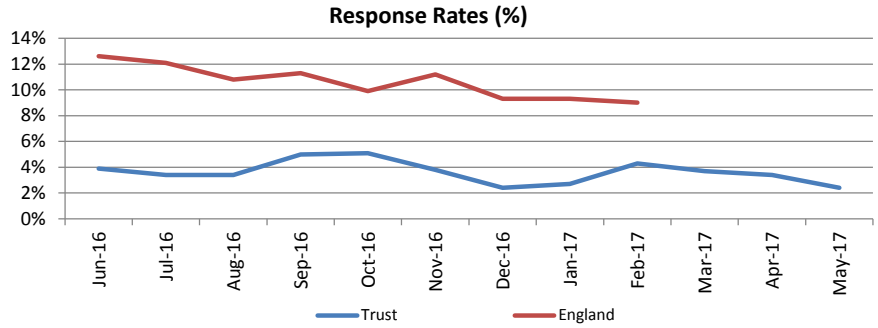
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

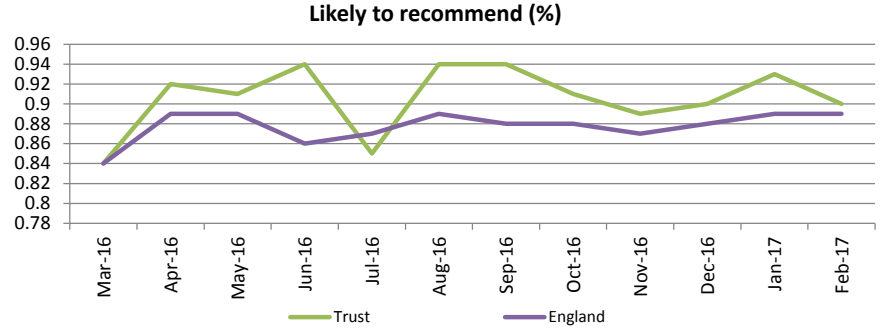




Accident & Emergency

Please note: At the time of producing this report no further benchmarking data is available from NHS England.





Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Workforce - May 2017 (Month 2)

Sickness absence

At the timing of the previous report month 1 sickness absence data was not available. The information provided in the report provided the sickness absence rate for year end which was 4.46%, representing a slight reduction over the last few months of the previous financial year. This is a trend which has continued for the first 2 months of the current financial year, the Trust saw a reduction in April to 4.01% and a further reduction again in May to 3.25% which is below the Trust target of 3.50%. We continue to benchmark favourably across Yorkshire and Humber and the P&OD Team will continue to support managers across the Trust to maintain the performance in this area.

Appraisals

There has been a slight increase in the Trusts appraisal completion rate, increasing from 57.72% to 58.51%. We continue to renewed focus as part of the revised accountability meetings with particular attention given to all senior managers having their appraisal as close to the start of the financial year as possible and other staff's appraisals being aligned to meet the peaks and troughs of operational demand. In order to enhance the quality of appraisals a review of the current paperwork has been undertaken and the paperwork updated (this will not detract from appraisals continuing in the meantime) .

SET

We have seen a very slight reduction in compliance with Statutory and Essential Training compared to April's figures which were 68.42%. to May's figure of 68.41% but generally across most areas the upwards trajectory continues.

Staff in post

Please see attached tab covering staff in post by staff group

Workforce: Sickness Absence - May (Month 2)

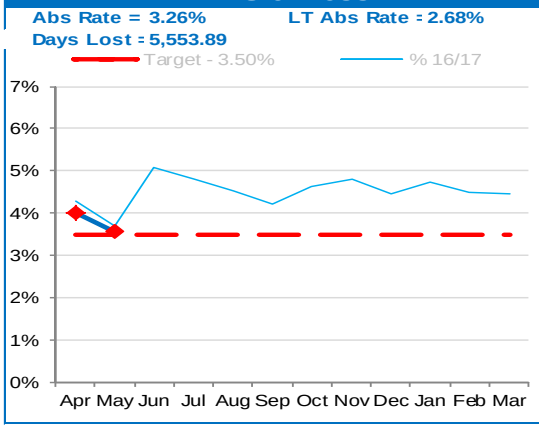
CG & Directorate Sickness Absence - May 2017 (Q1)

RAG: Below Trust Rate - Above Target - Above Trust Rate

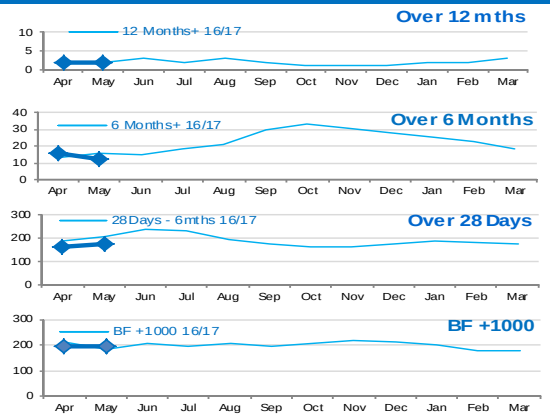
Sickness

Abs Rate = 3.26% LT Abs Rate = 2.68%

Days Lost = 5,553.89



Absence Occurences



	May-17		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**5553.89**	**3.26%**	**11,972.85**	**3.57%**
Chief Executive Directorate	0.00	0.00%	21.00	1.25%
Children & Family Care Group	672.61	3.75%	1,473.58	4.16%
Diagnostic & Pharmacy Care Group	507.84	2.72%	1,220.05	3.32%
Directorate Of Strategy & Improvement	0.00	0.00%	1.00	0.11%
Emergency Care Group	931.75	4.19%	1,959.41	4.46%
Estates & Facilities Directorate	892.26	5.09%	1,993.22	5.77%
Recharge Medics	0.00	0.00%	1.00	0.03%
Finance & Healthcare Contracting Directorate	13.40	0.60%	57.00	1.29%
IT Information & Telecoms Directorate	39.13	1.15%	106.10	1.59%
MSK & Frailty Care Group	681.04	2.71%	1,388.90	2.82%
Medical Director Directorate	0.00	0.00%	2.00	0.46%
Nursing Services Directorate	24.80	1.51%	58.07	1.82%
People & Organisational Development Directorate	34.00	1.18%	76.28	1.36%
Performance Management Directorate	102.52	1.60%	222.92	1.77%
Speciality Services Care Group	574.26	3.13%	1,143.17	3.18%
Surgical Care Group	1080.28	3.48%	2,249.16	3.68%
Trust Funds (included in Finance)	0.00	0.00%	0.00	0.00%

Top 10 Absence Reasons

Absence Reason	Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illne	1,862.00	21.90
S12 Other musculoskeletal problems	1,082.00	12.70
S25 Gastrointestinal problems	782.00	9.20
S98 Other known causes - not elsewhere classified	733.00	8.60
S28 Injury, fracture	557.00	6.50
S11 Back Problems	521.00	6.10
S26 Genitourinary & gynaecological disorders	471.00	5.50
S13 Cold, Cough, Flu - Influenza	364.00	4.30
S27 Infectious diseases	310.00	3.60
S15 Chest & respiratory problems	262.00	3.10

Benchmarking - Sickness Absence* March 2017

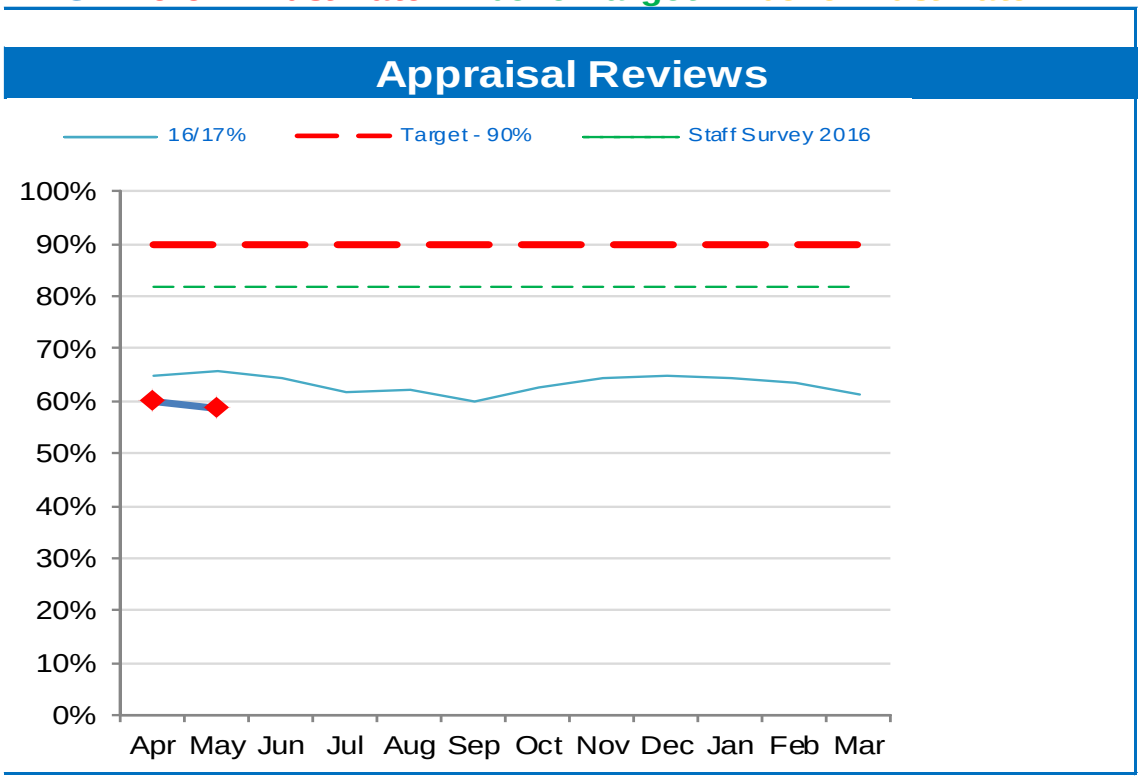
Your Trust:	Region	Absence Rate
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	Yorkshire and the Humber	3.9%
Acute Average		4.1%
All Trusts:	**Region**	**Absence Rate:**
LEEDS COMMUNITY HEALTHCARE NHS TRUST	Yorkshire and the Humber	5.4%
SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	Yorkshire and the Humber	5.4%
YORKSHIRE AMBULANCE SERVICE NHS TRUST	Yorkshire and the Humber	5.3%
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	Yorkshire and the Humber	5.1%
BRADFORD DISTRICT CARE TRUST	Yorkshire and the Humber	5.0%
SHEFFIELD CHILDRENS NHS FOUNDATION TRUST	Yorkshire and the Humber	4.9%
HUMBER NHS FOUNDATION TRUST	Yorkshire and the Humber	4.9%
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Yorkshire and the Humber	4.9%
MID YORKSHIRE HOSPITALS NHS TRUST	Yorkshire and the Humber	4.4%
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Yorkshire and the Humber	4.3%
YORK TEACHING HOSPITALS NHS FOUNDATION TRUST	Yorkshire and the Humber	4.2%
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	Yorkshire and the Humber	4.1%
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	Yorkshire and the Humber	4.0%
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	Yorkshire and the Humber	3.9%
LOCALA COMMUNITY PARTNERSHIPS	Yorkshire and the Humber	3.9%
CITY HEALTHCARE PARTNERSHIP	Yorkshire and the Humber	3.8%
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	Yorkshire and the Humber	3.8%
AIREDALE NHS FOUNDATION TRUST	Yorkshire and the Humber	3.7%
THE ROTHERHAM NHS FOUNDATION TRUST	Yorkshire and the Humber	3.7%
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	Yorkshire and the Humber	3.7%
CARE PLUS	Yorkshire and the Humber	3.7%
LEEDS TEACHING HOSPITALS NHS TRUST	Yorkshire and the Humber	3.7%
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	Yorkshire and the Humber	3.7%
NAVIGO	Yorkshire and the Humber	3.7%
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	Yorkshire and the Humber	3.6%
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	Yorkshire and the Humber	3.4%
SPECTRUM COMMUNITY HEALTH	Yorkshire and the Humber	3.3%
FOCUS INDEPENDENT ADULT SOCIAL WORK CIC	Yorkshire and the Humber	2.3%
Grand Total		4.1%

Workforce: Appraisals - May (Month 2)

Appraisal Reviews

CG & Directorate Appraisals - May 2017 (Q1)

RAG: Below Trust Rate - Above Target - Above Trust Rate

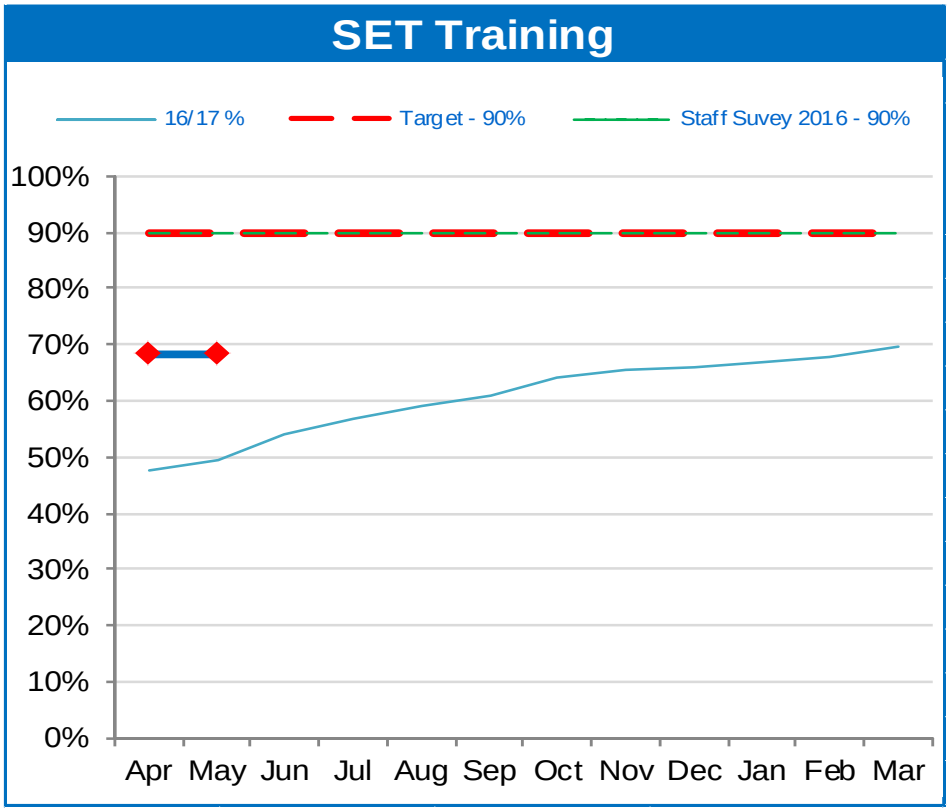


	% Completed
Doncaster & Bassetlaw Teaching Hospitals	**58.51**
Chief Executive Directorate	37.04
Children & Family Care Group	71.01
Diagnostic & Pharmacy Care Group	61.07
Directorate Of Strategy & Improvement	71.43
Emergency Care Group	56.80
Estates & Facilities	25.78
Finance & Healthcare Contracting Directorate	6.67
IT Information & Telecoms Directorate	40.00
MSK & Frailty Care Group	77.69
Medical Director Directorate	75.00
Nursing Services Directorate	9.52
People & Organisational Directorate	79.80
Performance Directorate	73.89
Speciality Services Care Group	46.68
Surgical Care Group	67.36
Trust Funds	0.00

Workforce: SET Training - May (Month 2)

SET Training

RAG: Below Trust Rate - Above Target - Above Trust Rate



	% Compliance
Doncaster & Bassetlaw NHS FT	**68.41%**
Chief Executive Directorate	**73.15%**
Children & Family Care Group	**73.69%**
Diagnostic & Pharmacy Care Group	**74.96%**
Directorate Of Strategy & Improvement	**96.64%**
Emergency Care Group	**66.05%**
Estates & Facilities	**47.21%**
Finance & Healthcare Contracting Directorate	**69.94%**
IT Information & Telecoms Directorate	**80.68%**
MSK & Frailty Care Group	**79.32%**
Medical Director Directorate	**74.16%**
Nursing Services Directorate	**74.57%**
People & Organisational Directorate	**93.36%**
Performance Directorate	**29.54%**
Speciality Services Care Group	**72.65%**
Surgical Care Group	**74.51%**

Workforce: Staff in post - May (Month 2)

Staff in Post

	FTE	Headcount	FTE	Headcount
Staff Group	**Apr-17**		**May-17**	
Add Prof Scientific and Technic	173.34	189.00	173.68	189.00
Additional Clinical Services	1,116.66	1,356.00	1,124.68	1,365.00
Administrative and Clerical	1,089.28	1,338.00	1,097.51	1,344.00
Allied Health Professionals	317.79	369.00	316.78	367.00
Estates and Ancillary	572.83	825.00	571.80	827.00
Healthcare Scientists	129.53	143.00	129.10	142.00
Medical and Dental	498.11	523.00	497.26	522.00
Nursing and Midwifery Registered	1,593.42	1,850.00	1,593.67	1,850.00
Students	3.00	3.00	0.00	0.00
Grand Total	**5,493.97**	**6,596.00**	**5,504.48**	**6,606.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Nursing Workforce Information**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Moira Hardy, Acting Director of Nursing, Midwifery & Quality** **Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Quality**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		✔

Executive summary containing key messages and issues

This paper updates the Board of Directors on key issues relating to the Nursing Workforce, using information from the June 2017 UNIFY return which relates to May 2017 actual and planned hours:

- The workforce data submitted to UNIFY demonstrates the overall planned versus actual hours worked to be 100% for May 2017
- Three wards, all at Bassetlaw Hospital, had a deficit in excess of 10% between planned versus actual hours worked. These wards are B6, ITU and Labour Ward and are due to lower occupancy, acuity and dependency of patients on Ward B6, significant sickness absence on Labour ward and a vacancy HCSW post for ITU.
- Care Hours Per Patient Day (CHPPD) for May 2017 shows a slight decrease from April from 7.6 to 7.5 overall in May, but a slight increase for registered staff and a slight reduction for non-registered staff. Data held within the Model Hospital portal has not been updated since the previous report.
- The Trust position regarding safe nurse staffing and efficiency (Agency Capping) from TDA, Monitor, NHSE, CQC and NICE remains within the 3% cap and was at 1.0% for May 2017, a decrease from 2.2% in April 2017.
- Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), including How to ensure the right people, with the right skills, are in the right place at the right time (2013) and Safe staffing for nursing in adult inpatient wards in acute hospitals (2014) relating to Hard Truths demonstrates that one ward was rated Red for Quality in April 2017. This is Ward 17.

Key questions posed by the report

- Are the control measures for managing the nursing workforce provision achieving the

desired outcome of adequate staffing levels, within the agency cap requirements?

- Are the systems to monitor quality providing an appropriate early warning sign for intervention?
- Are we complying to the relevant standards in reporting the staffing levels as part of Hard Truths, for both external and internal reporting requirements?
- Does the triangulation of staffing and quality data provide the assurance on the adequacy of resources balanced with quality improvement potential?

How this report contributes to the delivery of the strategic objectives

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Focus on innovation for improvement
- Develop responsibly, delivering the right services with the right staff

How this report impacts on current risks or highlights new risks

Risks associated to the inability to recruit to establishment and develop staff to provide harm free care, delivered with compassion and of appropriate quality.

Risk associated with not meeting regulatory and commissioner requirement.

The risks identified have been mitigated by the use of temporary staffing to provide planned versus actual hours worked at 100% in May. Despite the use of temporary staff to maintain safe staffing levels the Trust has remained within the 3% agency cap. The main risk in relation to staffing continues to be the recruitment to Registered nurse and midwifery vacancies and opportunities to recruit are actively being explored.

Ward 17 has been identified as at risk this month, so will have a quality summit to review processes and plan with the team, the steps to make the improvement required.

Recommendation(s) and next steps

The Board of Directors is asked to NOTE the content of this paper and SUPPORT the actions identified to ensure that the risks associated with inappropriate nurse staffing levels are appropriately managed.

Key issues and actions include:

- the continuing work of the Non-Medical workforce utilisation programme as part of DBH Strategy and Improvement programme
- Exploring recruitment opportunities for nursing and midwifery
- Complete AUKUH data collection from 01 July, ward nurse staffing requirements will be available to the Board of Directors in September 2017.

1. INTRODUCTION

This paper provides the Board of Directors with detailed information relating to the Nursing Workforce; highlighting issues which may impact upon the Trusts ability to provide appropriate staffing levels and skill mixes. It also updates the Board of Directors on the implementation on Care Hours per Patient Day (CHPPD), which has been a required national return since 01 May 2016 and the data submitted to UNIFY.

This report also provides the committee with the Trust position in relation to the agency and frameworks caps from NHSI, NHSE, CQC and NICE

2. BACKGROUND

This paper provides the DBHFT Board of Directors with the relevant information to consider staffing levels and skill mixes across the Trust. It provides the planned and actual workforce information, along with the Care Hours per Patient Day (CHPPD) for May 2017, which has been submitted to the UNIFY system, with additional information relating to the May Quality Metrics dashboard for each ward, focusing on those areas that require improvement.

3. WORKFORCE INFORMATION

The workforce data submitted to UNIFY provides the actual hours worked in May 2017 by registered nurses and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 100% in May 2017, the same as April.

3a. Actual versus planned staffing levels (based on daily data capture)

The actual staffing levels for May were collected manually, mostly contemporaneously, and validated by the Matrons and Heads of Nursing (HoNs) retrospectively. The Matrons based the planned levels on the agreed planned staffing levels in the 2017/2018 funded establishments. The planned hours are adjusted each month to account for the number of days in the month. The fill rate includes shifts used to support escalation and closed beds.

Data collection for the planned staffing levels for intensive care, paediatric and midwifery areas has led to planned staffing levels being based on actual acuity and dependency requirements on a day by day basis to reflect occupancy levels.

The data for May 2017 (Appendix 1) demonstrates that the actual available hours compared to planned hours were:

- within 5% for 25 Wards (61%), five more than April
- between 5% – 10% for 9 Wards (22%) seven less than April
- surpluses over 10% for 4 Wards (10%) two more than April
- deficits over 10% for 3 Wards (7%) the same as April

The wards where there were surpluses in excess of 10% of the planned hours are Gresley, Mallard, Rehab 2 and Ward 16 (Acute Stroke); each ward requiring additional staff to support patients requiring enhanced care.

The wards where there were deficits in excess of 10% of the planned hours are B6, ITU and Labour Ward at Bassetlaw Hospital. The lower than planned staffing levels were due to:

- Lower occupancy, acuity and dependency of patients on Ward B6 allowed staff to be safely moved to support other clinical areas.

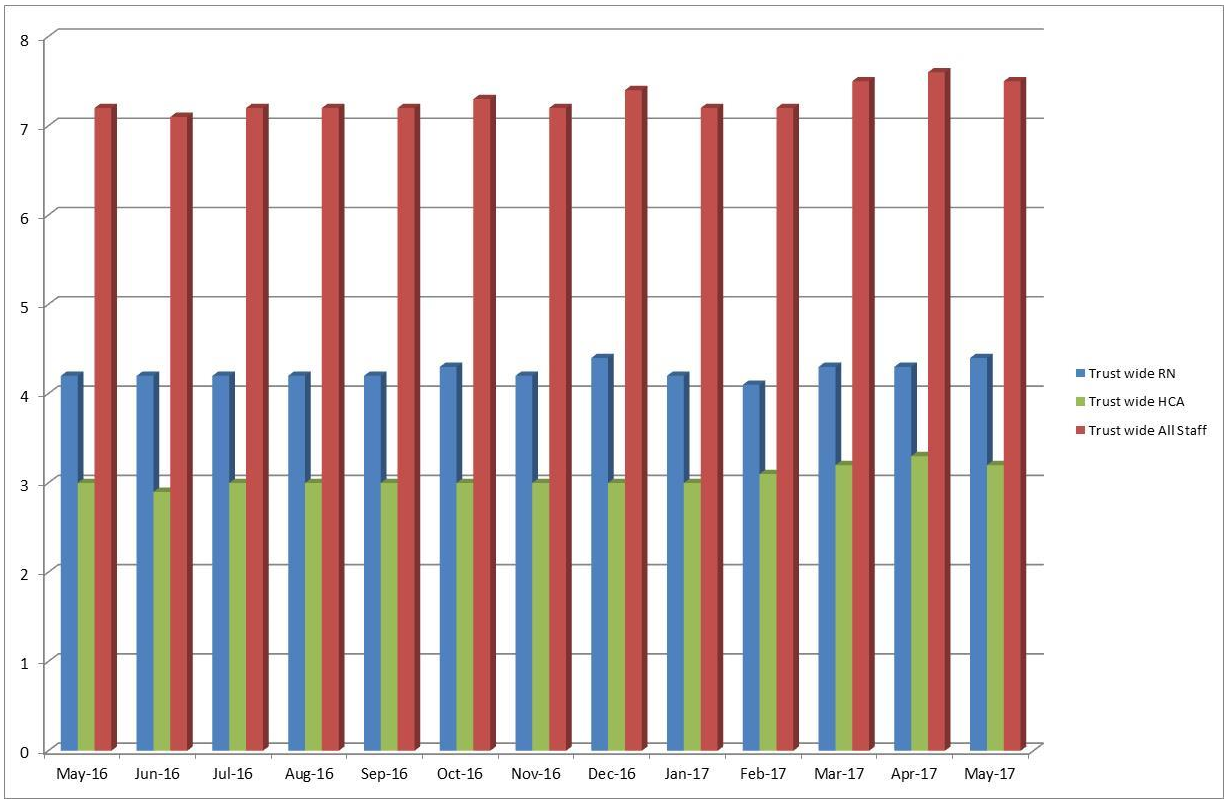
- Labour Ward is due to staff sickness absence and vacancies. The service was optimised through the maternity service on call management and use of community staff to ensure safe services.
- Bassetlaw ITU had sufficient staff for the acuity of patients, with a shortfall of a HCA, due to a vacancy, impacting on the overall position.

3b. Care Hours Per Patient Day (CHPPD)

From 01 May 2016, CHPPD has become the principle measure of nursing and healthcare support worker deployment. Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for May 2017 are shown below, with a slight increase in the overall and registered midwives and nurses:

Care Hours Per Patient Day (CHPPD) – May 2017			
Site Name	**Registered midwives/ nurses**	**Care Staff**	**Overall**
BASSETLAW HOSPITAL	5.2	3.3	8.6
DONCASTER ROYAL INFIRMARY	4.4	3.2	7.5
MONTAGU HOSPITAL	2.2	2.7	4.8
TRUST	**4.4**	**3.1**	**7.5**

The CHPPD care hours data from May 2016 – May 2017 remain relatively consistent.



Data held within the Model Hospital portal has not been updated since March 2017 when it was reported to the Board of Directors.

3c. Safe Staffing and Efficiency

A cap of agency expenditure for registered general and specialist nursing staff, midwives and health visitors has been in place since November 2015. The annual ceiling for DBHFT has been set at the lowest level of 3% which is a reflection of the relatively low level of bank and agency usage when compared to the national picture. The Registered Nurse rate for May is 1.0%, a decrease from April which was 2.2%, so well within the 3% cap level.

Information relating to the use of off-framework, high cost nursing agency staff continues to be reported to NHSI on a weekly basis, as does the work to eliminate the use of off framework agencies so that the Trust is compliant with the guidance.

3d. Nurse Manager Clinical Time

To ensure that the Heads of Nursing, Head of Midwifery and Matrons have a visible presence in the clinical areas HoN/Ms have identified that they are aiming to work at least one clinical shift a month in one of their clinical areas, with the Matrons working two clinical shifts a month. This information is collected as part of the monthly Hard Truths returns. In addition senior sisters/charge nurses are expected to have 2 days per week as managerial/supernumerary time and this information is also being recorded monthly.

The Clinical and Supervisory Time in May 2017 was:

Care Group	HoN/M Clinical Time	Matrons Clinical Time	Ward Supervisory Time
Surgical			
MSK and Frailty			
Specialty Service			
Emergency			
Obstetrics and Gynae			
Children's			

The majority of HoN/M's and the Matrons have undertaken their clinical time in order to support ward areas clinically. The Specialties Care Group, HoN was on a "phased return" following sick leave and the Children's Service have prioritised duties to support staff through their external commitments during May.

Approximately half of senior sisters/charge nurses have been unable to fully maintain their 2 days a week supernumerary time as they have been working clinically due to staffing and operational challenges during May.

3e. Quality and Safety Profile

The Quality Metrics (appendix 1) for adult wards include 18 indicators that cover each of the five CQC Key Assessment Criteria (safe, effective, caring and responsive, with the overall score illustrating well led). The review of the Metrics has increased to 18 measures in 2017/18, mainly comprised of data that is collected for other purposes. For metrics that have continued from previous years, there has been a resetting of the baseline to the outturn of 2016/17, revising trajectories for CDI, PU, falls with harm and multiple falls. New measures for this year include the complaint/concern rate, category 2 pressure ulcers and the audit of appropriate fluid balance chart use linked with work to reduce the impact of acute kidney injury.

The quality data for May illustrates Ward 17 being assessed as red for quality and therefore a quality summit is planned in the coming few weeks.

The quality summit process is a management meeting with the Matron and Head of Nursing for the relevant area, led by the Acting Deputy Director of Quality and Governance.

The 2016/17 end of year position for the Quality Assurance Tool outcomes has been finalised, with a presentation of outcomes held at a celebratory event on 26th May 2017. The ratings for the end of year position are shown in the summary table for Quality Metrics.

4. PLANNED ACTIONS AND KEY RISKS

The major issue facing most acute hospitals nationally, and locally, continues to be the challenge of filling qualified vacancies. The actions to mitigate the risks which have been detailed in previous papers are continuing, along with systems and processes to meet the expectations outlined in the safe staffing and efficiency correspondence. These are:

- The Trust has put measures in place to reduce use of non-framework agencies and to minimise the breaching of the price cap.
- Monitoring and use of escalation processes are in place to tightly control use of registered and non-registered agency usage
- Continue to progress the Non-Medical workforce utilisation programme as part of DBH Strategy and Improvement programme utilising enabling tools e.g. Calderdale Framework, including;
    - Challenging and reviewing skill mix to make better use of Non-registered staff exploring the development of extended roles
    - Reviewing the non-ward staff roles and responsibilities
    - Reviewing the wards with higher usage of specialling
- Provide further detailed comparison CHPPD data as this becomes available nationally
- Continue to explore recruitment opportunities for nursing and midwifery
- Complete AUKUH data collection from 01 July, ward nurse staffing requirements will be available to the Board of Directors in September 2017.

5. RECOMMENDATION

The Board of Directors is asked to NOTE the content of this paper and SUPPORT the identified actions.

APPENDIX 1: HARD TRUTHS June 2017 Paper

ce /Quality/Safety Profiles May 2017 Data

				anned v Actu	Safe	Effective	Caring	Responsive	Well Led	Profile		WQAT annual assessment 2015/6	WQAT annual assessment 2016/17
Care Group	Matron	Ward	No of Funded Beds	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality	Rating	Rating
Surgical	NS	B6	16	84%	0.5	0.0	0.0	1.0	1.5				
	NS	20	27	102%	0.5	1.0	2.5	1.5	5.5				
	NS	21	27	101%	0.5	1.0	0.0	1.0	2.5				
	LM	S12	20	103%	0.5	0.0	1.0	2.0	3.5				
	RF	SAW	21	96%	0.5	0.0	3.0	2.0	5.5				
	LC	ITU DRI	20	99%	0.5	0.0	0.0	2.5	3.0				
	LC	ITU BDGH	6	88%	0.0	0.0	0.0	1.0	1.0				
				97%									
MSK and Frailty	SS	A4	24	98%	1.0	0.0	0.0	1.0	2.0				
	SS	B5	30.7	98%	0.5	1.0	0.0	1.5	3.0				
	AH	St Leger	35	97%	1.0	1.0	2.0	1.5	5.5				
	AH	1&3	23	109%	0.5	0.5	0.0	1.5	2.5				
	SS	Mallard	16	111%	1.0	1.0	0.0	1.5	3.5				
	SS	Gresley	32	113%	0.0	1.0	0.0	1.5	2.5				
	SS	Stirling	16	104%	0.0	1.0	0.5	1.0	2.5				
	KM	Adwick (rehab2)	29	123%	1.0	0.0	0.0	2.0	3.0				
	KM	Wentworth (rehab1)	29	103%	0.0	0.0	0.5	2.0	2.5				
				106%									
Specialty Service	JP	18	12	100%	0.5	1.0	0.0	1.0	2.5				
	JP	18 CCU	12	100%	0.5	0.0	0.0	2.0	2.5				
	AW	32	18	97%	1.0	0.0	0.5	2.0	3.5				
	AW	16	24	113%	0.5	0.0	1.0	2.0	3.5				
	RM	17	24	98%	2.0	1.0	3.0	4.0	10.0				
	JP	CCU/C2	18	102%	2.0	0.0	0.0	2.0	4.0				
	RM	S10	20	93%	1.0	0.0	0.5	1.0	2.5				
	RM	S11	19	99%	0.5	0.5	0.0	2.0	3.0				
				101%									
Emergency	MH	ATC	21	96%	1.0	0.5	1.0	1.5	4.0				
	SS	AMU	40	104%	3.0	1.0	1.0	2.5	7.5				
	MH	A5	16	108%	1.0	0.5	0.0	3.5	5.0				
	MH	C1	24	101%	1.5	0.0	1.0	2.0	4.5				
	SC	24	24	103%	1.5	1.5	2.0	1.5	6.5				
	SC	25	16	102%	2.0	0.5	1.5	2.5	6.5				
	SC	Respiratory unit	56	97%	2.5	1.0	2.5	2.0	8.0				
				101%									
Children and Families	AB	SCBU	8	102%	0.0	0.0	0.0	1.0	1.0				
	AB	NNU	18	96%	0.0	0.0	0.0	2.0	2.0				
	AB	CHW	18	97%	0.0	0.0	0.0	1.0	1.0				
	AB	COU/CSU	21	94%	0.0	0.0	0.0	0.0	0.0				
	SS	G5	24	94%	0.0	0.5	1.0	2.0	3.5				
	SS	M1	26	91%	0.0	2.0	0.5	1.5	4.0				
	SS	M2	18	93%	0.0	1.5	1.0	1.5	4.0				
	SS	CDS	14	90%	0.0	0.0	1.5	1.5	3.0				
	SS	A2	18	92%	0.0	2.0	0.0	2.0	4.0				
	SS	A2L	6	76%	0.0	0.0	1.0	1.5	2.5				
				91%									
		Trust Position		100%									

Appendix 1. Quality Indicator Metrics

Measure	Detail	Parameters			
		Red	Amber	Green	Blue
SI's (excluding pressure ulcers)	number (avoidable)	any		none	none
Falls resulting in harm	number per 1000 bed days per month against trajectory	more falls than 2014/5	Same number of falls as last year	less falls than last year (by 0.1-9.9%) less than trajectory	exceeds 10% improvement and no avoidable
Repeated falls	number per 1000 bed days per month against trajectory	more multiple falls than 2014/15	same number of repeated falls as last year	within trajectory	exceeds 10% improvement
Clostridium Difficile	number against trajectory plan	exceeds trajectory		within trajectory	better than trajectory and no avoidable
Safety thermometer - pt harms	% new harms (new P ulcers, new VTE's and new UTI's)	<92% harm free	92-93% harms free	93-95% harm free	>95% harm free
Pressure ulcers	avoidable severe Pressure Ulcers	exceeds trajectory		within trajectory	better than trajectory and no avoidable
Physiological observation audit	Productive ward data until Safety Facilitators review	<85%	85-94.9%	>=95%	>=98%
FFT INPATIENT					
FFT	net adopter - % positive scores	Less than 94%	94% - 95.49%	95.5% - 96.99%	97% and above
FFT	Unlikely to recommend	Greater than 1%	0.5% - 1%	0.1% - 0.5%	0%
FFT	response rate	Less thsiu 23%	23% - 29.49%	29.5% - 35.99%	36% and above
FFT MATERNITY TOUCH POINT 1					
FFT	net adopter - % positive scores	Less than 91%	91% - 94.49%	94.5% - 97.99%	98% and above
FFT	Unlikely to recommend	Greater than 2%	1.5% - 2%	1% - 1.49%	Less than 1%
FFT MATERNITY TOUCH POINT 2					
FFT	net adopter - % positive scores	Less than 93%	93.01 - 95.49%	95.5% - 97.99%	98% and above
FFT	Unlikely to recommend	Greater than 1%	0.5% - 1%	0.1% - 0.5%	0%
FFT	response rate	Less than 38.5%	38.5% - 64.99%	65% - 76.99%	77% and above
FFT MATERNITY TOUCH POINT 3					
FFT	net adopter - % positive scores	Less than 88%	86% - 91.49%	91.5% - 96.99%	97% and above
FFT	Unlikely to recommend	4% and above	2.6% - 3.99%	1.0% - 2.59%	Below 1%
FFT MATERNITY TOUCH POINT 4					
FFT	net adopter - % positive scores	Less than 80%	80.01% - 89.99%	90% - 98.99%	99% and above
FFT	Unlikely to recommend	2.0% and above	1.5% - 1.99%	1.0% - 1.49%	Below 1%
OVERALL RATING		2 or more Red	1 Red indicator OR 2 Amber indicators	No red indicators OR 2 Blue Indicators OR 1 amber, 1 green 1 Blue	2 or more blue indicators with 1 green indicator
Patient discharges	35% discharges before 12 noon	<2014	between Trust 2014 result and 35%	meet target of 35%	Meet 35% target and a 10% improvement on 2014 ward result
Length of Stay	reduce LOS by 10% based on 2014/5 out-turn	>LOS from 2014/5	A longer LOS than Dr foster case mix adjusted LOS but improved by 10% from 2014/5	At the Dr Foster case mix adjusted LOS or less	Lower than Dr Foster case mix adjusted LOS by 10%exceeds 10% improvement and no avoidable
Appraisal	rolling 12 month appraisal rate	<65%	65%-89%	>90%	>92%
Statutory and Essential to Role training	rolling SET training rate	<65%	65%-89%	>90%	>92%
E roster	effective time should be 76%	>80% or less than 70%	77-80% or 75-70%	75-77	green for 6 months
Complaints attributed to Care Group	Care Group rather than ward level	>complaints than 2014/5	Same number as 2014/5	less complaints than 2014/5	less complaints than 2014 and exceeds 10% improvement

No avoidable
Results in top 10% consistently - 75% of time including 2 months prior to assesment
Results above 2014/15 and through assessment period with 50% being in top 20%
Results above 2014/15 and through assessment period but not in top 20%
results below 2014/5

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Well Led Governance Review**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Matthew Kane, Trust Board Secretary**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues

In line with the NHSI Code of Governance and the Trust's enforcement undertakings given on 29 February 2016 the Board of Directors commissioned an external review of its governance arrangements under the Well Led Framework with the review being undertaken during Q3 2016/17.

The review was carried out by Deloitte LLP and examined the Trust's approach towards the four domains of the Well Led framework:

- strategy and planning;
- capability and culture;
- process and structures; and
- measurement.

The review made 18 recommendations which were approved at Board on 31 January. A working group comprising the Chair, Chief Executive, two NEDs and the Trust Board Secretary was established to scope the actions that would contribute to each of the recommendations.

Attached is the action plan together with progress against each of the recommendations. To help Board distinguish between those actions that it is directly involved in and those driven by management, Board-level and operational actions have been separated.

Key questions posed by the report

- Is the Board assured that the Well Led action plan is being addressed?

- Are there any areas for concern or further work?
- In what ways can the action plan be improved?

How this report contributes to the delivery of the strategic objectives

A number of the areas in progress contribute to the corporate objectives particularly around board development, partnership working and the development of tools to monitor progress against the strategic ambitions.

How this report impacts on current risks or highlights new risks

This action plan provides assurance against key risks identified in the Corporate Risk Register including engagement of staff, partnership working and achievement of operational performance.

Recommendation(s) and next steps

That Board notes progress in respect of the Well Led action plan.

Board Level Actions

Recommendation	Report ref and page	Actions planned	Action Owner	Lead	Target date	Expected impacts	Evidence and progress	RAG rating
The new Chair should revisit the Board calendar to enable greater time to focus on strategic development and monitoring. As part of this process, there needs to be collective agreement amongst the Board on the gaps and priorities for debate in this area.	1A Page 15	Remove unminuted 'Board Brief' and use Part 2 Board meetings to ensure discussions on strategy are recorded and captured in the Board domain.	Trust Board Secretary	Chief Executive	Mar-17	Clarity of strategic objectives Strategy undertaken more visibly at Board level Board given greater understanding of what is happening on the ground Strategy kept refreshed and relevant Strategy aligned to STP in South Yorkshire Greater partnership working across SY trusts	Board Brief concluded January 2017 and strategy items included on Board agenda from March 2017. Care groups and corporate directorates invited to highlight best practice to Board - so far received presentations on bariatric surgery, R&D and patient experience. Board has received presentations on strategic direction – April 2017. Also board strategy day planned for June 2017.	
		Invite care groups and others to give Board regular 'insight' presentations into a specialism, area of good practice or lesson learned within their area	Trust Board Secretary		Mar-17			
		Hold annual Board strategy workshops for strategic developments and to consider any amendments to strategic objectives	Director of S&I		Jun-17			
Ensure that there is consistent and explicit review of progress against strategic objectives, including a focus on impact and outcomes, at Board and committee level.	1A Page 16	Develop a quarterly 'exception' report for Board showing progress against strategic objectives, focussed on outcomes rather than activity. The report to show recent trends but also look forward, anticipating potential downturns in performance and identifying suitable mitigation	Director of S&I	Chief Executive	Jul-17	Closer monitoring of strategic objectives Board in a better position to pre-empt downturns in performance and formulate action plans to address them	New performance report in development. Chair and NEDs have set objectives to develop strategic thinking. Chair and CEO are participating actively in the WTP/STP in South Yorkshire and executives are members on STP work-streams Strategic direction reviewed at Board in April 2017. Mission and values reviewed as part of Exec Team Strategy Session in April 2017 and Board Strategy session June 2017.	
		Board should review mission, vision and values to ensure it is still relevant to illustrate what kind of organisation the Board expects it to be			Jun-17			
Ensure that the annual planning process is clearly documented, is fully understood by all involved, and enables sufficient interaction between the Board and Care Groups throughout the year.	1A Page 16	Produce an annual calendar of activities of the corporate year to include business and CIP planning, appraisals, annual report, contract agreement etc	Trust Board Secretary following consultation with execs and Exec Team	Chief Executive	Jun-17	Care groups have clear sight of the 'rhythm of the Board' and feel more engaged in corporate business planning	Calendar to be developed in light of new Board committee structure being approved. New leadership development programme being put in place to enhance care group leadership capability.	
		Calendar to be monitored by Management Board each month. Deviations from plan to be addressed in action plan goes to the new F&P Committee.	Trust Board Secretary following consultation with execs and Exec Team		Jun-17			
		Process to empower care group leadership triumvirate to run the care group in line with budget, pilot new ideas, present business cases for change and break even or produce surplus for reinvestment	Chief Operations Officer		Jun-17			
The format and use of the BAF and CRR need to be revised to take into account the commentary made in 1B.1: -The need to refresh training for all staff has been recognised; -Risk reporting and scrutiny at a Care Group level requires significant formalisation in order to ensure robust escalation to the Corporate Risk Register (CRR); -The value added by the CRR and Board Assurance Framework needs to be reviewed as we noted confusion around their purpose at both Board and senior management level.	1B Page 19	Arrange risk training for senior managers within DBTH	Deputy Director – Governance and Quality/Trust Board Secretary	Chief Executive	Jul-17	Heightened profile of risk management across the organisation Main assurance tool focussed around strategic risks and operational issues rather than simply being a summary of the risk register Increased awareness of risk in organisation and of purpose of BAF amongst senior managers Compliance with best practice Board is trained and guided on how to use the new BAF and ensure that they see evidence which mitigates risks as a regular reporting process.	Presentation for Exec Team on purpose of BAF and CRR which set out change was considered and agreed in April 2017. New BAF and CRR in development following meetings of F&P and QEC in May and June. Presented to Executive Team 21 June 2017. New committee TORs and work-plans now include rotational deep dives into relevant areas of strategy and risk - F&P and QEC holding the first of these June 2017. Deputy COO developing standard care group agendas which will incliude standing risk escalation items.	
		Include standing risk escalation item on care group agendas	Chief Operating Officer		Jun-17			
		Develop a report for Exec Team explaining purpose of BAF and proposal for changes then implement change	Trust Board Secretary		Jun-17			
		Assurance and risk mapping exercise to be undertaken by new Board committees	Trust Board Secretary		Jun-17			
		New BAF to be formulated focussing on current strategic objectives and operational issues as well as horizon threats/opportunities	Trust Board Secretary		Jun-17			
		Develop new BAF further with NED committees and approve through Management Board	Trust Board Secretary		Jun-17			
		Include on new committee TORs and work-plans rotational deep dives into relevant risks to provide further assurance to Board	Trust Board Secretary		Jun-17			
Further develop the CIP planning and execution process by: • Ensuring that all CIPs have sufficient clinical engagement at both the identification, QIA and sign-off stage; • That all major schemes are subjected to a post-implementation review which incorporates staff and patient feedback (e.g. through surveys); • Strengthening CIP assurance reporting from the Turnaround Programme Board to the F&P and QEC	1B Page 20	Develop a report to MB detailing how future CIP process will function to include: - New language for CIPs - Impact on CCG - Quality impact on proposals - Benefits and quality of experience for patient	Director of S&I	Director of S&I	Jul-17	Service changes recognised as clinically led Workforce sees CIP process as bottom up not top down and is about improvement not just cost reduction External assurance of PIR process through audit process	New language for CIPS adopted and clinical input mapped for each workstream to ensure it is sufficient and appropriately focussed. PIR process under review with further development on benefits realisation included. Turnaround Board amended to Transformation Board and action notes will be shared with F&P and QEC.	
		Ensure Internal Audit Plan 2017/18 includes audit of PIR process	Director of S&I	Director of S&I	Jul-17	Quality impact clearly evidenced through quality committee		
Implement a programme of development for the executive team and Board. This should focus on the points outlined within the Well Led report, and build in greater time for strategy as well as team development.	2A Page 22	Arrange an externally facilitated Board development session with dates throughout the year around: - the unitary board; - board behaviours; - functional and dysfunctional boards; - horizon scanning; and - giving and receiving constructive challenge.	Director of People & OD	Chief Executive	Jun-17	Increased calibre of debate and scrutiny Greater mutual support amongst executives A Board more representative of its members and wider patient community Chair to draw executives into debate more where appropriate Clearer alignment to the NHS 50:50 by 2020 report	Board Development Programme to commence on 27 June 2017 and be followed by Strategy session (28 June) and team building event. Plans being put in place for NED recruitment - external offer of help provided by Chair of York Teaching Hospitals. Executives now members of F&P and QEC.	
		As part of NED recruitment in 2018, develop a paper focussing on Board diversity including regulatory expectations and proposed open recruitment process to be presented to Governors' A&R Committee in the Summer with a view to starting a programme of selection in early 2018 and spreading awareness of the Trust's interest in having a diverse board	Trust Board Secretary		Aug-17			
		Executives to join as members of committees	Trust Board Secretary		Jun-17			

As part of its refresh in 2017 ensure that the People and Organisational Development Strategy includes a more explicit focus on equality and diversity throughout all job roles and levels in the Trust.	2A Page 22	Develop specific E&D policy and action plan around protected characteristics including how to attract a diverse workforce, governors and board	Director of People & OD	Director of People & OD	Jun-17	Trust's E&D initiatives underpinned by sound policy and principles Commitment to prioritising E&D rather than seeing it as an 'add on' Reports to Board and statistical analysis of diversity	Equality and diversity policy in development. A new E&D group has been established with a number of activities taking place across the Trust.	
Reconsider how NEDs and governors engage meaningfully with staff and gain assurance within their current time allocation at the Trust, including through refreshing the existing NED service visits.	2B Page 24	NEDs to take a full part in Board Development activity and new Governor briefings.	Trust Board Secretary	Chief Executive	Mar-17	Increased NED visibility Increased NED knowledge of ward challenges and best practice Clarity on processes and opportunity to see good practice and ask questions regarding ideas for change and improvement More teams presenting reports to Board	Chair and NEDs attending board development and governor briefings. NEDs now invited to QAT and CQC assessment visits. Programme of presentations at Board meetings in place and embedded.	
		Revise protocol on NED/Governor ward visits to focus on peer assessment and the NED ambassadorial role	Deputy Director – Governance and Quality/Trust Board Secretary		Jul-17			
		Include NEDs sometimes in QAT and CQC clinical assessment visits	Trust Board Secretary		Mar-17			
		Schedule Board presentation on clinical assessment with a focus on fluid balance and health promotion	Trust Board Secretary		Jun-17			
		Hold a rolling programme of presentations at public Board meetings on key operational areas	Trust Board Secretary		Mar-17			
To further increase the effectiveness of ANCRC, the Trust should: •Update the committee work plan to reflect the revised terms of reference, incorporating the elements of good practice referenced in 3.A.1; •Maintain the more concerted focus on follow-up of internal audit recommendations in line with the proposals made in September 2016; •Increase the level of focus and scrutiny on the effectiveness of risk management arrangements; and •Review the reporting lines for the ANCRC sub-groups.	3A Page 28	Undertake review of committees, their terms of reference and workplans, to align them to the Single Oversight Framework and strategic diretcion.	Trust Board Secretary with DoF	Chief Executive	Jun-17	Compliance with best practice Clear accountability structures Increased ability to handle strategic and operational risk	ANCR reviewed and additions made to workplan. Reporting lines for H&S Group to be reviewed in July following receipt of findings from KPMG.	
		KPMG to explore reporting lines in other trusts for IG and H&S Groups and feed back to ANCR	KPMG		Jul-17			
		Highlighted best practice to be added to the ANCR workplan	Trust Board Secretary		Jun-17			
CGOC should: •Consider ways in which it can better align its agenda to the Quality Strategy goals to increase focus in this area, and also awareness of the strategy; •Using the BIR as a starting point, introduce a CGOC dashboard to direct debate towards key areas of exception and redress the balance of committee reporting between analysis and narrative; •Ensure that items which are not relevant to the ToR are appropriately referred to FOC or ANCRC; and •Update the ToR and work plan to reflect the good practice areas discussed in this report.	3A Page 29	Undertake review of committees, their terms of reference and workplans, to align them to the Single Oversight Framework and strategic diretcion.	Trust Board Secrtary with MD, DONS and DP&OD	Chief Executive	Jun-17	Better alignment with Single Oversight Framework and strategic objectives Compliance with best practice	CGOC recast as Quality and Effectiveness Committee with revised TOR and workplan aligned to SOF and strategic diretcion. Proposed additions incorporated.	
Revise FOC to expand the focus of the committee, including greater focus on: capital and investment priorities and plans; performance against plan, and SLR. As part of these changes, the Trust should seek to reduce any existing duplication between the work of FOC and other forums.	3A Page 29	To review and recast FinOC as the Finance and Performance Committee incorporating quality and workforce aspects with terms of reference to incorporate the points identified by Well Led and Internal/External Audit.	Trust Board Secretary with DOF and COO	Chief Executive	Jun-17	Better alignment with Single Oversight Framework and strategic objectives Compliance with best practice	FinOC recast as Finance and Performance Committee with revised TOR and workplan aligned to SOF and strategic diretcion. Proposed additions incorporated.	
Revise reporting lines for WEC so that quality aspects of its business are reported to CGOC, and workforce transformation and efficiency aspects are reported to FOC.	3A Page 30	Consider revised terms of reference in line with new Quality and Effectiveness Committee	Trust Board Secretary with Director of People & OD	Chief Executive	Jun-17	Compliance with best practice	As part of the new committee structure, WEC will report into Quality and Effectiveness Committee as it was felt reporting into two committees may result in a blurring of accountability. However, the Director of P&OD will sit on both the F&P and QEC to ensure relevant issues are reported into the relevant committee.	
In preparation for the forthcoming changes in the Board, a stakeholder mapping exercise should be undertaken to ensure clear responsibility and transition of relationships.	3C Page 34	Identify key stakeholders	Trust Board Secretary	Chief Executive	Jun-17	Clarity of, and good relationships with, local and national partners Strategy will allow the Trust to see where the value of its partnerships lie and to invest time appropriately	Key meetings have been arranged with the CCGs, Council, Universities, Members of Parliament and relevant Chairs/CEOs of other trusts. Wider engagement strategy in development.	
		Arrange meetings for Chair/Chief Executive with identified key stakeholders						
		Develop a wider engagement strategy to include key principles, audiences and delivery	Head of Communications and Engagement		Jun-17			
Update the BIR to incorporate the elements of good practice defined in 4A.1: –Greater alignment of indicators to the Trust's strategic objectives; –The inclusion of data quality kite marks as planned; –Improving the timeliness of information which usually has a lag of two months; and –Greater use of performance forecasts.	4A Page 35	Develop an integrated BIR report to Board to include metrics on: - quality; - patient experience; - research; and - finance	Exec Team	Chief Executive	Jul-17	Compliance with best practice	Nine key metrics have been initially identified to report on and the first version of the revised BIR was brought to Exec Team in June.	

Operational Actions

Recommendation	Report ref and page	Actions planned	Action Owner	Lead	Target date	Expected impacts	Evidence and progress	RAG rating
Undertake a review of the frequency and effectiveness of service and speciality level clinical governance meetings, addressing any findings and reporting assurance on progress to the CGOC.	2C Page 26	Develop a new kite mark approach for CG meetings on the basis of earned autonomy with a standard agenda to include: - risks; - learning and development; - performance; - learning from complaints	Medical Director and DoNS	Medical Director and DoNS	Jun-17	Consistency of approach to CG meetings Increased staff engagement and involvement	The frequency of Care Group and Specialty level meetings has been reviewed and monitored monthly centrally by the Governance office. This has formed part of the CGC reports to QEC. There has been significant improvement in attendance at both Care Group and Specialty level governance meetings. Effectiveness of Care Group governance meetings was undertaken in the summer of 2016, and findings were addressed through Care Group Governance Lead appraisals. Effectiveness of specialty governance teams is to be undertaken by the Care Groups during the next few months. Standard template agenda and workplan for both Care Group and Specialty governance meetings are in place (which includes risks, learning and development, learning from complaints). Performance is addressed through the Care Group Accountability meetings with the Chief Operating Officer. Care Groups report on a six monthly basis to CGC on set objectives. These have been reviewed for 2017/18 using HED metrics. Metrics have been developed for each Care Group. A paper will go to CGC in July with set targets for each of the metrics to be agreed with Care Groups.	
		Assurance provided in the form of a regular report to the CGQC.			Jun-17			
Alongside recommendation 10 to review specialty level CG structures the Trust should also review the arrangements for ward teams to meet to discuss learning and improvement alongside introduction of a standard agenda for discussion which should include team level quality performance data.	2C Page 26	As per recommendation 10	Medical Director	Medical Director	Jun-17	Consistency of approach to ward team meetings Increased staff engagement and involvement	Ward staff attend Specialty clinical governance meetings which follows a standard template agenda. Ward Managers feed into the governance process and disseminate key learning at ward level. Ward Managers hold ward meetings to monitor the Ward Quality Assessment Tool – which is regularly assessed by the Matron and formally assessed by an external Head of Nursing (and team) to award appropriate RAG rating. Safety Thermometer data is shared at ward level. Hard Truths data is shared and discussed at ward level	
The Trust should look to rationalise its performance and structures at Care Group level, where possible creating a single forum for holding each Care Group to account for delivery and performance. These should have consistent ToR, agendas and governance structures and should take place at a frequency appropriate to the track record of performance and delivery in each group.	3B Page 32	Review and rationalise the current CG accountability meetings, grip and control meetings, and cancer, A&E and RTT meetings in each care group	COO	COO	Jul-17	Increased autonomy for sustained high levels of performance and delivery Reduced duplication Performance of care groups reported through new F&P Committee. Care groups attend to be held to account.	Rationalisation of CG accountability meetings is being considered through the Single Oversight Framework by the DoSI. The Deputy Chief Operating Officer is currently undertaking a piece of work around standardising CG meetings.	
		Ensure sufficient formalisation of CG meetings through a common agenda and papers, aligned to the Trust's strategic priorities						
		Ensure action logs capture timescales, action owners and monitoring arrangements						
		Develop a consistent set of dashboards with a separate paper outlining the five key risks for each care group to be presented at each relevant CG meeting						

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**CQC inspection update**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Moira Hardy – Acting Director of Nursing, Midwifery and Quality** **Rick Dickinson – Acting Deputy Director of Nursing, Midwifery and Quality**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✓
	Information		

Executive summary containing key messages and issues

The CQC has responded to a consultation on the next phase of regulation for providers following the completion of comprehensive inspections. The key points for the Trust are:

- A new monitoring framework has been outlined called CQC Insights
- There will be annual Provider Information Request (PIR) covering the Trust Well Led arrangements and core services in an acute hospital context.
- Core service inspections (unannounced), accompanied by a Well Led inspection (announced) will be the norm, targeting a proportional inspection frequency to overall and service ratings, with annual inspections whilst a Trust or core service is Inadequate.
- There will be the potential for a ratings review where core services are reviewed along with Well Led Trust level inspection, with professional judgement guidance being refreshed.

Engagement meetings with the CQC continue on a quarterly basis, with occasional issues being raised with the Trust by the CQC, in a similar frequency to the previous months and year.

Self-assessment and mock inspection activities are being refreshed across the Trust, by Care Groups, with independent checks from the DNS team.

There are some services which require interventions to improve their quality of services in order to achieve a good rating.

It is likely that the Trust will receive a PIR and have an unannounced inspection in the coming months, focusing on requires improvement core services and will be followed with an announced Well Led inspection.

Key questions posed by the report

- How does the Trust achieve monitoring of the quality of services provided in order to determine the level of compliance to the CQC essential standards?
- How does the variability of day to day activities and human behavior impact on the risk

of compliance?

- What is the impact and potential duplication of regulators duties and stakeholders in providing information, assurance and demonstrating good quality care?
- Are the systems of Ward Quality Assurance Tools and self-assessment through care group mock inspection and internal independent mock inspection processes able to adequately assess the overall characteristics of good quality care in all core service areas?

How this report contributes to the delivery of the strategic objectives

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Focus on innovation for improvement
- Develop responsibly, delivering the right services with the right staff

How this report impacts on current risks or highlights new risks

- Self-assessment helps to identify quality issues and risks by virtue of testing the systems in place.
- The triangulation of externally reported data, local intelligence and exposure through the CQC's revised Key Lines of Enquiry assists the Trust to identify issues before a regulator.
- The CQC template for information requests from providers organisations exposes opportunities to prepare, check and verify the data requested and take actions where necessary to tackle issues that can be identified through analysis.

Recommendation(s) and next steps

- Continue engagement meetings with the CQC hospital inspection team.
- Mock inspections and self-assessment processes are taken across all services to highlight issues that could impact on the objective of achieving good or better core service and well led inspection ratings.

CQC

1. CQC Inspection & Publication of Reports

The Trust underwent a comprehensive inspection by the Care Quality Commission (CQC) commencing on 14 April 2015, with unannounced visits 2 weeks later.

2. Engagement meetings

The most recent engagement meeting took place on 25 May 2017. At this time the CQC were poised to share the outcome of their consultation on how to inspect and monitor NHS organisations. During the meeting issues that have been raised were discussed and updates provided. The rate of issues raised remains at a similar level to recent months, with occasional issues being raised with the Trust. There is no specific inspection schedule shared by the CQC, but did highlight the outline on what changes were being considered for the consultation. It is recognised that there is an increasing likelihood of inspection as it is 2 years since the comprehensive inspection.

3. Update on CQC response to its next phase of regulation consultation

The CQC have provided a report on their response to the consultation described above, which considers new models of care, assessment frameworks and changes to the regulation of NHS Trusts. This can be found here:
http://www.cqc.org.uk/sites/default/files/20170612_next%20phase%20consultation%201%20response_final.pdf

The key points are:

Monitoring – using CQC Insight, which is a collated set of data from existing data collections. The Insight reporting arrangements will be highlighted when they are published, following a pilot in each type of provider. We anticipate that they will have some overlaps with the HEDLines dataset and Single Oversight Framework.

Relationship management – Expected to be quarterly meetings with an improved structure as found to be helpful to organisations who responded, which concurs with the ongoing benefits of working towards this with CQC hospital inspectors.

Provider Information Requests (PIR) – An annual data collection will take place, in a cycle that would enable there to be responsive inspection of services. This is being commenced from mid-June, so anticipate receiving the request in the coming weeks. The template for this has been published, so is being considered with the NHS Improvement Well Led framework which overlaps parts of the Well Led domain. The templates (Trust level and Sector) can be found here:
http://www.cqc.org.uk/guidance-providers/nhs-trusts/provider-information-request-pir-nhs-trusts

Inspections – Well led inspections are to be undertaken as a Trust Level activity. Core service inspections are proposed to be proportionally inspected, with annual review for Inadequate

services, half of those rated Requires Improvement, a third of the Good rated and one fifth of Outstanding rated. These inspections will be unannounced in the main. The Inspections fall into 3 main areas:

- Core Service with Well Led – Scope of the Core Service and a smaller team than a comprehensive
- Comprehensive – Trust wide inspection, all core services and will be rarely used.
- Focused – targeted to a specific theme or activity.

Accreditation schemes – where they exist they will be considered, but not preclude the need for an inspection. The CQC sought to have accreditation processes aligned to their structure of inspection, but would not penalise any absence in accreditation.

Rating – Provider level rating for Trusts will remain, and there will be hospital level inspection reports and ratings. There will be scope for more professional judgement in the inspection rating determination. This is set out in the Ratings principles section of the provider guidance: How the CQC regulates NHS Trusts.

Other aspects are unchanged, including enforcement actions, displaying ratings and factual accuracy of reports.

Supporting documents that guide how the CQC will manage their processes and inspections and set out the key lines of enquiry (KLOE) that will be considered in an inspection, with ratings characteristics for each KLOE.
http://www.cqc.org.uk/sites/default/files/20170612-how-cqc-regulates-nhs-trusts-v1-1.pdf
http://www.cqc.org.uk/sites/default/files/20170609_Healthcare-services-KLOEs-prompts-and-characteristics-FINAL.pdf

4. Self-assessment and mock inspection

The Care Groups are undertaking self assessments and mock inspections of their services building on the last 6-9 months of activity in assessing the Quality Assurance Tool outcomes for wards. Most wards were assessed to be good, with 3 Outstanding and 3 as Requiring Improvement in 2016/17. The detail is provided in the Nurse Staffing report. The self-assessments returned so far highlight mainly Good outcome forecasts, with some specialties having some areas for improvement.

The core services that are expected to be inspected include:

- Urgent and Emergency Care
- Obstetrics and Gynaecology
- Outpatients (including radiology)

We anticipate exploration of mental health provision in an acute hospital, information governance, use of resources and health promotion to feature more prominently in the inspections and so will include these as part of future mock inspections.

To provide some independent scrutiny, the DNS team will also inspect unannounced and follow up on specific action points, in order to demonstrate embedded systems.

5. Conclusion

The revised approach set out following the most recent revision of CQC inspection methods provides an adjustment to the approach, but does not distract from the ongoing monitoring arrangements in the Trust. It does provide the opportunity to recognise the potential for an imminent inspection and take steps to ensure embedded changes in practice are sustained in order to provide safe, caring, effective, responsive care for our patients, with effective leadership, management and governance.

6. Next steps:

- Continue engagement meetings with the CQC hospital inspection team.
- Complete the actions identified from the CQC compliance internal audit
- Mock inspections and self-assessment processes are taken across all services to highlight issues that could impact on the objective of achieving good or better core service and well led inspection ratings.

7. Recommendation

The committee is asked to:

- Note the report and support the next steps identified above.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDS' Report**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Suzy Brain England, Chair**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The report covers the Chair and NEDs' activity in May/June 2017 and includes updates on a number of activities.
Key questions posed by the report
• Does the Board support the actions required to comply with the required best practice in respect of a more diverse Board? • In support of the Chair's role with NHS Providers, what are the key issues for the Trust that the Board feel the Chair should develop as and when the opportunity arises? • How do we ensure we deliver our statutory responsibility to ensure new governors are adequately trained following recent elections?
How this report contributes to the delivery of the strategic objectives
The report relates to all of the strategic objectives.
How this report impacts on current risks or highlights new risks
The report highlights the Trust's position in relation to women on boards and the potential reputational and effectiveness risks should the Board not tackle its current challenges in this area.

Recommendation(s) and next steps
That the report be noted.

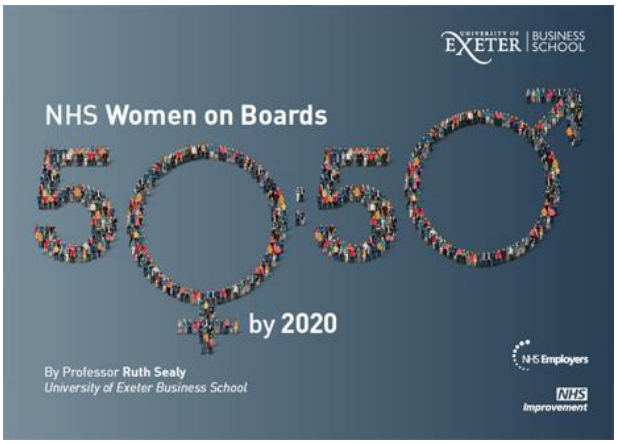
Chair's Report – June 2017

Women on Boards – 50/50 by 2020

Earlier this month I attended a seminar at the NHS Confederation Conference in Liverpool on Women on Boards. This was on the back of a letter to all chairs of NHS foundation trusts last year from NHS Improvement committing to achieving the goal of a 50/50 gender balance on all NHS boards by 2020 as well as a recent study by the University of Exeter Business School revealing high levels of female under-representation on NHS boards (a copy of this report was sent to you on 15 June).

It is a fact that while the NHS workforce is 77 per cent female, and women medical school graduates have outnumbered men since 1991, just 42.7 per cent of board seats are held by women and only 37.4 per cent of NEDs on trust boards are female. Executive roles are more or less balanced 50:50 although the report recognises there are significant imbalances in particular roles (DoFs are largely male whereas DONS are overwhelmingly female for instance).

At DBTH, despite the fact that 4/5ths of our workforce and two thirds of our senior managers and membership are female, only four women (30 per cent) hold voting rights on our Board of Directors. Excluding myself, only one of the six NEDs are female. This is an improvement on 2016 when DBTH closed the year with just one female voting Board member (8 per cent) but it is still way behind the northern average of 43.41 per cent.



Successive studies have found a correlation between gender balanced boards and better recruitment and retention, better outcomes for patients and better decision-making. A report by the King's Fund recognised a link between diversity, leadership, organisational performance, the quality of care and better use of resources. The private sector has already grasped this nettle through the Davies report.

In order to meet the 2020 challenge, which we expect will be mandated, we have to act soon. Accordingly, we will be taking a report to Governors at the end of the Summer 2017 seeking an open recruitment exercise for all NED positions whose terms of office end in 2018.

If we are to address the 50/50 2020 challenge then the governors should consider how to achieve this in planning for the NED terms which cease in 2018. In order to be fit for purpose to meet the 50:50 challenge by 2020 it is important that the Trust makes strenuous efforts to address its 'diversity deficiency'.

NHS Providers

I have been very thankful for the congratulations I received following my appointment as a trustee for acute services chair on the NHS Providers Board.

We already make use of a lot of their services, for example I will be at the NHSP Network Event on 20 June and I have asked that they come to Doncaster in the near future to give training to some of new and not so new governors as part of the governor induction programme.

I hope it will be extremely helpful and beneficial for the Trust and I hope we will all use this new national role to our full advantage.

Doncaster surgeon awarded OBE

I was delighted that Mr Muhammad Shahed Quraishi, a Consultant Ear, Nose and Throat (ENT) Surgeon was appointed an Officer of the Order of the British Empire (OBE) in the Queen's Birthday Honours List 2017. Mr Quraishi is a surgeon who has worked in the NHS for over 30 years, 16 of which have been at this Trust.

The prestigious accolade is recognition of the excellent care and treatment he has provided to the many patients he has seen over those years. It is also recognition for the thousands of patients he helped to treat indirectly through the expert training that he has provided to hundreds of trainee surgeons across the world through his innovative 'ENT Masterclass' programme. I am sure you will join me in congratulating him on this exemplary achievement.

Governor update

We welcome the following people on to the Board of Governors following recent elections:

- Mark Iain Bright and Lynne Logan in Doncaster
- Andrina Hardcastle, Peter Abell and Steven Marsh in Bassetlaw
- David Cuckson (returning) and Liz Staveley-Churton in Rest of England and Wales
- Lorraine Robinson (returning), Duncan Carratt and Karl Bower in the various staff constituencies.

They will take their seats on 23 June. We are also anticipating a new partner governor from Doncaster MBC to be announced shortly.

I would like to place on record our thanks to Peter Husselbee (Bassetlaw), John Plant (Doncaster) and Pat Knight (Partner) for their service as governors to the Trust over the past decade.

Some of the new governors will be attending the Timeout session on 26 June which focusses on our new governance for Charities, Friends and Family Test, Procurement and Perfect Ward.

We held another successful Governor Briefing on 13 June where Simon and Kirsty came to speak and answer governors' questions on cyber security and estates including the new catering contract. My thanks to everyone who attended the session.

WTP Meeting

Richard and I attended the Working Together Partnership Chairs' and Chief Executives' meeting on 5 June which focussed on Children's Surgery and Anaesthesia and the Sustainable Hospital Services Review.

Board should be aware that there is a discussion about aligning Board of Directors dates across the STP patch. I am aware some draft Board and committee dates for 2018 have already been circulated. We will keep you updated.

Tour of A&E

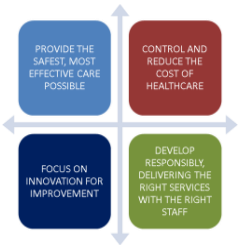
I will attend a walk-around of the Emergency Department at DRI on 21 June with Lesley Hammond and Kate Carville.

NED updates

Martin McAreavey chaired the Governor's briefing on 23 May which explored clinical developments and found it a very useful forum for updating Governors. He also attended two of the recent Friday lunchtime lectures, one on medical appraisal and one on the role of the Coroner's office. Both were well delivered, informative, and provided an opportunity to talk with staff and colleagues.

Martin chaired another Consultant appointments panel where a Histopathologist was successfully recruited. On 8 June, Martin attended the NHS Providers 'Quality Day' in London which included a talk on value based healthcare and 'Well-led for Quality', the latter explored the evidence relating to high quality healthcare organisations and Board behaviour. Other strategic issues included ANCR and the Annual Trust accounts as well as the preparation for the new Board sub-committee structure.

Chief Executive's Report
27 June 2017



SYB in first wave of Accountable Care Systems

I attended the NHS Confederation Conference earlier this month where South Yorkshire and Bassetlaw was announced as one of the first wave Accountable Care Systems by Simon Stevens. There is "indicative potential" for the eight ACS to access a share of £450m, over four years. The eight new ACS are:

- Frimley Health;
- South Yorkshire and Bassetlaw;
- Nottinghamshire, with an initial focus on Greater Nottingham and the southern part of the sustainability and transformation partnership;
- Blackpool and Fylde Coast, with the potential to spread to other parts of the Lancashire and South Cumbria STP at a later stage;
- Dorset;
- Luton, with Milton Keynes and Bedfordshire;
- West Berkshire; and
- Buckinghamshire.

In a letter to SYB chief executives, our STP lead Sir Andrew Cash indicated that, in exchange for taking on "accountability" for improving population health the SYB ACS will have the opportunity to take on delegated powers, bringing the potential for new relationships between partners including health regulators and assurers to better achieve the ambitions set out in the Sustainability and Transformation Plan and the five Place Based Plans.

This is clearly significant news for the region and the next step towards bringing more joined up and efficient health services to the SYB region.

CQC Surveys

There were some positive results from the latest CQC inpatient survey which was sent to 1,250 patients who were admitted at one of our sites last year.

The CQC asked people to answer questions about different aspects of their care and treatment and based on their responses we received a score out of 10 for each question (the higher the score the better). Here is a flavour:

• 8.9/10 patients staying in our hospitals have confidence and trust in the doctors treating them

• 9.0/10 patients staying in our hospitals describe the hospital room or wards as clean

• 9.1/10 of patients staying in our hospitals say they were offered a choice of food.

The results show we are on the right track for our upcoming inspection.

Assistant Nurse Practitioners

Staff involved in the training and education of health workers at Doncaster and Bassetlaw Teaching Hospitals are piloting a new role which will help improve care for patients.

The Assistant Practitioner role has been introduced as part of an 18 month pilot scheme, jointly funded by Health Education England and the Trust, in partnership with Sheffield College, to better meet the needs of the region's workforce.

Assistant Practitioners will help bridge the skills gap between an experienced Health Care Assistant and a Registered Nurse. The first group of 22 trainees embarked on their development programme at the end of January, with a further five starting 30 March.

Once qualified the 27 trainee Assistant Practitioners will support staff on specialist wards and clinical departments across Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital. They will also contribute to care for older patients and those with conditions of the muscles and skeleton (bones).

TriHealth on the move

On 25 May, TriHealth Doncaster moved its genitourinary medicine (GUM), sexual health and HIV services from Doncaster Royal Infirmary into East Laith Gate House, near Doncaster town centre.

The team will be joining the TriHealth Contraception Service, bringing Doncaster's sexual health services under the same roof, providing a one-stop location for local residents.

Improvements to mental health

The NHS Five Year Forward View identified the integration of mental and physical health as one of the key priorities for driving up the quality and efficiency of NHS care. By now we should be in no doubt of the pressing need to improve both the mental health support in general hospitals as well as the overall need to bring together mental and physical health care inside and outside of hospital settings. With their system-wide perspective, STPs are well placed to take the lead on this challenge, which is crucial to the future sustainability of NHS services.

To support each of the STPs in addressing this, NHS England has commissioned The Strategy Unit within Mids & Lancs CSU to develop a bespoke data pack for each STP which helps to make the case for integrating mental and physical health care for each STP area:

- The life expectancy gap between users and non-users of mental health services users, and how this gap compares to other STPs;
- The opportunities for reducing utilisation of acute services for different cohorts of people using mental health services in each STP;
- The financial savings that could be generated by better integrating the mental and physical health care; and
- The types of services we should be investing in in order to realise some of these savings.

Changes to email

Over the next few weeks, all Trust email accounts will be migrating to NHSmail 2. In a nutshell this means that instead of Joe.Bloggs@dbh.nhs.uk we will move to Joe.Bloggs@nhs.net. As the email system will be common across the sector, it is likely that many people will also have a number as part of their address.

FOCUS ON INNOVATION FOR IMPROVEMENT

NHSMail 2 is a secure email service and will be the only system that can be used for safely exchanging confidential patient information. By moving to @NHS.net we will have an improved communication service for the entire Trust and we will also have access to the NHS Directory, which contains contact details for many partner organisations within the health service.

We will roll-out this new service over the next few weeks, hoping to have the process completed by September. Before the migration happens, you will be notified of your new email address.

Advancements in Sepsis

The Trust has devised some Integrated Pathways of Care (IPOC's) to help recognise and treat Sepsis early.

Every year in the UK there are 150,000 cases of Sepsis, resulting in a staggering 44,000 deaths – more than bowel, breast and prostate cancer combined. Board members may have recently attended a Friday lunchtime lecture led by Dr Ken Agwuh where this was set out.

The new IPOC's will be launching soon into all acute areas and are in line with NICE guidance for the management and treatment of Sepsis - there are four new IPOCS with a fifth (around Maternity) to follow.

All clinical staff are encouraged to access Sepsis training via the National Patient Safety Suit's virtual college.

Changes to Well-led

NHSI has issued new guidance around changes to their Well Led framework.

Previously the NHSI framework and the CQC framework were different. Under new guidance issued this month the NHSI Well-led framework (KLOEs and the characteristics) is now wholly shared with the Care Quality Commission (CQC), and underpins CQC's regular regulatory assessments of the well-led question. Additionally, within the guidance, there are some specific questions that the CQC should ask as part of their examination of Well-led.

The framework is now made up of eight shared questions covering the following issues:

- Leadership, capacity and capability
- Vision and strategy
- Culture
- Responsibilities, roles and systems of accountability
- Risks and performance
- Information
- People, staff and external partner engagement
- Learning, improvement and innovation

Trusts are still required to have an externally facilitated governance review like DBTH had last year (known in the new guidance as a 'developmental review') but timescales have expanded from three years to 3-5 years and when trusts are required to do it will depend upon their segmentation within the Single Oversight Framework. In addition, the Board should undertake a performance review using the self-assessment tool (known in the guidance as a 'self-review') on an annual basis. The self-review should feed into the CQC inspection of Well-led.

NHS Improvement

We strongly encourage providers to use the new framework to undertake developmental reviews as part of their own continuous improvement.

<u>Queen's Speech 2017</u>

The Government's 2017 legislative programme was announced in the Queen's Speech on 21 June and included three areas for reform:

- A Draft Patient Safety Bill which will set out a framework to help improve patient safety in the NHS and instil greater public confidence in the provision of healthcare services in England.
- Mental health reform which will prioritise mental health within the NHS.
- Social care review which will consider options to improve the social care system and how it is financed.

<u>Meeting with NHS Improvement</u>

CONTROL AND REDUCE THE COST OF HEALTHCARE

I and members of the Executive Team met with Andrew Morgan, our regional NHSI Lead, last week to discuss the Trust's performance in relation to the following strands of the Single Oversight Framework:

- Finance and use of resources
- Operational performance
- Quality of care
- Strategic change

Andrew confirmed that the Trust continues to remain outside the list of trusts over whom NHSI have specific concerns. Our year end of year financial and operational performance should help to facilitate a move out of segmentation three later in the year, with or without an application to come out of breach with the Provider License.

Sector cuts financial deficit

Following the election, NHSI announced that the provider sector's deficit has been cut by two-thirds in the financial year just ended – from £2.4 billion in 2015/16 to £791 million in 2016/17. These figures represent an improvement of £1.7 billion, driven by savings of over £3.1 billion with over £700 million saved on locum and agency use in the year.

This is against a backdrop of rising demand and a significant increase in delayed transfers of care. NHSI's analysis showed that providers experienced a 24.5% increase in delayed days in 2016/17 compared to 2015/16. Locally we have significantly less delayed days than the sector average.

The challenge for NHS providers next year is to reduce the current planned deficit of around £500 million. This figure is based on the aggregation of provider plans and its delivery is dependent on a number of key assumptions around risk management, agreed activity levels and beds being freed up as the current issues which prevent patients leaving hospital are addressed.

Appointments and staffing

It was my pleasure to congratulate the Chair, Suzy Brain England OBE, on her recent election to the NHS Providers Board.

DEVELOP RESPONSIBLY, DELIVERING THE RIGHT SERVICES WITH THE RIGHT STAFF

Following on from Suzy's congratulations in her report, I was also very pleased to hear of Mr Quraishi's OBE in the recent Queen's Birthday Honours. As well as being an outstanding surgeon, his ENT masterclasses are internationally renowned. This is what being a teaching hospital is all about, Mr Quraishi's work has put Doncaster on the map and his award is much deserved.

Heather Jackson, our Practitioner Services and MSK Clinical Lead, is a finalist for the Workforce Transformation Lead at the National AHP Awards.

Nominations have opened for the DBH Star Awards which is taking place on the new date of 7 September 2017 at the Keepmoat Stadium. This year the event has been taken in house and the deadline for submissions is 7 July at 1pm.

DBTH Stars Annual Awards

Following the election results it has been confirmed that Jeremy Hunt MP remains as Secretary of State for Health with Philip Dunne MP also reappointed as Minister of State for Health. There are two new junior ministers at the Department of Health, Jackie Doyle-Price MP and Steve Brine MP. Former DoH ministers, Nicola Blackwood and David Mowat both lost their seats in the Commons.

Clinical Governance Oversight Committee

Annual Report 2016/17

1 Background

1.1 The purpose of this report is to provide the Board of Directors with a summary of the work of the Clinical Governance Oversight Committee ("the committee") for the year 2016/17 in line with the committee's Terms of Reference.

2 Terms of reference

2.1 During the year, the committee has worked to Terms of Reference approved in July 2015.

2.2 Meetings and membership

The Committee met on four occasions during 2016/17 and the committee's membership and attendance was as follows:

		Apr '16	Jul '16	Oct '16	Jan '17
Committee members:	Martin McAreavey, Chair	X	X	X	X
	Alan Armstrong	A	X	X	X
	Geraldine Broderick	X	X	n/a	n/a
	Philippe Serna	X	A	X	X
Officers in attendance:	Sewa Singh, Medical Director	A	X	X	X
	Richard Parker, Director of Nursing, Midwifery & Quality	X	X	X	n/a
	Moira Hardy, Acting Deputy Director of Nursing, Midwifery and Quality	n/a	n/a	n/a	X
	Rick Dickinson, Deputy Director Quality & Governance	X	X	X	X
	Lisette Caygill, Acting Deputy Director of Quality & Governance	n/a	n/a	n/a	X
	Maria Dixon, Head of Corporate Affairs	X	n/a	n/a	n/a
	Matthew Kane, Trust Board Secretary	n/a	X	X	X
Governor observers:	John Plant, Public Governor	X	A	A	X
	Clive Tattley, Partner Governor	X	X	X	X
CCG observer:	Andrew Beardsall, Bassetlaw CCG	A	X	X	A
Internal audit representatives		X	n/a	X	X

2.3 During these meetings and throughout the year, internal auditors have not raised any issues of concern that have not also been covered in the full meetings of the committee.

The committee has sought assurance that the necessary co-operation has been received from Trust managers and staff and that auditors had been able to undertake their work without their independence being compromised.

2.4 Minutes of each of the meetings have been formally presented to a subsequent meeting of the Board of Directors, with the Committee chair drawing any key issues to the attention of the Board.

2.5 Sub-committees

The committee has formally received the minutes of the Clinical Governance and Quality Committee, which reports to it, and approved the terms of reference of those committees where appropriate. The sub-committee structure is shown in the appendix to this report.

3 Work plan

3.1 The committee's agenda throughout the year was largely dictated by, but not limited to, the work plan. The committee's agenda has also been influenced by the matters arising from internal audits during the year, and matters escalated from the Clinical Governance Quality Committee.

4 Engagement with stakeholders

4.1 Two governor observers and one CCG observer are invited to attend each meeting of the committee, to provide an opportunity for stakeholders to gain assurance regarding the Trust's clinical governance processes. (Attendance is shown above.)

5 Internal audit

5.1 The Trust's internal audit services were provided by KPMG during 2016/17.

5.2 The internal audit plan for 2016/17 was approved at the Audit and Non-clinical Risk Committee meeting on 23 September 2016, and the work conducted by internal audit on clinical quality and patient care related matters during 2016/17 was as follows:

Audit	Planned / Status	Assurance Level
Booking management	Complete	Partial
Data Quality / Performance Indicators	Complete	Partial
CQC compliance	Complete	Partial
Medicines Management	Complete	Partial
Patient Safety & Infection Control	Complete	Significant
Incident Reporting, Investigation and Learning	Complete	Partial
Duty of Candour	Complete	Partial

5.3 At each meeting the committee reviews the issues and recommendations from audits which related to clinical quality, and reviews the overall risk rating. The committee subsequently follows up on areas of concern as it considers appropriate.

5.4 An Internal Audit Plan for 2017/18 was approved by the Audit & Non-clinical Risk Committee on 24 March 2017. The Chair of the Clinical Governance Oversight Committee was involved in the work to develop the plan, and the Committee was consulted regarding its contents, in order to ensure that the plan had an appropriate level of focus on clinical quality and patient care related matters.

6 Quality Account

6.1 The Board of Directors reviews and approves the Quality Account, with advice and input from the Chair and other members of this committee.

7 Committee evaluation, effectiveness & training

7.1 The Committee was subject to two assessment processes in the year. During Q3, they participated in the Well Led Governance Review of the Trust which made some recommendations in respect of the Committee's terms of reference and work-plan.

7.2 Further to this, in January 2017, the Committee conducted an annual assessment of its effectiveness, using a questionnaire process which mirrored the self-assessments conducted by the Audit & Non-clinical Risk Committee. Ten recommendations were made although some of these were similar to those from the Well Led Review.

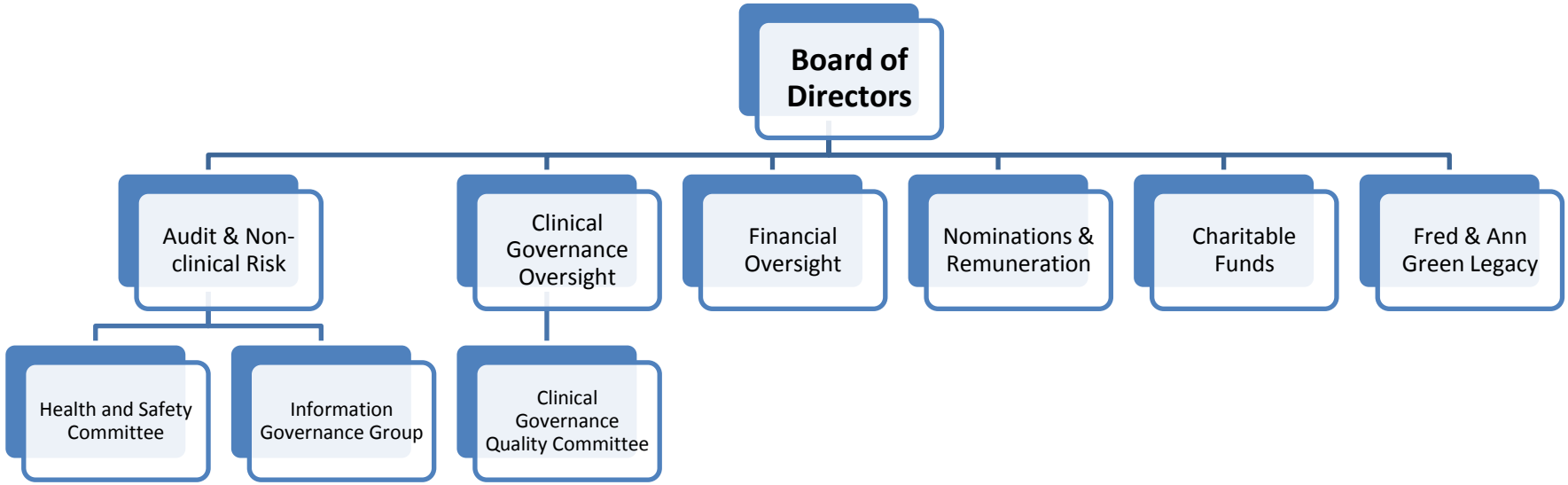
7.3 In Q4, the Trust took the decision to review its committee structure to align it with the Single Oversight Framework and emerging strategic direction. This process was finalised in May 2017 and saw the Clinical Governance Oversight Committee recast as the Quality and Effectiveness Committee.

8 Conclusion

8.1 The Committee has received and reviewed much information and considered carefully the assurance provided from both internal and independent sources. Overall, the committee concludes that the Trust has a generally sound system of internal control in relation to clinical quality and patient care. The committee thanks those who have attended meetings and/or provided information and support to it for their valuable help and assistance.

Martin McAreavey
Chair, Clinical Governance Oversight Committee
June 2017

APPENDIX: 2016/17 DBTH Committee Structure



DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:15 m on Monday 22 May 2017
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-executive Director (Chair) John Parker, Non-executive Director Philippe Serna, Non-executive Director
IN ATTENDANCE	:	Jon Sargeant, Director of Finance Karen Barnard, Director of People & OD David Purdue, Chief Operating Officer Marie Purdue, Acting Director of Strategy & Improvement Anna Moulding, Acting Deputy Director of Finance Andrew Thomas, Project Consultant Bev Marshall, Governor Observer Matthew Kane, Trust Board Secretary Angela O'Mara, Exec Team PA
WORKSTREAMS	:	Sewa Singh, Medical Director Kirsty Edmondson-Jones, Director of Estates & Facilities

Action

Apologies for Absence

17/5/1 None.

Introductions

17/5/2 Anna Moulding was welcomed to the meeting and introductions were made around the table.

Minutes of the previous meeting

17/5/3 The minutes of the meeting held on 24 April 2017 were APPROVED as a true record.

Matters arising

17/5/4 There were no matters arising and the action notes were reviewed and updated.

Request for any other business

17/5/5 No additional items of business were declared.

Medical Productivity Workstream

17/5/6 Sewa Singh, Medical Director, provided a verbal update on progress to date. Anticipated year-end savings of 750k were noted, 670k of which related to

Obstetrics and Gynaecology (O&G) and Paediatrics, with the remainder from the Surgical Care Group, namely Ophthalmology, ENT and Orthodontics.

17/5/7 Revisions to service models were required in Paediatrics and O&G, to incorporate the recommendations from the Royal College of Obstetrics & Gynaecology review. The Medical Director highlighted that the financial savings identified were based on current and not revised service models.

17/5/8 The majority of savings within the Surgical Care Group were to be realised in Ophthalmology and whilst team job planning had been completed in this area the individual plans were yet to commence. Plans were in place for completion in June 2017, with delays attributed to a change in Care Group leadership. A number of personnel matters were reported to have negatively impacted upon the rate of progress, including the lack of a clinical lead until January 2017, an expected change of the workstream's project lead and the level of HR support received.

17/5/9 In response to a question from John Parker, Sewa Singh confirmed that agreement had not been reached with the LNC regarding job planning, however, communication continued with the Chair to offer assurance regarding the Trust's pragmatic approach.

17/5/10 The Director of Finance enquired of the anticipated saving for this year, however, as the majority of savings were expected from O&G the Medical Director felt it was difficult to comment as the service model was yet to be determined and costed. During 2016/17 savings of 257k were noted against a plan of 413K, planned savings of 416k in 2017/18 currently showed a slippage of 260k. Jon Sargeant suggested it would be helpful to undertake a review of all consultant posts and the risk associated with them. **SS/JS**

17/5/11 The Chair enquired of any support required by the Medical Director and it was agreed there was a need to review the provision of HR support.

17/5/12 The following requirements were agreed for future workstream presentations:

- To provide sufficient notice of attendance, a minimum of three weeks was suggested.
- To receive the update in a standard format presentation.
- Presentation to include components causing difficulty, actions taken, level of confidence and support required from the Committee.
- Validation of data by S&I/Finance prior to being presented to the Committee.

The Workstream SROs would be notified of the Committee's requirements. **MP**

The Medical Productivity update was NOTED.

Infrastructure Workstream

17/5/13 Kirsty Edmondson-Jones presented to the Committee an overview of the various strands of the workstream, summarising 2016/17 achievements and

plans for the current financial year.

17/5/14 In response to a question from John Parker regarding the impact on staff of the catering bid the Director of Estates and Facilities confirmed that the 84 WTE colleagues affected would be subject to a TUPE transfer. The contract included appropriate clauses to ensure the Trust was not liable for future costs arising from the transfer, provision for staff to utilise the commercial space to consume their own food and drink and the offer of a set priced meal, including healthy options to comply with the CQUIN.

17/5/15 The Committee were advised that the workstream had over delivered by 506k in 2016/17 and subject to approval of the catering bid at this month's Board would overachieve against the 2017/18 plan. In addition further schemes were being explored in order to support the current organisational gap of unidentified CIPs.

17/5/16 In response to a question from Marie Purdue, Kirsty Edmondson-Jones confirmed she was confident there would be no further slippage with regards to the catering bid. A project plan was in place and the preferred bidder was an experienced provider who would also wish to progress the matter in a timely manner. Meanwhile, the HSDU programme was still in the early stages of invitation to tender. However, any agreement to delay would be for the benefit of the scheme, and all steps would be taken to mitigate the risks wherever possible. Medical staff were already involved in the HSDU process, although a greater level of engagement was expected as the process progressed.

17/5/17 Cross referencing the information provided in the Strategy & Improvement report to the presentation Philippe Serna sought clarity on the in-year savings. A slippage was noted due to the change in forecast following tender revisions and a subsequent delay in mobilisation date.

17/5/18 Before Kirsty Edmondson-Jones left the meeting the opportunity was taken to allow her to comment on the workforce data presented in the performance section. The data was recognised to require improvement and the Director of Estates & Facilities updated the Committee on actions taken to address this, which included a paper based approach to SET. In relation to appraisal completion rates, delays had occurred to enable objectives to be cascaded appropriately throughout the directorate. John Parker confirmed that many of the issues faced within Estates and Facilities were not unique to the Trust and were inherent of the workforce group.

The Infrastructure Workstream presentation was NOTED.

Finance Report – Month 1 2017/18

17/5/19 Jon Sargeant, Director of Finance, presented to the Committee a paper summarising performance in Month 1. The position was reported as a deficit of 3.9m, 39k ahead of the planned position.

17/5/20 Income levels and CIP achievements were both lower than plan; with income levels lower than expected due to a reduced level of emergency activity at

Bassetlaw. Work to understand the reasons behind this were underway.

17/5/21 A cash balance of 10m was reported at the month end due to delays in invoice processing following the migration to NHS Shared Business Services.

17/5/22 The Director of Finance confirmed the month 1 position was not as favourable as anticipated at this stage. There was a clear need to understand the lower emergency income from Bassetlaw. However, until investigations had been completed it was difficult to comment, as there had been a number of service/procedural changes at Bassetlaw last summer which may now be presenting a different view, not previously seen during the winter months.

17/5/23 In response to a question from Philippe Serna, Jon Sargent confirmed that approximately 4,400 invoices had being received into the wrong work queue, as a result these were not automatically matched to an order and were currently being worked through. Suppliers were aware of the change in service provision, including the need for all invoices to quote a purchase order and as many suppliers were national companies they would already be familiar with this process due to widespread use of SBS in other Trusts.

The Finance Report was NOTED.

Strategy & Improvement Update

17/5/24 Marie Purdue, Acting Director of Strategy and Improvement, presented to the Committee a paper to summarise progress on 2017/18 CIPs, an update on NHSI grip and control measures and the strategic planning progress.

17/5/25 Planned delivery for 2017/18 CIP was reported at 14.5m, with actual delivery in month 1 of 340k, against a plan of 489k. The underperformance related to the procurement workstream and local workstreams within care groups and corporate.

17/5/26 To date 6.3m of CIPs were yet to be identified, in excess of thirty potential new projects had been identified but these were not yet fully evaluated and further work was required in this area before a more accurate picture could be presented. Meetings with the Care Groups and Directorates were underway with PMO and Finance colleagues working to agree identified schemes and generate new ideas to bridge the gap.

17/5/27 The Chair enquired of the level of confidence with the schemes already identified and Marie Purdue confirmed this varied. Once the round of meetings was completed further discussions would take place with the Executive Team. The Director of Finance recognised there was still much work to be done but this was in line with expectations of a month 1/2 finance report. The Chair confirmed that a more visible plan would be required to offer assurance to the Committee and reinforced that not only did the Care Groups need to agree to the schemes but they needed a firm strategy for delivery also.

17/5/28 It was agreed that an outline plan would be provided at the next meeting with detail around already identified schemes, including a level of confidence, with a

more detailed plan to be provided in July 2017. At the next meeting a view would be taken as to whether there was a need to escalate the volume of unidentified CIPs to the Board. **MP/JS**

17/5/29 In terms of workstreams for escalation a wider discussion took place around Medical Productivity and the Committee's view was that the Medical Director and Mr Pillay, Deputy Medical Director, should attend to provide a further update in June 2017. **SS/WP**

17/5/30 *Karen Barnard and David Purdue joined the meeting at this point.*

17/5/31 In relation to the HR support concerns expressed by the Medical Director, Karen Barnard acknowledged that the post holder did have other responsibilities, however, there was an issue around clarity of expectations, especially as job planning moved from the project phase to business as usual. Moving forwards the establishment of a medical staffing team would allow a resource across the organisation, including support around medical productivity. In order to clearly identify the support required it was suggested that colleagues meet to discuss requirements. A meeting to review the sustainability of job planning had already been scheduled for w/c 29 May and this matter would be addressed at this time. **KB/MP /SS**

17/5/32 In respect of NHSI's Grip and Control measures the Committee were advised that all actions had been RAG rated as at the end of 2016/17 with those newly identified actions allocated to an owner to ensure appropriate implementation and review. An initial view highlighted limited opportunities as many of the actions were process and governance focussed.

17/5/33 The Chair reinforced the requirement for a timetable of workstreams to be provided at the next meeting and in addition to the return of Medical Productivity next month it was also agreed that the Procurement workstream would attend to brief the Committee. **JS**

The Strategy & Improvement Report was NOTED.

Escalation items from workstreams

17/5/34 No items were noted for escalation.

Performance

Business Intelligence Report

17/5/35 The Chair clarified his expectations with regards to the aims of the performance element of the meeting. Whilst the full BIR would be received for information the suggestion was to produce a report/balanced scorecard to sit above the BIR to identify the key core activities that were crucial to the Trust's success. This would allow a more strategic view with deep dives into specific areas scheduled to run parallel to this.

17/5/36 David Purdue, Chief Operating Officer, updated the Committee on the work currently underway to develop the Single Operating Framework (SOF). This

would consist of nine core elements of performance. The key elements linked to achievement of monthly NHSI standards would include; 4 hour access, referral to treatment (including diagnostic waits), 62 day cancer wait and infection control. A second national programme, named Action on A&E, had been launched to review urgent care across the system.

17/5/37 From the information provided it was agreed that benchmarking data would be helpful to allow performance to be monitored against target, peers and at a national level. Consideration would also be given to include data on readmissions, outpatient cap and cancelled operations. An initial draft of the report would be presented to the Committee next month. **MP**

17/5/38 The following areas were proposed as deep dive activities for the next quarter:

- June - RTT
- July - Locums **DP/KB**
- August - A&E

Each session would include a 20 minute presentation, followed by a Q&A session.

17/5/39 The Director of People & OD confirmed that the inclusion of workforce data within the dashboard had not progressed at the same rate and options to extract information from the Electronic Staff Record were still being considered. In the interim period data would be reported separately. For the purpose of this Committee the following were felt to be of primary importance:

- Establishment/staff in post (to demonstrate a reliance on temporary staff)
- Turnover

A secondary interest was noted for sickness/absence due to the potential need to recruit temporary staff and also the CQUIN attached to health and wellbeing initiatives such as flu and staff survey responses.

17/5/40 A summary of April's performance was provided with 90.4% of visitors to ED being seen within 4 hours. IR35 was noted to have had a significant impact on staffing in the department due to the reliance of locums, especially at Bassetlaw. In response to a question from John Parker, David Purdue advised of steps taken to improve the situation and attract those self-employed locums onto Trust contracts. Steps included an offer of enhanced terms for non-standard hours and a deferred recruitment and retention premia for middle grade colleagues. Moving forward, as part of the winter plan, the skill mix in ED would expand to include support from other specialties.

17/5/41 RTT performance was noted at 90.4%. The main areas of non-compliance were within the Surgical Care Group, notably, Ophthalmology, ENT, Pain Management and General Survey. Waiting lists at a specialty level were reviewed weekly by the Deputy COO, in addition to demand and capacity issues as part of the monthly Planned Care Board attended by Doncaster and

Bassetlaw CCGs.

17/5/42 Philippe Serna enquired of any necessary activities to ensure the Trust maintained its Teaching Hospital status. A variety of factors were considered, including an appropriate consultant body for supervision and maintenance of the quality of training and research. The impact of the level of student placements and education provision was far reaching and the Chair agreed to discuss this with Linn Phipps, Chair of the Quality and Effectiveness Committee. **NR**

17/5/43 *John Parker left the meeting at this point.*

17/5/44 Diagnostic performance was reported at 97.4%, as compared to the target of 99%, with plans put in place to address the capacity issues in audiology.

17/5/45 The two week wait performance for Quarter 4 was noted to be 89%. Capacity issues within urology and dermatology had been seen, although the greatest breach contributor related to patient choice.

The Business Intelligence Report was NOTED.

Mapping the Risks for Finance & Performance

17/5/46 Matthew Kane, Trust Board Secretary, presented to the Committee the end of year Corporate Risk Register (CRR) and Board Assurance Framework (BAF). Currently risks were owned by the Clinical Governance Oversight Committee, Financial Oversight Committee and Audit and Non-Clinical Risk Committee, however, moving forward risks would be assigned to either the Finance & Performance Committee or Quality & Effectiveness Committee with the role of ANCR being to monitor the effectiveness of the framework.

17/5/47 A reformatted risk register was proposed which would be reviewed by the Executive Team and Management Board on an ongoing basis to ensure it remained relevant and up to date.

17/5/48 The current risks were reviewed and ownership appropriately assigned. Matthew Kane would meet with the relevant executives outside of the meeting to consider the inherent and residual risk ratings and any new risk not currently identified. **MK**

17/5/49 In respect of risk 14 (Risk of Fraud), Philippe Serna, Chair of ANCR, agreed to consider this outside of the meeting and feedback to Matthew Kane. **PS**

The update for Mapping the Risks for Finance an Performance was NOTED.

Any other business

17/5/50 In order to accommodate a pre-meet for the Chair and key personnel it was agreed that the start time of the meeting would be moved to 9:15. The Chair welcomed feedback on the structure of the meeting.

Time and date of next meeting:

Date: 23 June 2017
Time: 9:15am
Venue: Boardroom, DRI

Signed:…….. **…….**
Neil Rhodes **Date**

UNAPPROVED DRAFT

Clinical Governance Oversight Committee Meeting
Held on Tuesday 18 April 2017 at 9am
In the Boardroom, DRI

PRESENT	:	Martin McAreavey, Non-Executive Director (Chair) Philippe Serna, Non-Executive Director Alan Armstrong, Non-Executive Director
IN ATTENDANCE	:	Sewa Singh, Medical Director Moira Hardy, Acting Director of Nursing, Midwifery & Quality Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Quality Lisette Caygill, Acting Deputy Director of Quality & Governance Sue Cordon, KPMG Clive Tattley, Governor Observer John Plant, Governor Observer Matthew Kane, Trust Board Secretary Linn Phipps, Non-Executive Director

Action

Apologies for absence

17/61 Introductions were made around the table. There were no apologies received.

Introduction & Welcomes

17/62 The Chair began by reflecting on the past 12 months and the work that the Committee had undertaken around clinical governance, medicines management, the selection of the new auditors, the development of the HED data report and its review of committee effectiveness.

Minutes of the meeting held on 16 January 2017

17/63 The minutes of the meeting held on 16 January 2017 were approved as a true record of the meeting.

Matters arising and action notes

17/64 There were no matters arising. The action notes were reviewed and updated.

CGQC Report

17/65 The CGQC report for the period January to February 2017 was presented by Sewa Singh, Medical Director. Continued progress on quality measures was noted and updates were provided for:

- Deep clean programme
- Blood culture training
- 24/7 GI Bleed Rota
- Point of Care Testing
- Enhancing Assurance: Reporting on Health Evaluation Data
- Chlorhexidine for Skin Preparation
- SI Action Plans
- MHP
- Medical Records
- Internal Audit Report
- Clinical Governance Leads posts
- Update on attendance at Clinical Governance meetings

17/66 It was reported that deep cleaning had been suspended due to recruitment issues for a period of time but this would be reinstated from April 2017. Plans were in place and Clinical Governance and Quality Committee were monitoring.

17/67 There was a brief discussion around the Trust's plans for additional CT scanning capacity and the risks to not achieving this, especially to patient safety and the wider plans for the Sustainability and Transformation Partnership. It was agreed that this be escalated for consideration on the Corporate Risk Register.

17/68 Additional key risks and issues were identified around the impact of IR35 tax rules, staffing vacancies within radiography and the pipeline of cost improvement plans.

17/69 Items escalated to this Committee included concerns raised by the Surgical Care Group about Ward B6 on the Bassetlaw site now that it was a Monday to Saturday morning ward, and used for medical overflow on weekends. This was not a funded area and patients were cared for by locum staff. The Chief Operating Officer was taking responsibility for investigating any incidents recorded on DATIX.

17/70 The CGQC Report was REVIEWED and NOTED.

Ernst & Young (EY) Sector Update

17/71 The update covered issues which may have an impact on the Trust and the NHS sector as a whole. The report had been produced by the EY national Government and Public Sector (GPS) team. It included detailed briefings on Government and economic news, accounting, auditing and governance and regulation news. The Chair reflected on the new Learning, Candour and Accountability role for providers. The Acting Director of Nursing, Midwifery and Quality would brief the Committee on the new Quality Framework that was mentioned in the paper. **MH**

17/72 The Ernst & Young Sector Update was NOTED.

Internal Audit Technical Update

17/73 The report highlighted the main technical issues which were currently having an

impact on the health sector and included issues relating to NHS Improvement, NHS England and the Department of Health.

17/74 Articles believed to have an impact on the Trust were flagged using ratings. Technical updates rated red where action was required were:

- 2017/19 National tariff published
- Transforming costing in acute, mental health and ambulance providers
- Very Senior Manager guidance for off-payroll interims
- NHS England publish new guidelines on tackling conflicts of interest

17/75 Use of medical agency locums continued to be a key issue for the Trust. The Medical Director was meeting with the other northern directors to discuss in due course.

17/76 The Internal Audit Technical Update was NOTED

Internal Audit Plan 2017/18

17/77 Sue Cordon presented the Audit Plan which outlined the proposed input from KPMG to the Trust's internal audit service in 2017-18 and beyond. It provided a risk based analysis of the Trust's activities and included the suggested audit coverage for the year, the timing of the work and a summary of the scope of each review KPMG planned to conduct. The following key areas were reviewed:

- Risk assessment 2017-18
- Annual and Strategic Internal Audit Plan
- Indicative timetable and outline scope
- Internal Audit Team
- Description of levels of assurance provided
- Internal Audit Charter

17/78 Linn Phipps requested that a process be explored whereby NEDs could input into early scopes of internal audit proposals. This would be discussed and brought back to the next meeting. A request for audit to look at the Trust's education strategy was also proposed. **SC**

17/79 The Internal Audit Plan 2017/18 was REVIEWED and NOTED.

CQC Compliance Report/Action Plan

17/80 Moira Hardy presented the report which provided the Committee with a briefing on actions planned following the CQC inspection and reports, and illustrated the ongoing monitoring arrangements for CQC regulatory compliance and quality of the Trusts services.

17/81 It was reported that future versions of the action plan would include an embedded column and that any areas where compliance was weak would be included within clinical governance objectives. It was agreed that the report would return **MK**

in July.

17/82 The CQC Compliance Report / Action Plan was REVIEWED and NOTED.

CQC Compliance Audit Report

17/83 Sue Cordon presented the report which outlined the findings of the KPMG review of the implementation and progress of the Trust's action plan to address the CQC's findings from its last inspection in April 2015. KMPG had visited the following areas across the four sites:

- Outpatients; Diagnostic Imaging
- Maternity; Gynaecology
- Urgent and Emergency Services.

17/84 The overall level of assurance provided was partial assurance with improvements required. The report highlighted several areas of good practice. There were 18 recommendations raised as a result of the review; 2 high, 7 medium and 9 low. Assurance that the areas identified were being tackled was provided within the action plan. It was agreed to add a column to the action plan to indicate the extent to which the action had been embedded.

17/85 The CQC Compliance Audit Report was REVIEWED and NOTED.

Committee Effectiveness Review

17/86 The Committee had undertaken its self-assessment at its meeting in January following the completion of surveys by members and regular attendees of the meeting. The report included an action plan which set out the recommendations and proposed actions to address them as well as the full survey results.

17/87 The Committee Effectiveness Review was REVIEWED and NOTED.

Quality Accounts

17/88 The report set out the draft Quality Accounts for 2016/17 which would be included as part of the Annual Report. While the document was still in a very draft state, the Committee were invited to consider the key quality information for 2016/17 that would be issued by the Trust prior to consideration by Board of Directors on 25 April.

17/89 The Acting Director of Nursing, Midwifery and Quality undertook to keep the Committee updated on particular aspects contained within the Quality Report. Further comments from Linn Phipps would be sent to the Acting Deputy Director of Nursing, Midwifery and Quality for incorporation.

17/90 The Quality Accounts Report was REVIEWED and NOTED.

Enhancing Assurance: Reporting of Health Evaluation Data Update

17/91 Rick Dickinson presented the report which provided the Committee with a briefing on the use of HED data and Quality Metrics.

17/92 MRSA bacteraemia was now showing a higher rate than expected in the past 12 months, with three cases in the last year. Two of the three cases were contaminants. This would remain as a higher rate until the older cases come off the 12 month period, but should improve as a statistic by September 2017 if there are no more cases.

17/93 The rate of E.coli infection had been reviewed and was associated to patients presenting with E.coli infections, rather than hospital acquired. This remained in the monitoring regime in the Infection Prevention and Control Committee.

17/94 The Enhancing Assurance: Reporting of Health Evaluation Data Update was REVIEWED and NOTED.

Ward Quality Metrics

17/95 The Committee reviewed a series of ward quality metrics across each of the five CQC domains. There was a brief discussion around the need for soft intelligence to also be taken into account and there was an acknowledgement that collection of soft intelligence could be improved.

17/96 The Ward Quality Metrics report was REVIEWED and NOTED.

Executive Attendance at CGOC

17/97 The Trust had developed a protocol to outline the process by which members of the executive would be requested to attend the ANCR should the committee feel that there has been unsatisfactory progress in the closure of audit (or other) recommendations. This protocol was developed with the Chair of ANCR and was supported by the Executive Team. It was proposed that this also be adopted by CGOC. A summary of the process was provided in the paper.

17/98 The Executive Attendance at CGOC report was AGREED.

Board Assurance Framework & Corporate Risk Register

17/99 This report set out the Trust's Board Assurance Framework (BAF) and Corporate Risk Register for Q4 2016/17.

17/100 In the quarter, three risks were changed:

1: Failure to achieve compliance with financial performance aspects of the Monitor Risk Assessment Framework and provider licence, triggering regulatory action (20 reduced to 16)

3: Failure to deliver financial plan (16 reduced to 4)

4: Failure to deliver Cost Improvement Plans in this financial year leading to impact on Turnaround (9 reduced to 6)

The movement downwards in relation to the three financial risks was attributable to the likelihood of meeting plans by the end of 2016/17.

17/101 The Committee NOTED the Board Assurance Framework and Corporate Risk Register.

Minutes of the Clinical Governance & Quality Meetings held on 20 January, 17 February & 17 March 2017

17/102 The minutes of the Clinical Governance & Quality meetings were NOTED.

Procedures for Determining Low Clinical Value

17/103 The verbal update on Procedures for Determining Low Clinical Value was NOTED.

CCG Feedback

17/104 There was no report.

Issues escalated from sub-committees

17/105 No items were escalated from the committees other than those previously covered.

Issues for escalation to Board of Directors

17/106 It was agreed that the procedures for determining low clinical value would be escalated.

Any other business

<u>Clinical Audit Strategy</u>

17/107 The Committee considered an update to the Clinical Audit Strategy including the national audits that the Trust had participated in.

17/108 The Clinical Audit Strategy & Policy was revised and published in October 2016 to reflect the recommendations that were outlined in the internal audit report on clinical audit in 2015/16. The key recommendations regarding monitoring of audit completion and action plans had been embedded within the Quality and Effectiveness Forum processes and terms of reference.

17/109 In addition all Quality and Effectiveness departmental staff who provided training were now accredited trainers via the Clinical Audit Support Centre, a recognised national body affiliated to HQIP and NICE.

17/110 During 2017/18 increased collaboration and partnership working with the new

Quality Improvement and Innovation team was anticipated to strengthen the clinical effectiveness portfolio with greater emphasis on quality improvement and patient/stakeholder participation.

17/111 It was agreed that details of how many clinical audit outcomes the Trust had implemented be shared with the Committee. **RD**

17/112 The Clinical Audit Strategy update was NOTED.

Time and date of next meeting:

Date: 17 July 2017
Time: 9am
Venue: Boardroom, DRI

Signed:

…….. …….

Martin McAreavey **Date**
Chair

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
JULY 2017			
CE Report	Chief Executive's Objectives		Reference Costs
Business Intelligence Report	Complaints, Compliments, Concerns and Comments Report		Diversity and Inclusion
Nursing Workforce	R&D Strategy metrics (in BIR, to include R&D annual summary)		
MB Minutes	Safeguarding & maternity metrics (in BIR)		
Financial Oversight Minutes	ANCR Minutes		
NHSI Undertakings tracker	P&OD Quarterly report		
AUGUST 2017			
CE Report	Monitor Quarterly Declaration Q1	Proposed AMM arrangements	Annual Revalidation update(medical)
Business Intelligence Report	CGOC minutes	Annual Security Report	Health and Wellbeing
Nursing Workforce	Board Assurance Framework & corporate risk register Q1	Infection Control Annual Report	
MB Minutes	ANCR Minutes		
Financial Oversight Minutes			
NHSI Undertakings tracker			
SEPTEMBER 2017			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Risk Policy	
Business Intelligence Report	Monitor Q1 Results Notification	Fred & Ann Green Legacy minutes	
Nursing Workforce			
MB Minutes			
Financial Oversight Minutes			
NHSI Undertakings tracker			
OCTOBER 2017			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives		
Nursing Workforce	Complaints, Compliments, Concerns and		

As at 15 December 2016

	Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Financial Oversight Minutes	Safeguarding & maternity metrics (in BIR)		
NHSI Undertakings tracker	P&OD Quarterly report		
NOVEMBER 2017			
CE Report	CGOC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	CaMIS 12 months post-implementation review
Business Intelligence Report	Monitor Quarterly Declaration Q2		
Nursing Workforce	Board Assurance Framework & corporate risk register Q2		
MB Minutes			
Financial Oversight Minutes			
NHSI Undertakings tracker			
DECEMBER 2017			
CE Report	Monitor Q2 results notification		
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)		
Nursing Workforce			
Grip & Control Plan			
MB Minutes			
Financial Oversight Minutes			
NHSI Undertakings tracker			
JANUARY 2018			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Financial Oversight Minutes	Safeguarding & maternity metrics (in BIR)		
	P&OD Quarterly report		
FEBRUARY 2018			
CE Report	CGOC Minutes	Budget Setting / Business Planning / Annual Plan	

Business Intelligence Report	Monitor Quarterly Declaration Q3		
Nursing Workforce	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Financial Oversight Minutes			
MARCH 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Budget Setting / Business Planning / Draft Annual Plan	
Business Intelligence Report	Monitor Q3 Results Notification	Staff Survey	
Nursing Workforce		Fred & Ann Green Legacy minutes	
MB Minutes			
HWB Decision Summary			
Financial Oversight Minutes			
APRIL 2018			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Business Intelligence Report	Chief Executive's Objectives	Draft Quality Account	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report	Budget Setting / Business Planning / Final Annual Plan	
MB Minutes	R&D Strategy metrics (in BIR)		
HWB Decision Summary	Safeguarding & maternity metrics (in BIR)		
Financial Oversight Minutes	P&OD Quarterly report		
MAY 2018			
CE Report	Monitor Quarterly Declaration Q4	Annual Report	
Business Intelligence Report	CGOC Minutes	Quality Account	
Nursing Workforce	Report from the Chair of the ANCR committee (Verbal)	Annual accounts	
MB Minutes	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)	ISA260 and quality account assurance	
HWB Decision Summary		Charitable Funds minutes	
Financial Oversight Minutes			
JUNE 2018			

CE Report	Board Assurance Framework	MB Annual Report	
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Monitor Q4 Results Notification	ANCR Annual Report	
Bed Plan			
MB Minutes			
Financial Oversight Minutes			
OTHER ITEMS			
Review the appointment of Peter Brindley (Executor of Fred and Ann Green Will)			3 yearly (May 2018)
Constitution review			3 yearly (Jan 2018)

Minutes of the meeting of the Board of Directors
Held on Tuesday 23 May 2017
In the Boardroom, Doncaster Royal Infirmary

Present:	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Acting Director of Nursing, Midwifery and Quality
	Martin McAreavey	Non-executive Director
	Richard Parker	Chief Executive
	John Parker	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	David Cuckson	Public Governor
	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Marie Purdue	Acting Director of Strategy and Improvement
	Simon Marsh	Chief Information Officer
	Matthew Kane	Trust Board Secretary
	Emma Shaheen	Head of Communications and Engagement

ACTION

Welcome and apologies for absence

17/05/1 Apologies were presented on behalf of Linn Phipps.

Declarations of Interest

17/05/2 There were no interests declared in respect of the business of the meeting.

Actions from the previous minutes

17/05/3 The actions were noted and updated.

Research and Development at DBTH

17/05/4 The Board received a presentation from Trevor Rogers and Emma Hannaford from the Research and Development Team that set out current research activity and future plans at the Trust.

17/05/5 Details of the team's recent achievements were set out. The current research programme included a balanced programme of work across the entirety of the Trust's activities. The team's programme had generated in excess of £1m in 2016/17 and developed a team of dedicated research nurses.

17/05/6 The team was four years into a five-year strategy and had consistently achieved its key performance indicators. Key issues outstanding including the absence of a clinical research facility, the integration of research into job plans and management of monies from commercial trial activity were highlighted. An issue raised relating to room space within the Research and Development Team would be addressed by the Chief Executive and Director of Estates and Facilities outside the meeting. **RP**

17/05/7 The Trust's work as part of the Collaboration for Leadership in Applied Health Research and Care was considered. The Trust had previously match funded the work from the Fred and Ann Green Legacy but there was a question over lack of non-cash match from the CLAHRC and a way forward was sought. The Board were advised that any future match funding should be subject to a business case through the usual channels with an understanding as to who was paying for what and an evaluation as to how the CLAHRC monies had added value in the past.

17/05/8 Future ambitions included making academic joint appointments, expanded clinical accommodation and increasing the prestige and clinical excellence, building on the recent attainment of Teaching Hospital status.

17/05/9 In response to questions from Alan Armstrong and Martin McAreavey around expansion, the Board were advised that the team were looking to develop academic care groups. In addition, there were plans to use monies from the Fred and Ann Green Legacy to support sensible developments in areas of rehabilitation with the intention of it becoming a centre of excellence with a professor post, working alongside local Universities.

17/05/10 The presentation was NOTED.

Annual report (including quality accounts)

17/05/11 The Board considered a report of the Head of Communications and Engagement that sought approval of the 2016/17 draft Annual Report.

17/05/12 All changes and amendments from the previous drafts had been incorporated into the final draft. Sections of the report and external audit's comments on them had been considered by Audit and Non-clinical Risk Committee on 26 May.

17/05/13 The draft Annual Report 2016/17 was APPROVED for submission to NHSI.

Draft Accounts 2016/17

17/05/14 The Board considered a report of the Director of Finance that presented the Trust's unaudited accounts for the financial year-end dated 31st March 2017.

17/05/15 Audit was taking place and there were no changes that had a material impact upon the year end position, although an additional £200k in Sustainability and Transformation Funding had been provided taking the end-of-year deficit to £6.4m. The draft audit letter would be circulated to Board members.

17/05/16 The deadline for submission of the accounts, with a final opinion, was 31 May 2017. Board had already delegated final sign off of the annual accounts to ANCR, which would meet on 26 May 2017.

17/05/17 The Board NOTED the draft accounts prior to submission to NHSI.

NHS Self-Certification

17/05/18 The Board considered a report of the Chief Executive that sought sign off of documentation as part of the Trust's self-certification for 2016/17.

17/05/19 The purpose of self-certification was to carry out assurance that the Trust continued to comply with its licence conditions. There were three licence conditions against which the Trust was required to self-certify. Relevant documentation supplied by NHSI had been completed showing how the Trust complied with the relevant licence conditions and the risks that were required to be managed.

17/05/20 The Board would sign off the self-certification following a meeting with Governors on the evening of 23 May. While the Trust was no longer required to submit the documentation to NHSI, trusts would be audited in July to ascertain that they had complied.

17/05/21 The Board APPROVED the self-certification documents attached as appendices to the reports, subject to any comments from governors.

Review of Committee Structure

17/05/22 The Board considered a report of the Trust Board Secretary which sought approval of a new structure for Board-level committees, including new memberships, terms of reference and meeting cycles in order to align with NHSI's Single Oversight Framework and the Trust's emerging strategic direction.

17/05/23 Board APPROVED to:

(1) Disestablish the existing Clinical Oversight Committee and Financial Oversight Committee.

(2) Establish the new committee structure as set out below with the terms of reference attached as an appendix to the report, with effect from 1 June 2017:

(3) Update the Board's standing orders in accordance with the new structure.

(4) Approve the committee membership set out in the report.

(5) Note the separate piece of work on the charities committee structure.

(6) Seek expressions of interest from governors to sit on the new committees as observers.

Managing Conflicts of Interest in the NHS

17/05/24 The Board considered a report of the Trust Board Secretary that set out new rules around managing conflicts of interest in the NHS.

17/05/25 The guidance defined a number of common situations which could give rise to risk of conflicts of interest, including:

- Gifts and hospitality
- Outside employment
- Shareholdings and other ownership interests
- Patents
- Loyalty interests
- Donations
- Sponsored events, research and posts
- Clinical private practice

17/05/26 Under the new guidance, the Trust was required to decide which individuals were to be designated decision-making staff. Such staff would be required to complete annual declarations or nil returns that would be published on the Trust's website. Individual items over £50 or a number of cumulative items that amounted to £50 were still required to be registered. There was also a requirement for the Trust to designate decision-making bodies with responsibility for spending significant amounts of taxpayers' money.

17/05/27 A proposal to buy into a South Yorkshire and Bassetlaw-wide electronic system for registering interests was also being considered.

17/05/28 Board APPROVED to:

(1) Note the new requirements regarding conflicts of interest in the NHS.

(2) Agree to designate the following groups as 'decision-making individuals' within the definition given in the guidance:

- Executive and non-executive directors
- All consultant staff
- All corporate and care group directors and assistant directors
- All staff on or above Agenda for Change Band 8C
- All staff within Pharmacy, IT and Procurement teams

(3) Agree to designate the following groups as 'strategic decision-making groups' within the definition given in the guidance:

- Board of Directors and its committees
- Charitable Funds Committee
- Fred and Ann Green Legacy Sub-Committee
- Executive Team
- Management Board
- Drug & Therapeutics Committee

(4) Note the discussions around joint procurement of an electronic system for making annual declarations.

National Cyber Security Issues and Response at DBTH

17/05/29 The Board considered a report of the Chief Information Officer which set out the background to the recent NHS cyber-attack and how DBTH responded, the impact at the Trust and nationwide, the tools and processes in place to manage cyber security at the Trust, the results of recent penetration testing and future key actions.

17/05/30 In response to a question from the Chair, the Board were advised the Trust had applied all patches issued to them from NHSI following an assessment of the compatibility with the Trust's systems. There was now a need to look at the Trust's wider suite of business continuity plans. It was agreed that once the Emergency Planning Officer had considered the existing plans, a presentation would be brought to Board and the plans would be tested by internal audit. **DP**

17/05/31 Given the issues across the sector, it was understood that additional funding may be made available for cyber security.

17/05/32 The Board NOTED the national cyber security issues and DBTH's response,

for assurance.

DBTH approach to recruitment

17/05/33 The Board considered a report of the Director of People and Organisational Development which provided details of the Trust's current vacancy rates, the use of temporary staffing and the approach being taken to fill gaps against a backdrop of national shortages for certain staff groups and specialties.

17/05/34 At month 1 of 2017/18 the Trust had a budgeted establishment of 6,012 wte with a contracted wte (i.e. staff in post) of 5,570 wte with a further 286 wte temporary resource during April. This equated to a vacancy rate of 7.3% against a target of 5%, although some areas (such as Medical and Dental) had much higher vacancy rates. Taking account of the temporary resource, this vacancy rate reduced to 2.4%.

17/05/35 The Executive Team recognised the importance of retaining the current workforce and to maximise their attendance at work. The work detailed within the staff survey action plan and the health and wellbeing action plan were key to this.

17/05/36 The paper detailed the range of activities underway to address recruitment, development of new roles, attracting and retaining the local workforce into both professional training and vocational training. It also described the work to up-skill current staff by use of the apprenticeship levy and funding from Health Education England.

17/05/37 The Chair emphasised the need for the Trust's recruitment work to be actively managed. This meant having a targeted workforce strategy in place, making the most of the modern apprenticeship approach and working with partners. Further workforce reports were also sought for Board around specific themes.

17/05/38 The Board NOTED the update.

Strategy & Improvement Update

17/05/39 The Board considered a report of the Acting Director of Strategy and Improvement that included updates on CIP progress, the 2017/18 CIP programme, the strategic planning process and the move from turnaround to transformation.

17/05/40 The planned delivery for the Improvement Programme for FY17/18 was £14.5m, with a reported actual delivery at M1 of £340k against a forecast delivery to NHSI of £489k. This was behind plan by £149k mainly as a result of underperformance in the procurement and locum work streams.

17/05/41 To date £8.252m of the £14.5m remained unidentified, although it was

expected that there would be £2.5m of non-recurrent grip and control savings. There were over 30 new projects in the pipeline list being evaluated to help to bridge this gap. It was reported that care group and corporate department meetings are underway with the PMO and Finance to sign off implementation of identified schemes and discuss new ideas.

17/05/42 Updates were also provided in relation to grip and control, the strategic direction and quality, improvement and innovation.

17/05/43 In response to a question from Alan Armstrong regarding how the current year's opportunities compared with the last, the Board was advised that this was likely to be a more challenging year given that opportunities for savings were less clear.

17/05/44 The Board RECEIVED the Strategy and Improvement Report for assurance.

Finance Report as at 30 April 2017

17/05/45 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 1, 2017/18.

17/05/46 The month one position for the 2017/18 financial year was £39k ahead of the planned deficit that was phased throughout the year.

17/05/47 The income level was £207k lower than expected for the month. However, non-pay underspends and current vacancies had counterbalanced this helping the Trust to achieve the overall position. The cash position was healthy.

17/05/48 The Board NOTED that the reported financial position was a deficit of £3.9m, which was £39k ahead of the planned position after month 1.

Business Intelligence Report as at 30 April 2017

17/05/49 The Board considered a report of the Chief Operating Officer, Medical Director, Acting Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and workforce performance in month 1, 2017/18.

17/05/50 Performance against key metrics included:

4 hour access – In April the Trust achieved 90.37% (91.46% including GP attendances) against the 95% standard. Performance above 90% was maintained over the Easter bank holiday period. The second national programme 'Action on A&E' had been launched which aimed to review urgent care across the system.

RTT – In April performance remained below the standard, achieving

90.4%, with eight specialities failing to achieve the 92% standard for the month.

Diagnostic rates – The Trust missed the 99% standard in April achieving 97.4%. It was as a result of some capacity issues in audiology, which have been addressed.

Cancer targets – In March two-week waits were 88.5% against 93% standard. The key issues related to patient choice and capacity in Dermatology and Urology departments. A full action plan was in place. The 62-day performance achieved 86.6% against the 85% standard.

HSMR – The Trust's rolling 12-month position remained better than the expected level of 100.

C.Diff – The Trust's target for 2017/18 remained the same as this year (40 cases). The number of cases in April was significantly higher than trajectory and investigations had identified how antibiotic choice was a factor in the cases where there were lapses in care. The IPC team would be working with staff across the Trust to ensure that it continued to adhere to the highest standards of IPC practice.

Falls – There were no cases of serious falls in April.

Pressure ulcers - In 2016/17 there was a 25% reduction in the number of hospital acquired pressure ulcers and the Trust had added a further 10% reduction target for 2017/18. In April there were seven cases.

Appraisal rate – The appraisal rate at the end of April was at 57.72%.

SET training – There had been a slight decrease in compliance with Statutory and Essential Training (SET) and at the end of April the rate was 68.42%.

Sickness absence –The cumulative sickness rate for the 2017/17 year was 4.46%, which compared favourably to trusts across Yorkshire and Humber.

17/05/51 Board was advised that executives were currently addressing issues relating to GPs letters to patients, complaints response performance, stroke and the Surgical Care Group. Work on complaints and the DNA working group would be brought to Board through the Finance and Performance Committee following quarter two. **DP**

17/05/52 The Business Intelligence report was NOTED.

Nursing Workforce Report

17/05/53 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality which provided detailed information relating to the nursing workforce, highlighting issues that could impact on the Trust's ability to sustain appropriate staffing levels and skill mixes.

17/05/54 The overall planned versus actual hours worked in March 2017 was 100%, up one per cent from March. Care Hours Per Patient Day (CHPPD) stood at 7.6 across the Trust. Details of the quality and safety profile were provided in the report. The data for April illustrated no wards being assessed as red for quality.

17/05/55 Further to a question from Linn Phipps, the Board was advised that a recent review of the Quality Assessment Tool had seen some wards move from green to amber. Details were also provided around the QAT celebration event.

17/05/56 The report in respect of Nursing Workforce was NOTED and the actions identified to ensure that the risks associated with inappropriate nurse staffing levels were appropriately managed was SUPPORTED.

Corporate Risk Register and Board Assurance Framework

17/05/57 The Board considered a report of the Trust Board Secretary, which presented the Q4 Board Assurance Framework and Corporate Risk Register, which was used to inform the Annual Governance Statement.

17/05/58 The report provided a review of where key risks had started and finished the year together with plans for future development of the tool.

17/05/59 The report was NOTED.

Reports for Information

17/05/60 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Financial Oversight Committee minutes, 24 April 2017
- Board of Directors' Calendar

Items escalated from Sub-Committees

17/05/61 None.

Minutes

17/05/62 The minutes of the meeting of the Board of Directors on 25 April was APPROVED as a correct record with an amendment to minute number 17/04/20 where the word "sale" should be replaced by "lease".

Any other business

17/05/63 The Chair consented to the following item of other business being taken in the public session of the meeting:

Medical records

Martin McAreavey raised an issue escalated through Clinical Governance and Quality Committee relating to the current state of the medical records department.

The Board was advised that there were a disproportionate number of temporary records but changes were being made to improve the library at DRI. The two areas with the most issues were Ophthalmology and Urology. A number of the notes storage bays had been reviewed and that work continued.

Changes in place for November including the implementation of the RFID project would see the library become a closed area and a full action plan would be put in place. It was noted that while capital was not available for an electronic patient record system it was on the Executive Team's list of priorities.

Governors questions regarding business of the meeting

17/05/64 David Cuckson asked questions on the consequences of breaching conflicts of interest regulations, noted the new workforce information and commented on the new RFID system.

Date and time of next meeting

17/05/65 9.00am on Tuesday 27 June 2017 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

17/05/66 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the 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 **Date**
Chair of the Board