Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday 29 August 2017 at 10.30am in the Boardroom, Bassetlaw Hospital

AGENDA
Part I

		Enclosures
1.	Apologies for absence	(Verbal)
2.	Declarations of Interest	(Verbal)
3.	Actions from the previous meeting	Enclosure A
4.	Learning from Deaths – Learning, Candour & Accountability Linn Phipps – Non-executive Director Sewa Singh – Medical Director	Enclosure B
5.	ENT Masterclass Mr Muhammad Shahed Quraishi – ENT Consultant	Presentation
Reports for decision		
6.	Emeritus Status Sewa Singh – Medical Director	Enclosure C
7.	Health and Well-Being Karen Barard – Director of People and Organisational Development	Enclosure D
8.	Risk Identification, Assessment and Management Policy Matthew Kane – Trust Board Secretary	Enclosure E
9.	Use of Trust Seal Matthew Kane – Trust Board Secretary	Enclosure F
Reports for assurance		
10.	Chairs Assurance Logs for Board Committees held 22 August 2017 Neil Rhodes – Chair of Finance and Performance Committee Linn Phipps – Chair of Quality and Effectiveness Committee	Enclosure G (QEC to follow)
11.	CQC Insights Sewa Sigh – Medical Director	Enclosure H
12.	Mixed Sex Accommodation Moira Hardy – Acting Director of Nursing, Midwifery and Quality	Enclosure I
13.	Strategy and Improvement Marie Purdue – Acting Director of Strategy & Improvement	Enclsoure J

14. Finance Report as at 31 July 2017 — Enclosure K
Jon Sargeant – Director of Finance

15. Business Intelligence Report as at 31 July 2017 — Enclosure L
Led by David Purdue – Chief Operating Officer

16. Nursing Workforce Report — Enclosure M
Moira Hardy – Acting Director of Nursing, Midwifery & Quality

Reports for information

17. Chair and NEDs' Report — Enclosure N
Suzy Brain England – Chair

18. Chief Executive's Report — Enclosure O
Richard Parker –Chief Executive

19. Proposed Arrangements for Annual Members' Meeting — Enclosure P
Matthew Kane – Trust Board Secretary

20. Minutes of Finance and Performance Committee, 20 July 2017 — Enclosure Q
Neil Rhodes – Chair of Finance and Performance Committee

21. Minutes of Quality and Effectiveness Committee, 22 June 2017 — Enclsoure R
Linn Phipps – Chair of Quality and Effectiveness Committee

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

Minutes

23. To approve the minutes of the previous meeting held 25 July 2017 — Enclosure T

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

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

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

Date: 26 September 2017
Time: 2.30pm
Venue: Lecture Theatre, DRI

27. **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

22 August 2017

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 25 July 2017

Location: Boardroom, DRI

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

Apologies: MM, LP, JS

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**17/01/13**	Director of Education to share the Teaching Hospital phase two development plan at a future Board.	**MK**	**September 2017**	Scheduled for Board next month (see Chair's Report for further details).
2.	**17/03/07 & 17/06/3**	A paper be prepared on how the Trust can assure itself that support is in place concerning changes to NHS Protect.	**JS/KEJ**	**September 2017**	Action not yet due.
3.	**17/04/32**	Timetable six month review of CIPs.	**JS**	**November 2017**	Action not yet due.

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**17/04/54**	Invite NEDs to future quality summit.	**MH**	**September 2017**	A quality summit has not been arranged since the last Board meeting. Target date updated to September 2017.
5.	**17/04/61**	Bring Learning from Deaths report back to Board in May.	**SS**	**August 2017**	Complete – on agenda.
6.	**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.
7.	**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**	**October 2017**	Action not yet due.
8.	**17/06/34**	Board to meet with care group directors regarding EEPs.	**MK**	**September 2017**	To be arranged. Target date updated to September 2017.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
9.	**17/06/46**	QEC approach to assurance reporting to be shared with Board.	**LP**	**September 2017**	Action not yet due.
10.	**C/17/07/12**	Cyber security action plan to be presented to September's ANCR.	**SM**	**September 2017**	Action not yet due.
11.	**C/17/07/13**	Assurance report to be presented to Board (Part 2) in August.	**KEJ**	**August 2017**	Complete – on August Part 2 agenda.

Date of next meeting: 29 August 2017
Action notes prepared by: M Kane
Circulation: SBE, AA, NR, KB, DJ, MH, MM, DP, JS, SS, JP, RP, LP, PS

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Learning from Deaths – Learning, Candour & Accountability**		
Report to	**Board of Directors**	**Date**	**26th September 2017**
Author	**Linn Phipps, Non-executive Director** **Sewa Singh, Medical Director**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	✓

Executive summary containing key messages and issues
This report details the current position with regard the Trust's response to the National Guidance on Learning from Deaths published in March 2017.
Key questions posed by the report
What is required to ensure that the Trust learns from in hospital deaths?
How this report contributes to the delivery of the strategic objectives
• By scrutinizing all in hospital deaths we will ensure that care is as safe and effective as possible and that the quality of the care is of a high standard. When care is not at the level expected this will be identified and learnt from. • Our services to the general public when a loved one dies must be of a high standard. By introducing a medical examiner role, timely accurate information will be available to aid their bereavement process.
How this report impacts on current risks or highlights new risks
If we do not ensure the process of identifying and investigating deaths is maintained and developed, there is a high risk of non-compliance with the strengthened CQC assessment**.**
Recommendation(s) and next steps
The Board is asked to note progress to date and discuss requirements to facilitate further progress.

BOARD REPORT AUGUST 2017: Learning from Deaths

1.0 Introduction and Background

Following events in Mid Staffordshire and Morecambe bay and the subsequent review of hospitals with regard to investigating and learning from deaths, the Care Quality Commission (CQC) published a report, *"Learning, candour and accountability*" December 2016. It concluded that learning from deaths was not given sufficient priority and recommended that:

"*Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers*"

This report was then followed in March 2017 with the National Quality Board's "*National Guidance on Learning from Deaths*" which aims to initiate a standardised approach to reviewing and investigating all in hospital deaths, including those deaths that occur in an Accident and Emergency department.

These guidelines state that all Trust Boards should ensure that their organisation has a clear policy in place to include the following:

- Non-executive director to have oversight of the mortality review process
- Systematic approach to identifying deaths that require review
- Uses an effective methodology for case review
- Have sufficient numbers of staff with appropriate skills through specialist training and protected time.
- Review deaths of all patients with a learning disability
- Review all deaths of patients following an elective admission
- Report to the Board on the numbers of deaths, numbers reviewed, numbers of avoidable deaths and qualitative information.
- Share the learning across the organisation and wider health economy.
- Introduce the Medical examiner role
- Engage meaningfully and compassionately with bereaved families and carers.

To this end the Learning from Deaths Policy has been developed.

Appendix 1 Learning from Deaths Policy

This Policy, underwent wide consultation and was agreed at the Clinical Governance Committee on 21st July 2017 and will be published on the intranet August 2017.

In order to be in a position to comply fully with National Guidance on "Learning from Deaths" and deliver a robust and comprehensive process, there is a requirement for additional resource. A business case is in development for consideration by the Corporate Investment Group.

2.0 Current Position

The Trust has in excess of 2000 deaths per year across 3 Sites. To undertake a full structured judgement mortality review of all of these deaths is neither practical nor necessary. However, the Trust aims to screen every death and undertake a review of all deaths meeting the criteria described within the "Learning from Deaths" policy.

Appendix 2 illustrates the number of in hospital and A&E deaths in patients aged 18 and over and how many have been screened/reviewed.

It also demonstrates the number that were categorised by degree of potential death avoidability in each group using the Structured Judgement Review (SJR) methodology.

A score of 1 - 6 is used where the following definitions apply:

- 1 = definitely avoidable
- 2 = strong evidence of avoidability
- 3 = Probably avoidable (more than 50:50)
- 4 = Probably avoidable but not very likely
- 5 = slight evidence of avoidability
- 6 = Definitely NOT avoidable.

This report includes all deaths of patients with a learning disability in line with the Learning Disabilities Mortality Review Programme (LeDeR). All LD deaths have a structured judgement review with input from the Learning Disability liaison nurse. From 1st April 2017 it is mandatory to report any LD death to the Local Area Contact (LAT) at the CCG.

In addition to this quantitative data, the SJR reviews the quality of patient care and management during several phases of a patient's journey. It does this by not only scoring overall care quality but also by making narrative comment on the standard of care. This enables analysis and themes to emerge which are then translated into quality improvement work.

3.0 Conclusion and Recommendations.

The Trust has already completed a significant amount of work and continues to make substantial progress in ensuring that in patient deaths are screened and that those requiring further investigation go on and have a structured judgement review. We need to continue to build on and develop the process to ensure it is comprehensive and robust. The introduction of a medical examiner role (pilot in place at Sheffield Teaching Hospitals and national mandate expected 2019) and the implementation of comprehensive screening of all deaths will facilitate:

- Early discussion with families and carers providing sensitive and compassionate information and answers to any queries they may have about the care provided to their loved one. Involve them, as appropriate in any investigation.
- Ensure accurate documentation to inform accurate and in-depth clinical coding
- Timely completion of death certificates ensuring families and carers are able to progress their arrangements.
- Timely referral to and better liaison with HM Coroner which will facilitate preparation for inquests.
- The ability to monitor compliance with the Learning from deaths policy
- Enhancement of the dissemination of learning that emerges from the Structured Judgement Reviews

There is anecdotal evidence from Sheffield that this reduces the amount of complaints around the bereavement service. However, this reduction is difficult to quantify. At present, it is not uncommon to have relatives waiting over a week for issue of a death certificate.

HM Coroner (HMC) will hold an inquest when the cause of death is either unknown or likely to have been preventable. They are also likely to hold an inquest if family raise any concerns about the death of a loved one. If these concerns have already been addressed in an open, timely and transparent way, family are less likely to raise them to the HMC.

The greatest benefit remains the accrual and dissemination of learning from the above process, which will significantly enhance the quality of care we provide

The Board is asked to note the progress that has been made to deliver compliance with “Learning from Deaths” and consider the resource requirement to progress achievement of a comprehensive and robust process.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Learning from Deaths Policy

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.**

Author/reviewer	Mandy Dalton
Date written/revised:	July 2017
Approved by:	Clinical Governance Committee
Date of approval:	21st July 2017
Date issued:	
Next review date:	
Target audience:	

CHART A

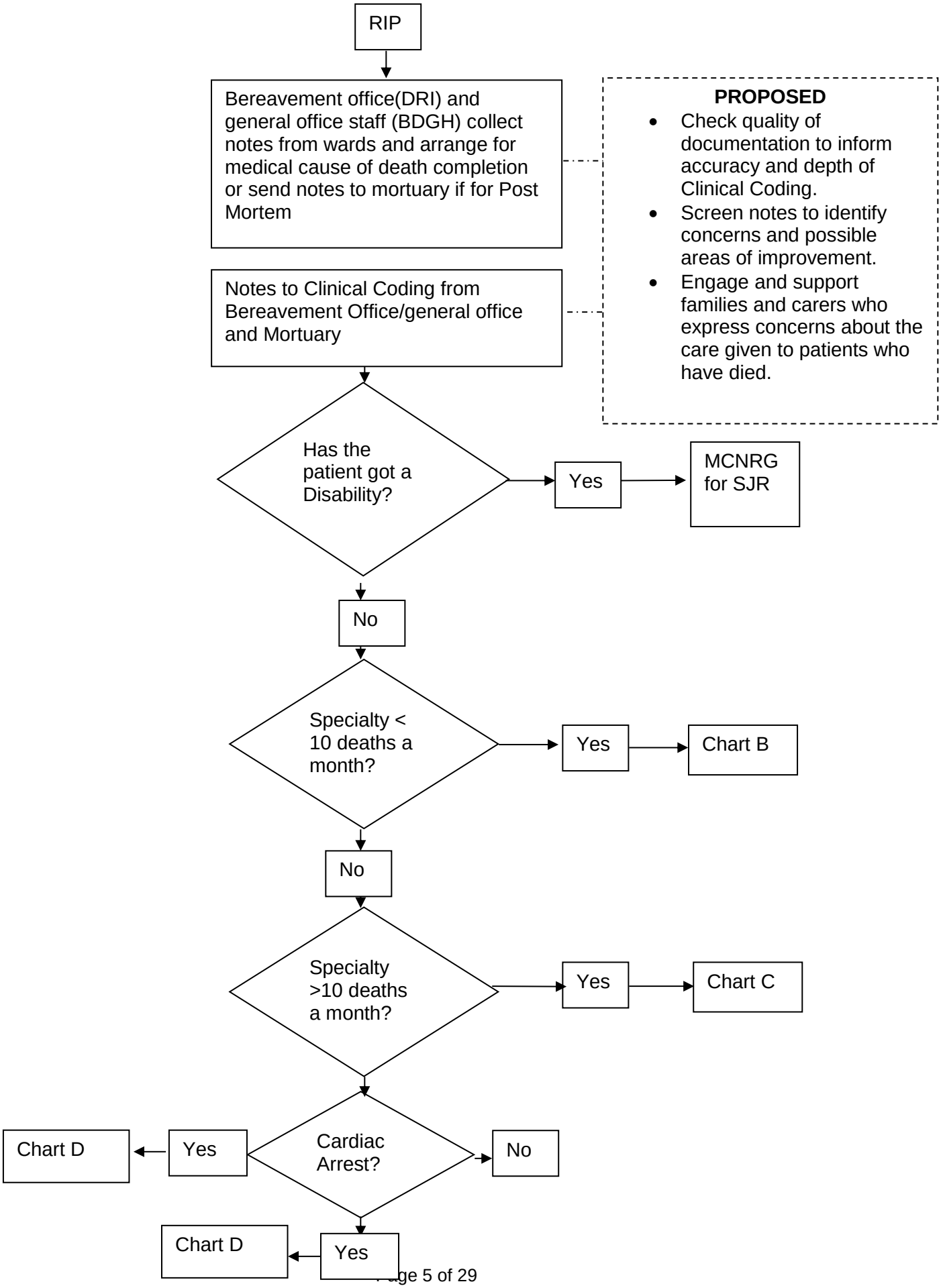

RIP
Bereavement office(DRI) and general office staff (BDGH) collect notes from wards and arrange for medical cause of death completion or send notes to mortuary if for Post Mortem
Notes to Clinical Coding from Bereavement Office/general office and Mortuary
PROPOSED
Check quality of documentation to inform accuracy and depth of Clinical Coding.
Screen notes to identify concerns and possible areas of improvement.
Engage and support families and carers who express concerns about the care given to patients who have died.
Has the patient got a Disability?
Yes
MCNRG for SJR
No
Specialty < 10 deaths a month?
Yes
Chart B
No
Specialty >10 deaths a month?
Yes
Chart C
Cardiac Arrest?
Yes
Chart D
No
Yes
Chart D

CHART B

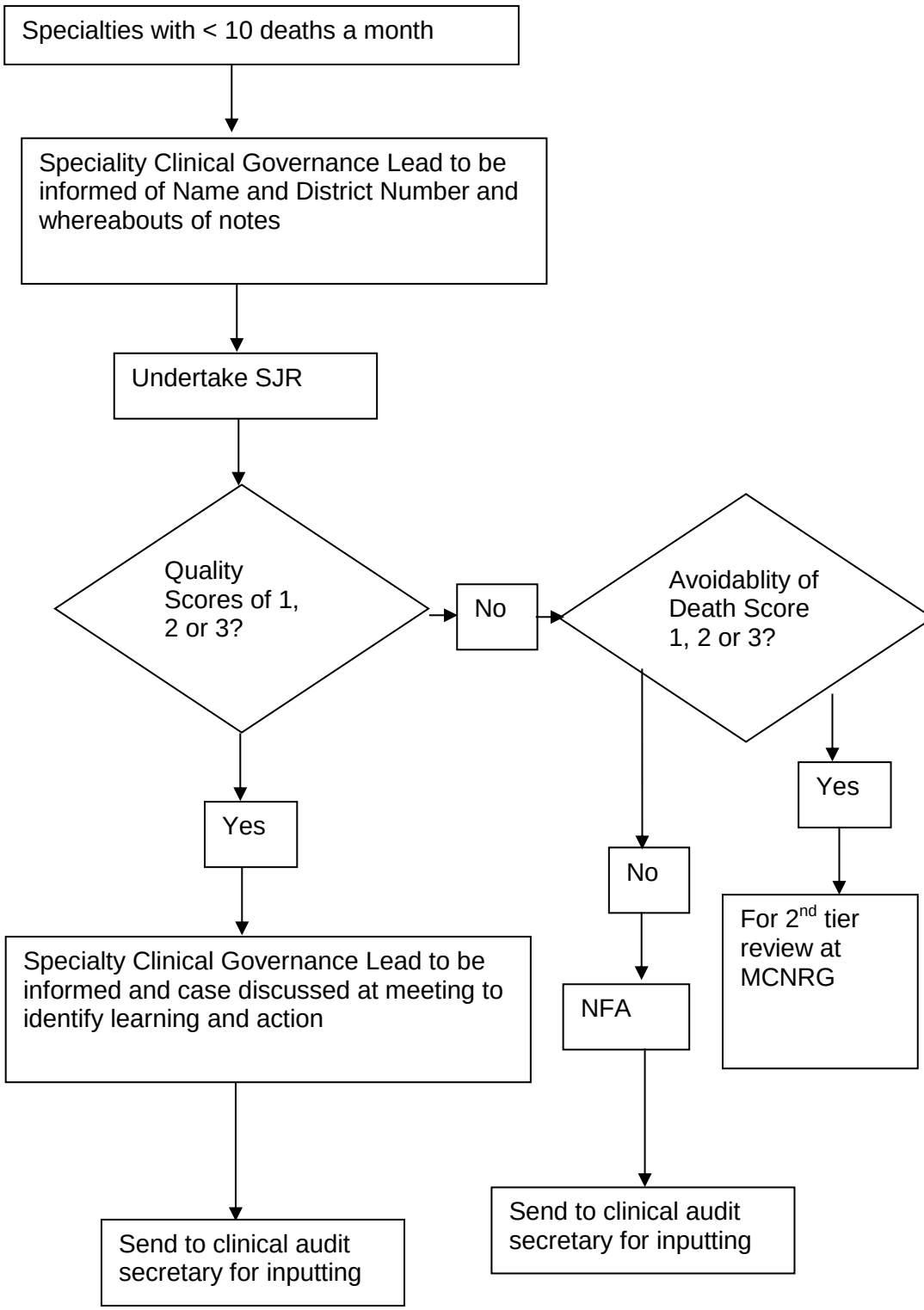

Specialties with < 10 deaths a month
Speciality Clinical Governance Lead to be informed of Name and District Number and whereabouts of notes
Undertake SJR
Quality Scores of 1, 2 or 3?
No
Avoidablity of Death Score 1, 2 or 3?
Yes
Yes
No
For 2nd tier review at MCNRG
Specialty Clinical Governance Lead to be informed and case discussed at meeting to identify learning and action
NFA
Send to clinical audit secretary for inputting
Send to clinical audit secretary for inputting

CHART C

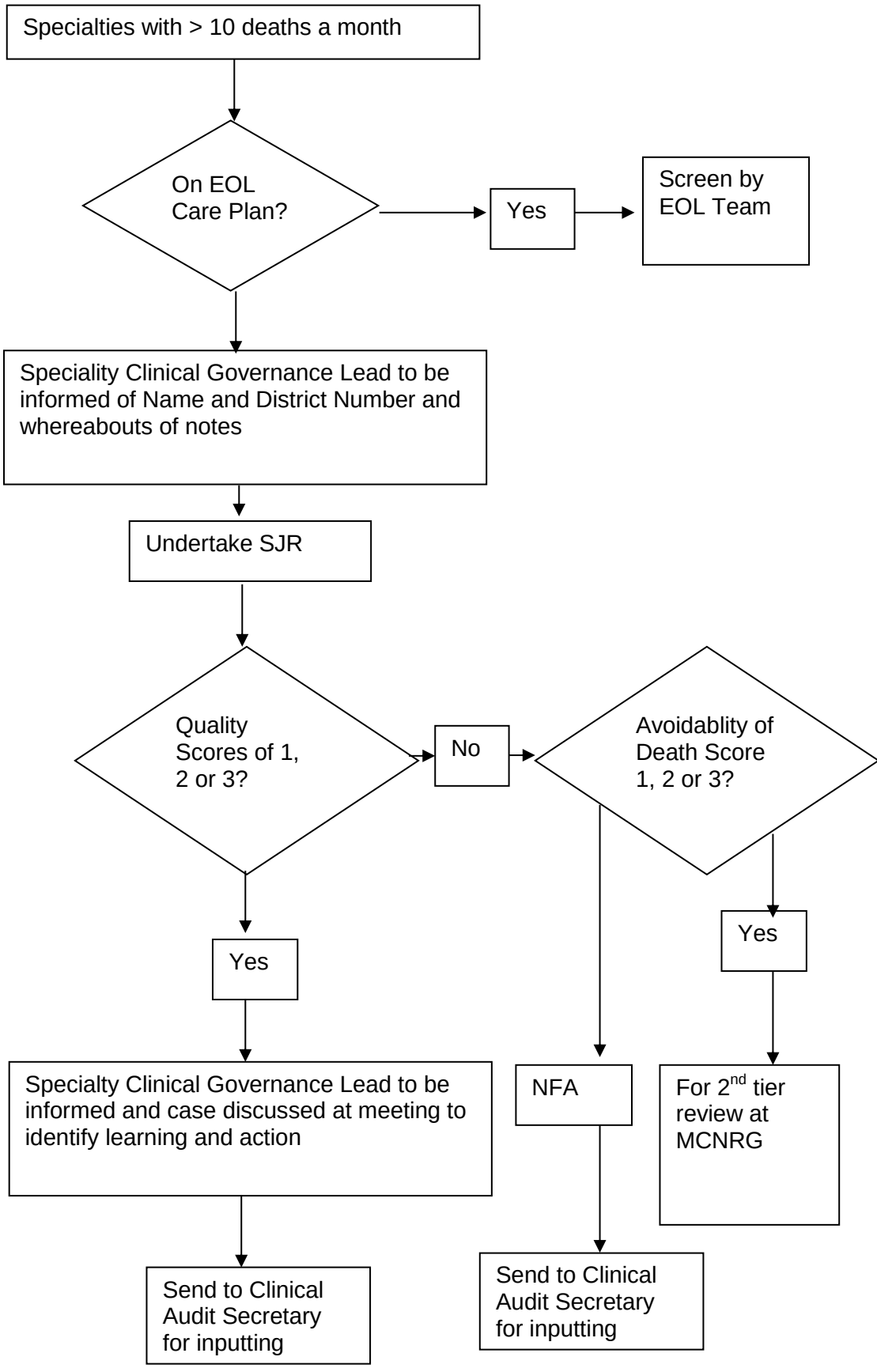
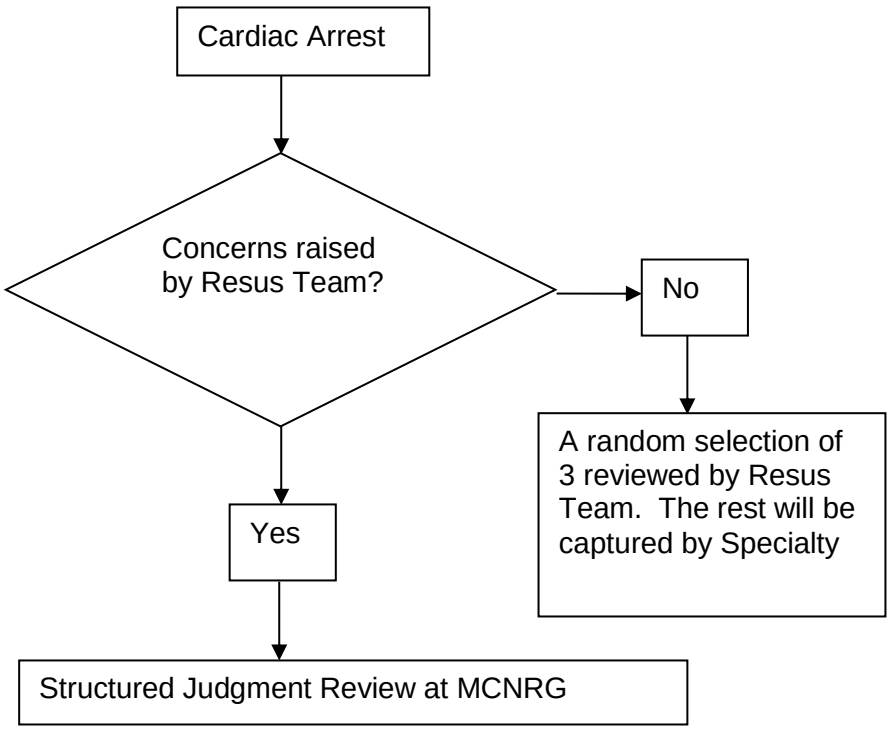

Specialties with > 10 deaths a month
On EOL Care Plan?
Yes
Screen by EOL Team
Speciality Clinical Governance Lead to be informed of Name and District Number and whereabouts of notes
Undertake SJR
Quality Scores of 1, 2 or 3?
No
Avoidablity of Death Score 1, 2 or 3?
Yes
Yes
Specialty Clinical Governance Lead to be informed and case discussed at meeting to identify learning and action
NFA
For 2nd tier review at MCNRG
Send to Clinical Audit Secretary for inputting
Send to Clinical Audit Secretary for inputting

CHART D


Cardiac Arrest
Concerns raised by Resus Team?
No
A random selection of 3 reviewed by Resus Team. The rest will be captured by Specialty
Yes
Structured Judgment Review at MCNRG

Contents

1. INTRODUCTION

1.1. In December 2016, the Care Quality Commission (CQC) published its review on the way NHS Trusts review and investigate the deaths of patients in England: *Learning, candour and accountability.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

1.2. On March 21st 2017 the National Quality Board published "*National Guidance on Learning from Deaths"* which includes very specific guidance on the roles and responsibilities of the Board of Directors and the Non-Executive .It is essential that this guidance be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks.

1.3. The guidance clearly states that the learning from mortality reviews should be integral to a provider's clinical governance and quality improvement work. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

1.4. The guidance also directs all Trusts to publish a Policy on how it responds to, and learns from deaths of patients who die under its management.

2. PURPOSE

2.1 This policy confirms the process to ensure a consistent and coordinated approach for the scrutiny and review of all hospital deaths, including those occurring in the Emergency department and how the process dove tails into existing governance structures.

2.2 This policy recognises the need to consider mortality rates and national mortality indicators, available at diagnosis and individual patient level.

2.3 The aim of this process is to identify any areas of practice both specific to the individual case and beyond that could potentially be improved, based upon peer group review. Areas of good practice are also identified, acknowledged and supported.

2.4 The process will ensure that there are clear reporting mechanisms in place, to escalate any concerns, so that the Trust is aware and can take appropriate actions.

2.5 Statutory Duty of Candour will be applied to all mortality reviews as appropriate

2.6 Deaths in hospital of patients under the age of 18 years and maternal deaths are excluded from this process document because they are reviewed under other

established Trust processes but learning and outcomes of these reviews are fed through to the Mortality Monitoring Group (MMG)

3. ROLES AND RESPONSIBILITIES

3.1 The Medical Director/ Deputy Medical Director will:

- Assure the Board that the mortality review process is in line with the National programme
- Ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.
- Provide advice to the mortality review lead and maintain an oversight of the process.
- Chair the Mortality Monitoring Group (MMG)

3.2 The Non-Executive Director will:

- Have an oversight of the mortality review processes.
- Constructively challenge and support any systems and processes linked to the review, investigation and learning of deaths.
- Ensure the Trust Board of Directors receives on a quarterly basis, data for which they can be assured is accurate and consistent.

3.3 The Trust Lead for Mortality Review will:

- Offer training and advice to colleagues involved with the mortality review process
- Chair the Mortality case note review group (MCNRG)
- Develop and maintain a robust and dynamic screening process ensuring all deaths are scrutinised.
- Arrange for cases graded as a concern by the “first reviewer” (based on phases of care scores and avoidability of death scores of 3 and below) to go to MCNRG for further review and action.
- Feedback concerns raised at MMG to relevant specialties using the specialty governance processes.
- Ensure a random selection of “no concern ” deaths from other specialties have a 2nd review at 6 monthly intervals
- Use the Trust incident reporting system (Datix) to report incidents identified as “serious” to enable review as part of the risk management process.
- In conjunction with the information department and clinical coding, scrutinise the HED data and ensure that external mortality alerts are investigated and any associated concerns are resolved.

- Provide monthly reports to MMG on specialty compliance with process and quarterly thematic analysis reports to specialty governance groups.
- Ensure that any actions identified in relation to mortality review are recorded, progressed and monitored.
- Ensure compliance with the Statutory Duty of Candour.

3.4 CARE GROUP MANAGEMENT TEAMS/CLINICAL GOVERNANCE LEADS WILL:

- Ensure that those specialties with <10 deaths per month review ALL deaths using the Structure Judgement Review form **(Appendix 1**)
- Ensure those specialties with > 10 deaths per month can demonstrate that all notes are "screened" using the trust approved screening tool (**Appendix 2)** and at least 10 have a full SJR.
- Ensure that all findings from mortality review are reported and discussed as part of the care group clinical governance process, to demonstrate compliance with Care Quality Commission (CQC) Regulation 17 "Good Governance"

3.5 THE BEREAVEMENT TEAM (DRI) AND GENERAL OFFICE (BDGH) WILL:

- Identify all in hospital deaths
- Ensure the first section of the mortality database is completed
- Send all notes of patient's referred for post mortem and cremation to the mortuary(DRI patients) Post mortems for BDGH patients are held at Nottingham Queens Medical centre. Notes will be sent with the body.
- Send all notes of patients for burial to Clinical Coding once the family have received the death certificate

3.6 THE CLINICAL CODING DEPARTMENT WILL:

- Collect notes from mortuary twice a week
- Code all "death notes" within agreed timescales
- Complete the clinical coding section of the mortality data base
- Provide support to the MMG and MCNRG
- Work with the mortality review lead to ensure a workable process for Consultants to access notes

3.7 SPECIALTY GOVERNANCE/MORTALITY LEADS WILL:

- Be responsible for the dissemination of notes requiring mortality review. Individuals reviewing cases for which they had sole responsibility should be avoided; the case should be reviewed by a Consultant/senior clinician NOT directly involved with the case

- Ensure that a summary of cases is discussed and minuted at the specialty clinical governance meeting and that action plans are completed and monitored
- Provide feedback to MMG of any key learning
- Provide reports and additional information on mortality reviews as requested by MMG
- Receive feedback and learning points from MMG and ensure learning outcomes and action plans are included in the specialty governance and audit plans.

3.8 REVIEWERS WILL:

- Specialty reviewers will review cases within 4 weeks of receipt of the cases identified utilising the Trust's structured judgement case note review methodology and completing the Structured Judgement review form (SJR) and return it to clinical audit for data inputting.
- Mortality review group members will review those cases identified by the mortality review lead on a monthly basis

3.8 END OF LIFE TEAM WILL:

- Screen all case records of patients within the specialty of acute medicine who are on an individualised plan of care for the last hours/days of life and refer cases to MCNRG as indicated on the screening tool.
- Be a member of the MCNRG at DRI and BDGH and participate at the monthly meetings.
- Provide input at MMG.

4. PROCEDURE

- In hospital death identified and entered onto Mortality data base by bereavement staff (DRI), general office staff (BDGH) **Chart A**
- Specialties with <10 deaths per month to undertake a full Structured Judgement Mortality review on all deaths**. Chart B**
- Specialties with > 10 deaths per month to undertake a full Structured Judgement Mortality review of at least 10 cases. **Chart C**
- Deaths of patients on end of life care pathways and within specialties having > 10 deaths per month will be screened by the end of life team. All other cases will be screened by the mortality review lead. **Chart C**
- Any review resulting in a care score or avoidability of death score of 1, 2 or 3 will be further reviewed at the MCNRG meeting and actioned accordingly.
- Any death of a patient with a learning disability will be reviewed at the MCNRG meeting and have input from the Learning disability liaison nurse. **Chart A**
- Patients who have in hospital cardiac arrest follow **Chart D**
- Specialty governance groups to receive the findings of mortality reviews, identify learning and monitor action plans
- A Random selection of 10 "no concern" deaths from each care group to be reviewed at MCNRG at 6 monthly intervals. If any of these reviews identify an

issue with care, the case must be taken to MMG for consideration of ongoing action.

5. ENGAGING BEREAVED FAMILIES AND CARERS

- Bereaved families and carers will be given an opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.
- Bereaved families and carers will be involved in the investigation of any death that is concluded to be avoidable as part of the Serious Incident investigation process. They will receive an investigation report including any actions taken to ensure lessons are learned.

6. TRAINING/ SUPPORT

- The Training and Education department will support development of educational tools to support any identified learning
- Group training will be available three times a year
- Care group trainers will ensure that sufficient clinicians within each specialty are trained in the use of SJR
- All reviewers will undertake at least 10 reviews per year

7. LEARNING

- Learning identified will be shared within the identified specialty and/or Trust wide, dependant on issue, following established clinical governance processes and structures.
- Themes will be identified as part of a quarterly thematic analysis and taken forward as Quality Improvement projects.

8. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Specialties with <10 deaths per month to undertake SJR on all cases	Mortality Monitoring group	Quarterly review of compliance	Report received at MMG and to form part of annual report to Trust Clinical Governance and Quality Committee (CGQC)meeting
Specialties with >10 deaths per month to	Mortality Monitoring group	Quarterly review of compliance	Report received at MMG and to form part of

undertake SJR on 10 cases, all others to be screened			annual report to Trust Clinical Governance and Quality Committee meeting
Receipt of review findings and identification of learning	Clinical Governance and Quality Committee	Annual	Care group clinical governance report received by CGQC

9. DEFINITIONS

MMG = Mortality Monitoring Group
MCNRG = Mortality case note review group
CGQC = Clinical Governance and Quality Committee
SJR = Structured judgement review.
SI = Serious incident

10. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 3)

11. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Serious Incident Policy CORP/RISK 15
- Being Open and Duty of Candour CORP/RISK 14

12. REFERENCES

1. Hutchinson A, National Mortality Case Record Review programme. Nov 2016
2. Learning, candour and accountability. CQC. December 2016
3. National Guidance on learning from Deaths. NQB. March 2017


Royal College of Physicians
National Mortality Case Record Review Programme
Using the structured judgement review method
Data collection form
(England version)
In partnership with:
Improvement Academy
Part of the Yorkshire & Humber AHSN
Datix
Software for patient safety
Commissioned by:
HQIP
Healthcare Quality Improvement Partnership

National Mortality Case Record Review Programme: Structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:
Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

Guidance for reviewers

1) Did the patient have a learning disability?

1. No indication of a learning disability – proceed with this review.
2. Yes – clear or possible indications from the case records of a learning disability. Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2) Did the patient have a serious mental health issue?

- No indication of a severe mental health issue – proceed with this review
- Yes- clear or possible indications from the case records of a severe mental health issues. Action: after your review, please refer the case to the hospital's clinical governance group.

3) Is the patient under 18 years old?

- No the patient is 18 years or older – proceed with this review.
- Yes- the patient is under 18 years old. Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child's Deaths review programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor 2 = poor 3 = adequate 4 = good 5 = Excellent

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*
   Yes ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
4. **Problem with infection management Yes** ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
5. **Problem related to operation / invasive procedure** *(other than infection control)*
   Yes ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐
8. **Problem of any other type not fitting the categories above Yes** ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Avoidability of death judgement score
(Most appropriately used at second stage review, if required)

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

Score 1 Definitely avoidable

Score 2 Strong evidence of avoidability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 Definitely not avoidable

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

Please note that this data collection sheet is subject to change following conclusion of the pilot phase of the programme.

Appendix 2

Mortality Review screening tool

Date of admission		Please affix patient label	
Source of admission			
Date of death			
Consultant			
GP		**Screening Completed by**	

Cause of death (as recorded on the Death Certificate)

1a	
1b	
1c	
2	

Clinician assessment

Reason for admission	
Main treating diagnosis	

Brief summary of case:

Was the admission potentially avoidable? Y/N

		YES	NO			YES	NO
1	Inappropriate/delayed management of sepsis			**6**	Inadequate bedside observations		
2	Problem with assessment, or diagnosis			**7**	Failed/delayed escalation of deteriorating patient		
3	Delayed/missed investigations			**8**	Poor communication		
4	Delayed/missed treatment			**9**	Inappropriate timing of commencement of EOL care plan		
5	Inadequate fluid balance monitoring			**10**	Learning disability/mental health problem		

If answered YES to any of the above, to go for full Structured Judgment Review

APPENDIX 3 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Learning from Deaths Policy	Corporate Directorate	Mandy Dalton	New Policy	July 2017

1) Who is responsible for this policy? The Corporate Medical Directorate

2) Describe the purpose of the policy: To ensure scrutiny and learning following all in hospital deaths.

3) Are there any associated objectives? Compliance with best practice and CQC requirements

4) What factors contribute or detract from achieving intended outcomes? – Non-compliance with policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? NO

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	no	
b) Disability	no	
c) Gender	no	
d) Gender Reassignment	no	
e) Marriage/Civil Partnership	no	
f) Maternity/Pregnancy	no	
g) Race	no	
h) Religion/Belief	no	
i) Sexual Orientation	no	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: July 2019 Checked by Mandy Dalton 7th July 2017

Appendix 2

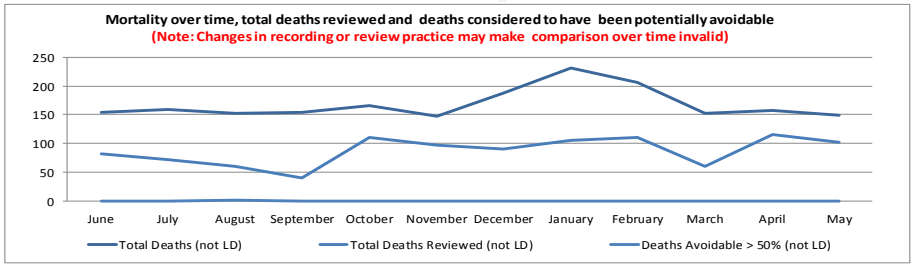
Doncaster & Bassetlaw Teaching Hospitals - Learning from deaths - 2017-2018
May 2017

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
149	158	102	115	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
307	590	217	276	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
307	2023	217	981	0	6



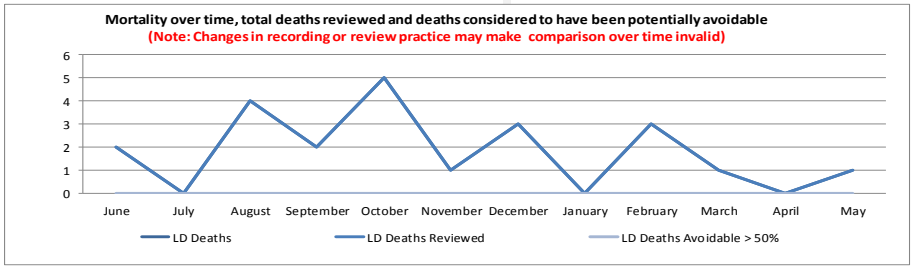
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.00%	This Month	0	0.00%	This Month	1	0.67%	This Month	100	67.11%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.00%	This Quarter (QTD)	1	0.33%	This Quarter (QTD)	4	1.30%	This Quarter (QTD	211	68.73%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.00%	This Year (YTD)	0	0.00%	This Year (YTD)	1	0.33%	This Year (YTD)	4	1.30%	This Year (YTD)	211	68.73%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	4	1	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	22	1	22	0	0



Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Emeritus Status**		
Report to	**Board of Directors**	**Date**	**29 August 2017**
Author	**Sewa Singh, Medical Director**		
Purpose			Tick one as appropriate
	Decision		X
	Assurance		
	Information		

Executive summary containing key messages and issues

Consultants retiring from NHS hospital appointments request, and may be offered, some form of Honorary Emeritus status.

Historically, the Trust has taken the view that it would wish retiring Consultants to maintain their contact with hospitals and their colleagues locally, and where requested, would consider offering Honorary Emeritus status, with its associated rights of access to the library and postgraduate meetings.

The title is awarded to Consultants who have provided meritorious service to the Trust.

Dr Northwood worked in the Trust for a period of 23 years as a Consultant Anaesthetist and held the role of Specialty Clinical Governance Lead for Anaesthetics prior to the organisational re-structure in 2014 and latterly as Care Group Clinical Governance Lead for the Surgical Care Group 2014-2017. He has undertaken a number of case reviews on behalf of the Medical Director's office in relation to professional standards concerns.

Key questions posed by the report

Not applicable.

How this report contributes to the delivery of the strategic objectives

Not applicable.

How this report impacts on current risks or highlights new risks

Not applicable.

Recommendation(s) and next steps
The Board of Directors is asked to grant Emeritus Consultant Status to Dr David Northwood, Consultant Anesthetist at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Health and Wellbeing update**		
Report to	**Board of Directors**	**Date**	**August 2017**
Author	**Helen Houghton, Health and Wellbeing Lead**		
Purpose			Tick one as appropriate
	Decision		✓
	Assurance		
	Information		

Executive summary containing key messages and issues

The purpose of this paper is to provide the Board of Directors with an update on the Trust's Health and Wellbeing activity.
The paper demonstrates the achievements made in the last 2 years and the positive impact this is having on the health and wellbeing of our staff and highlights the challenges going forward. A recent survey found the following improvements:

	2015	2017
Smoking prevalence	8.7%	8%
Eating 5 portions of fruit and Veg a day	70.39%	68%
Drinking alcohol 4 or more times a week	11.97%	9%
Physical activity- 3 or more times a week	45%	55%
Don't have some to talk to if they have a problem or worry	13%	9%

Awards and Achievements

- Achieved the Nottinghamshire Bronze, Silver and Gold Wellbeing at Work Award, and now working towards platinum
- Working towards National Workplace Health Charter status
- Achieved the Bronze NHS Sport and Physical Activity Award and now working towards silver.
- Achieved the Bronze NHS 'Race to Rio' Challenge

- NHS Employer Flu Fighter Champion winner 2017 and shortlisted for the HSJ 2017 Flu Award (first acute Trust to achieve 75% uptake)
- Flu Campaign Team shortlisted for the Trust Team of the Year star Awards

Impact on sickness absence rates

The actions have had a positive effect on the sickness absence rates and the first quarter of the financial year has seen a reduction on the sickness rates as outlined in the below table.

KPI		Absence		
Cumulative Q1 Trust / Target		%	3.83%	3.50%
Months		April	May	June
Trust	%	4.01%	3.26%	3.50%

Key questions posed by the report

Is the Board assured that adequate progress is being made to support the health and wellbeing of staff?

How this report contributes to the delivery of the strategic objectives

This report details the progress made so far and the proposed actions to ensure we can demonstrate the application of our values (We Care) across Team DBTH.

How this report impacts on current risks or highlights new risks

By supporting staff health and wellbeing this will help reduce the risk of increased levels of sickness absence and will support the organization in being an employer of choice

Recommendation(s) and next steps

The Board is asked to acknowledge the progress made with regards to health and wellbeing activity but also to acknowledge the challenges that lie ahead.
The Board is asked to re-affirm its commitment to improving staff health and wellbeing and supporting the agenda and actions moving forward

1. Introduction

The role of the Board of Directors and the clinical leadership of the Trust in creating an environment where the health and wellbeing of staff is actively promoted and encouraged is incredibly important to our organisation. We know a key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. We are also aware of the holistic offer that staff need to be able to access to ensure that they can lead a happy and healthy life whilst they are here at DBTH.

The aim of this report is to demonstrate our efforts so far in trying to improve employee health and wellbeing by providing enhanced lifestyle advice and facilitating interventions, whilst also promoting a culture of confidence and resilience amongst the workforce and positive manager/employee relationships.

2. Background

DBTH has a Health and Wellbeing Strategy that was approved at Board of Directors in September 2015; it identifies our starting point as an organisation and identifies our baseline data in terms of health behaviours of staff, our gaps in terms of the offer we provided to staff and it details the staff engagement that has been carried out to identify what action we needed to take forward. A lot of the activity identified within the strategy is required from us to achieve the CQUIN target set out for 2017-2019 and helped us to achieve our Health and Wellbeing CQUIN targets for 2016/17. Thus meaning we are already in a position to take forward the challenge of achieving the CQUIN with some confidence that we can achieve what is being asked of us.

3. Baseline Data – where are we now?

In 2015 we asked a range of lifestyle behaviour questions along with asking staff what they wanted and what would help them lead a healthier lifestyle. This provided us with a comprehensive list of the most frequent suggestions:

- Onsite exercise opportunities (including a gym)
- More affordable healthy options in the dining room
- Better healthy options in the canteen and vending machines
- Shower and changing facilities
- Regular and sufficient breaks
- Onsite weight management programmes
- Health Checks
- Incentives
- Free and reduced rate gym memberships
- Stress management support
- Cycle storage

- Evening food availability

The survey was repeated earlier this year (Feb 17) and saw the following results:

	2015	2017
Smoking prevalence	8.7%	8%
Eating 5 portions of fruit and Veg a day	70.39%	68%
Drinking alcohol 4 or more times a week	11.97%	9%
Physical activity- 3 or more times a week	45%	55%
Don't have some to talk to if they have a problem or worry	13%	9%

The survey was repeated in Feb 2017 and again we asked what people thought would help them to live a healthier lifestyle, the most popular answers were as follows.

- Calories on the board in the canteen
- Healthy eating at work
- Coupons
- More sleep, more exercise, less alcohol
- To lose weight
- More fruit in the canteen
- Better work life balance more time off work
- Recipe to appear in buzz
- Short regular breaks to improve productivity and decrease stress levels
- Allowing us to have hydration breaks, fruit/veg
- Free classes
- Family friendly work shifts
- Group sessions i.e. running clubs
- 45min break at work
- Physical exercise for poor mobility
- Healthy competitions between depts. i.e. running
- Gym
- Better bike facilities
- More understanding and support from manager
- Less stress at work
- Cheaper veg options

4. Our Offer so far

Our ambitions are high to achieve a significant step change in the health and wellbeing outcomes for our staff, those in their circle of influence and our patients' experience and as such we have thought about a range of solutions. Whilst some of these are initiatives

we have recently started we recognise the importance of introducing new initiatives to help us increase engagement.

A range of health and wellbeing activity has been developed and delivered across the organisation to support the delivery of our health and wellbeing strategy. This includes:

- Onsite smoking cessation classes for all staff
- A developing range of physical activities including onsite exercise classes, a walking programme, lunchtime walks and a range of team activities developed
- Onsite weight management classes for all staff
- National and local campaigns and challenges- Blood pressure campaign, Stoptober, Movember, De-Chox, Mental Health Week, a range of Cancer awareness campaigns, Dry January, Time to Change, Nutrition and Hydration, plus many more.
- Domestic Violence Awareness sessions for Managers
- Successful Flu vaccination programme which saw 77.6% of all frontline staff vaccinated against flu and flu vaccines offered to all non-frontline staff also.
- A calendar of social events and activities
- A range of mindfulness opportunities
- Onsite holistic therapies offered
- 'Coping with Stress' workshops, 'Mental Health First Aid' and 'Creating a mentally healthy workplace' training offered
- Lifestyle Assessment Service
- Draft Active Travel Plan
- Development of the Occupational Health and Wellbeing service

A number of additional strategic and operational improvements have been made which include:

- The development of a Health and Wellbeing Committee which is made up of a range of senior leaders from within the organisation. The committee has a clear line of accountability to the Board of Directors through the Workforce and Education Committee to the Quality and Effectiveness Committee. It also has a clinical and executive lead for Health and wellbeing which is a first for DBTH.
- The development of a Trust health and wellbeing hub on the intranet which makes it easy for staff to access all health related information and activity.
- The development of a team of health and wellbeing champions who are trained through the Royal Society of Public Health and are advocates for the agenda and are trained to support colleagues with behaviour change and support the roll out of the Making Every Contact Count Agenda.

5. **Achievements**

As well as the achievements in reductions of unhealthy behaviours which have been identified earlier on in this paper, the organisation has also recruited and are training over 55 health champions from within the organisation and the commitment to develop this further is great to see. We have seen an increase in the referral rates to our onsite staff physiotherapy service and we saw an additional 100 members of staff in 16/17.

In addition to this, as an organisation, we have also achieved the following awards and accolades:

- Achieved the Nottinghamshire Bronze, Silver and Gold Wellbeing at Work Award, and now working towards platinum
- Working towards National Workplace Health Charter status
- Achieved the Bronze NHS Sport and Physical Activity Award and now working towards silver.
- Achieved the Bronze NHS 'Race to Rio' Challenge
- NHS Employer Flu Fighter Champion winner 2017 and shortlisted for the HSJ 2017 Flu Award
- Flu Campaign Team shortlisted for the Trust Team of the Year star Awards

6. Sickness Absence Management

Up until the end of the previous financial year the Trusts sickness absence percentage rates had been gradually increasing month on month and the OH Team were providing additional support to the HR Business Partners to help introduce measures to halt the increase in the absence percentages and start to reduce the overall Trust position.

The team took a number of actions to address the trend and provided support to management teams to help reduce the volume of sickness absence across departments. The OH Team offered to undertake case conferences regarding individual cases, involving the HRBP, manager and OH Physician to identify support mechanisms that could be introduced and help to develop individual actions plans. The OH Team also supported the introduction of a review process for long term absence cases, initially that were in excess of 6 months to ensure all actions to support individuals were being taken and agree objectives and actions to help manage cases and support sustained return to work. These meetings have been very productive and have seen a reduction in relation to the numbers of staff off on long term sick, to progress the work further the threshold has been reduced to include staff that have been off long term for more than 4 months.

The actions have had a positive effect on the sickness absence rates and the first quarter of the financial year has seen a reduction on the sickness rates as outlined in the table below.

KPI		Absence		
Cumulative Q1 Trust / Target		%	3.83%	3.50%
Months		April	May	June
Trust	%	4.01%	3.26%	3.50%

7. **Moving forward and the challenges**

Moving forward it is important that the organisation is committed to continuing with the health and wellbeing activity that has started at DBTH. The delivery of the Health and Wellbeing Strategy along with the Health and Wellbeing CQUIN for 2017/18 and 2018/19 must remain a key objective for the organisation moving forward.

Whilst the results from the recent lifestyle survey to staff show in the last 2 years we have made an improvement in all areas of behaviour change, including, smoking prevalence, levels of physical activity, fruit and vegetable consumption and alcohol consumption and we have improved our percentage of staff who feel they have someone to talk to if they have a problem, worry or concern, the achievement of this year's CQUIN is reliant upon improvements to the results of the staff survey in relation to 2 out of the following 3 questions:

- Does your organisation take positive actions on health and wellbeing?
- In the last 12 months have you experienced MSK problems as a result of work activities?
- In the last 12 months have you felt unwell as a result of work related stress?

We have therefore been asking these questions as part of the quarterly Staff FFT surveys to gauge where we need to focus our attentions.

At recent Health and Wellbeing Committee meetings we have also paid attention to the resilience of staff, supporting managers in identifying staff who may be experiencing difficulties and ensuring that staff are taking adequate breaks.

We have also clearly identified through engagement with staff which activities they would like us to focus on and what type of information and campaigns they would be interested in. All of this will help us plan and deliver the next stage of our strategy and action plan and help us to improve the health and wellbeing of our staff which will in turn help us to deliver better patient care.

The occupational health service is accredited through the national awarding body SEQOHS. An inspection takes place every 5 years, with an annual renewal, to ensure the

service maintains the high standards it should be operating to. The service has recently undertaken the 5 year re-inspection and hopes to maintain its accreditation once a few key actions are put into place in the next 3 months. Appropriate support to ensure the service can achieve this re-accreditation has been put in place as the importance of this is recognised.

The challenges we face in taking forward our health and wellbeing strategy lie in a number of areas. As the organisation has and continues to move through a period of change, this will inevitably impact on staff wellbeing. We must ensure that staff health and wellbeing remains at the heart of the change process and ensure engagement with the health and wellbeing team to reduce the impact on staff as much as possible. Board members are asked to re-affirm their commitment to the health and wellbeing of the Trust's staff.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Risk Identification, Assessment and Management Policy**		
Report to	**Board of Directors**	**Date**	**29 August 2017**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		x
	Assurance		
	Information		

Executive summary containing key messages and issues
The Risk Identification, Assessment and Management Policy has been updated in view of the changes to the board committee structure and ongoing revisions to the BAF and Corporate Risk Register.
Key questions posed by the report
• Does the policy adequately cover the principles of identifying, assessing and managing risk?
How this report contributes to the delivery of the strategic objectives
The new Board Assurance Framework will enable greater oversight of key risks against the Trust's strategic and corporate objectives.
How this report impacts on current risks or highlights new risks
The policy sets out a framework for the Trust to be sighted on and better manage its corporate risks.
Recommendation(s) and next steps
Board is asked to approve the Policy.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Risk Identification, Assessment, and Management Policy

This procedural document supersedes: CORP/RISK 30 v.1

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.**

Author/reviewer:	Matthew Kane
Date written/revised:	July 2017
Approved by:	Board of Directors
Date of approval:	25 July 2017
Date issued:	?
Next review date:	July 2020
Target audience:	Trust-wide

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
Version 1	11 August 2014	This is a new procedural document and replaces CORP/RISK 18 v.2 – Risk Assessment Policy (Clinical and Non Clinical) and CORP/RISK 10 v.4 – Risk Management Strategy.	M Dixon
Version 2	September 2015	Minor changes to reflect the implementation of the online integrated risk management system (Datix).	M Dixon
Version 3	July 2017	Changes to reflect new committee structure and reformatted Board Assurance Framework	M Kane

Contents

Wards / Departments / Teams / Nominated Leads

- Identify risks and hazards
- Conduct risks assessments as appropriate
- Manages risks rated 1-7
- Escalates risks rated 8 or above.
- Reviews local risk assessments (at least annually).

Care Group / Directorate Management Teams

(Care Group Director / Executive Director = accountable lead)

- Accountable for all Care Group/ Directorate risks, including those escalated.

  Monitors and reviews Care Group / Directorate Risk Register (monthly).

-
- Ensures action plans in place, and monitors them.
- Escalates (but continues to review and monitor) risks rated 15 or

Management Board

- Monitors and reviews Corporate Risk Register (monthly).
- Approves additions / removals / changes to the Corporate Register.
- Where addition to the Corporate Register is not approved, specifies required action.
- Approves action, where appropriate.

Board of Directors

- Receives Corporate Risk Register (6-monthly).
- Determines risk appetite and tolerance
- Approves Board Assurance Framework (risks against strategic aims).

Care Group Clinical Governance Groups

- *Manages clinical risks on Care Group risk register.*
- *Identifies Care Group level risk themes from reported incidents, complaints and claims.*
- *Nominates appropriate leads to conduct formal risk assessments.*

CGC and other committees with a remit pertaining to specific areas of risk or clinical governance

- *Identifies risk themes within their remit.*
- *Nominates appropriate leads to conduct formal risk assessments where themes have been identified, and escalates where appropriate.*

ANCR, F&P and QEC

- *Seeks assurance regarding risk management and control on behalf of the Board of Directors*
- *Receives Corporate Risk Register*
- *Reviews Board Assurance Framework*
- *Identifies trust-wide risk themes.*
- *Nominates appropriate leads to conduct formal risk assessments where themes have been identified, and escalates where appropriate.*

GOVERNANCE ASSURANCE COMMITTEES

1. INTRODUCTION

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust ('the Trust') recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances all, by their very nature, involve a degree of risk. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust. Failure to manage risk effectively can lead to harm, loss or damage in terms of both personal injury but also in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation and adverse or unwanted publicity.

This policy covers all aspects of risk assessment and management within the Trust. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, organisational or financial. Risk management is embedded within the Trust's overall performance management framework and links with business planning and investment.

The Board of Directors has overall responsibility for corporate governance, including risk management. The Board has legal and statutory obligations to ensure that there are robust and effective risk management processes and structures in place.

The Trust uses an online integrated risk management system to record risk assessments and risk registers at all levels. The system enable risk register reports to be produced for review and audit purposes, and also enables risks to be escalated as appropriate, therefore supporting a culture of proactive risk management.

This policy is intended for use by all employees and contractors engaged on Trust work in respect of any aspect of that work. Although the management of key strategic risks is monitored by the Board, operational risks are managed on a day to day basis by employees throughout the Trust. The Trust's Board Assurance Framework and Corporate Risk Register provide a central record of the organisation's principal risks.

2. PURPOSE

2.1 The purpose of this policy is to ensure that risks to the following areas are identified, assessed and managed; in addition to being prevented and controlled so far as is reasonably practicable:

a. the Trust's patients, visitors and members of the public
b. the Trust's strategic objectives
c. the Trust's employees,
d. the reputation, finances and business continuity of the Trust
e. the property, sites and equipment owned by the Trust

2.2 This policy highlights the legal requirements placed on the Trust by the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, to carry out risk assessment to identify the hazards and risk associated with the workplace and the work carried out by employees.

3. DUTIES AND RESPONSIBILITIES

3.1 Chief Executive

The Chief Executive has overall accountability and responsibility for risk management within the Trust and for compliance with the relevant regulations, and is responsible for making the Trust's Annual Governance Statement. Delegated responsibility for the implementation of this policy is as shown below.

3.2 Employees

Management of risk is a fundamental duty of all employees whatever their grade, role or status. Employees are required to follow Trust policies and procedures, which explain how this duty is to be undertaken.

In particular, all employees must ensure that identified risks and incidents are reported and dealt with swiftly and effectively, reported in line with relevant Trust policies to their immediate line manager and, if appropriate, their health & safety representative, in order that further action may be taken where necessary. Health and safety is a core element of each employee's KSF (Knowledge and Skills Framework) outline.

3.3 Executive Directors

The Executive Directors are responsible for those risks which are relevant to their areas of responsibility. In particular, the Medical Director and Director of Nursing, Midwifery & Quality are responsible for risk that has a direct impact upon patient care, safety and quality of care, and the Director of Finance for financial risk. The allocation of risks to individual Directors is shown in both the Board Assurance Framework and Corporate Risk Register.

3.4 Deputy Director of Quality & Governance

The Deputy Director of Quality and Governance is responsible for the operation of the Trust's online integrated risk management system, and ensuring Care Group Directors and managers are supported to fulfil out their responsibilities in line with this policy.

3.5 Head of Corporate Affairs

The Trust Board Secretary, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and Corporate Risk Register.

3.6 Care Group Directors / Managers

Care Group Directors and managers of departments will ensure that they have a lead for:

- The development of a Care Group/department risk register using the Trust's online integrated risk management system.
- The implementation of risk management systems and processes, both clinical and non-clinical, in each ward or department concerned.
- Ensuring attendance of staff at appropriate education and training sessions.
- Implementing specific policies and procedures.
- Raising risk awareness amongst all staff at operational level.
- Ensuring compliance with external assurance assessments and standards.

3.7 Board of Directors

The Board of Directors is responsible for ensuring that robust systems of internal control and management are in place, and for reviewing the effectiveness of internal controls through its assurance framework. This responsibility is supported through the governance committees of the Board of Directors (see 3.8).

To inform the Annual Governance Statement made by the Chief Executive in the annual accounts, the Board of Directors must be able to demonstrate that it has been informed, through the assurance framework, about all significant risks and that it has arrived at its conclusions on the totality of risk, based on the evidence presented to it.

3.8 Board committees

The Audit and Non-clinical Risk, Finance and Performance and Quality and Effectiveness Committees are established as governance committees of the Board of Directors. The committees' primary role in respect of risk management is to seek assurance on behalf of the board that internal control and risk management systems are sufficiently robust to ensure delivery of organisational objectives. Where there are significant concerns or gaps in assurance or control, the committees escalate these to the Board.

Each committee owns relevant risks on the board assurance framework and corporate risk register. The committees review both documents at each of their meetings. The ANCR also monitors the integrity of the financial statements of the Trust, while the QEC monitors clinical governance standards.

3.9 Management Board

The Management Board is responsible for monitoring and reviewing the Corporate Risk Register on a monthly basis and approving any changes.

3.10 Clinical Governance Committee (CGC)

The Clinical Governance Quality Committee is responsible for the operational aspects of clinical risk, clinical governance and patient safety.

4. ASSURANCE FRAMEWORK AND RISK REGISTERS

4.1 Board Assurance Framework

The board assurance framework is a tool to enable the Board to assure itself that the principal risks to the achievement of its organisational objectives are being appropriately managed. It is interlinked with the corporate risk register and is structured around the Board's strategic objectives.

The framework summarises the controls in place to mitigate each risk, and highlights where there are gaps in these controls. It also provides a summary of positive assurances received by the Board and its sub-committees in relation to these controls, highlighting where there are gaps in assurance.

The Chief Executive is required to sign an Annual Governance Statement each year, and the board assurance framework informs the declarations to be made in this statement.

The framework shows a summary description of each risk, along with a numerical and red/amber/green risk rating for the current risk after controls, for ease of use by the Board. The assurance framework shall also show the executive lead, the relevant committee, the direction of travel, controls in place, assurance received, gaps in assurance, action being taken to address gaps and target rating.

The framework will be continually reviewed and updated to ensure that it continues to provide the Board with assurance.

The board committees review the full Board Assurance Framework in addition to receiving the Corporate Risk Register for information, in order to avoid taking a fragmented approach to risks at this level.

The board committees each focus on the risks which pertain to their remit and terms of reference. They seek assurance on behalf of the Board that key controls are in place and review risks through their annual work plans. The assurance framework is used to drive the agenda for the committees who will undertake occasional deep dives into the risks for which they are responsible.

The Board receives the board assurance framework and corporate risk register on a quarterly basis.

At least once a year, the Audit and Non-clinical Risk Committee will review whether the assurance framework process and format remain fit for purpose, and recommend changes to the Board where appropriate.

4.2 Corporate Risk Register

The corporate risk register is a tool to enable the Management Board to review and manage the organisation's most important risks. It is interlinked with the assurance framework, and is held on the Trust's online integrated risk management system.

The register will include:

- Source and consequence of the risk
- Executive owner and lead committee
- The original, current and target risk rating
- Controls that are in place
- New and developing controls
- Owner of the new/developing controls and target date

Escalation of risks for consideration by Management Board shall be through the Trust Board Secretary.

The Management Board shall review and approve the corporate risk register on a monthly basis. Where changes to risks are made, this shall be reflected in the assurance framework and reported to the board committees as appropriate.

Where changes to the corporate risk register are proposed which affect the content of the assurance framework (i.e. addition or deletion of risks), the proposed change shall be reported to the board committees as appropriate in addition to being presented to the Board of Directors for approval.

The board assurance framework and corporate risk register will be reported to each board committee meeting and to the Board of Directors on a quarterly basis.

At least once a year, the Management Board will review whether the corporate risk register process and format remain fit for purpose, and agree changes where appropriate.

4.3 Directorate / Care Group Risk Registers

Each Care Group and department will be responsible for maintaining their own risk register on the Trust's online integrated risk management system. The registers will be populated as a result of risk assessments, incidents, complaints and claims. The Care Group risk register will be a standing agenda item at clinical management team meetings.

Any risk identified as "Extreme" and that cannot be controlled and managed within the Care Group / directorate will be escalated to the corporate risk register for consideration by the Management Board via the Trust Board Secratary.

All high and extreme level risks identified within the corporate risk register will require a supporting action plan which will ensure that the risk is managed to an acceptable level. The action plans will be monitored by the Lead Director.

5. ORGANISATIONAL RISK PRINCIPLES

The Board of Directors has agreed the following principles with regard to its role in relation to risk:

(i) The Board will consider all aspects of risk in relation to the decisions it makes and the information it receives. This will include:

a. The risk of inaction
b. Reward, where applicable
c. How risks link to the Trust strategy, values and culture
d. The adequacy of risk management and controls
e. Structures and escalation processes
f. The overall risk profile and risk burden of the Trust, and its capacity to manage that risk

(ii) The Board will assess risks both initially and on an ongoing basis, recognising that where risks are dynamic its risk tolerance and strategies must be dynamic to reflect this.

(iii) The Board will work to ensure it has sufficient information regarding key risks by, among other things:

a. Seeking external advice where appropriate.
b. Seeking ongoing assurance from management regarding the control and management of risks.

(iv) The Board will mitigate risk as far as it feels that it is sensible and appropriate to do so.

(v) The Board will ensure that risk surveillance and triangulation are factored into its work and discussions on an ongoing basis.

6. RISK ASSESSMENT PRINCIPLES

Risk assessment is the process of identifying, describing, measuring and recording risks. Judgments are made about the harm that might arise from an activity and the probability that the harm will occur.

The main purpose of risk assessment is to determine whether planned or existing control measures are adequate or need to be improved. It also promotes an improved awareness of risk and a better appreciation of the necessity for control measures.

6.1 Risk Identification

The Trust operates two major systems to facilitate the identification of risk:

- Proactive risk identification, through identification of risks before they lead to harm. This includes interventional near miss reporting.
- Reactive risk identification, through the adverse incident reporting process; Datixweb.

In order to identify risk, teams should conduct a detailed review of the activity or area being reviewed, including any hazards perceived, and any incidents that have occurred. Once hazards and potential risks have been identified, they should be formally assessed.

6.2 Legal Requirements

The Management of Health and Safety at Work Regulations 1999 (MHSWR) require employers to assess the risks to the health and safety of the groups below which are created by their undertaking, in order to identify the measures that are required in order to comply with statutory provisions.

- employees whilst they are at work;
- non-employees
- new or expectant mothers
- young persons, taking into account the young persons' inexperience, immaturity and lack of awareness of risks;

Further specific risk assessments that are required to be completed in accordance with the MHSWR 1999 include:

- Lone Working
- Violence and aggression
- Stress
- Slips, Trips and Falls, including Working at Height
- Musculoskeletal Disorders

There are a number of other regulations which suggest a requirement for risk assessments, including the Health and Safety (First-aid) Regulations 1981; the Environmental Protection Act 1990 and the Provision and Use of Work Equipment Regulations 1998. The relevant regulations should be referred in relation to any area of work undertaken as part of the business of the Trust, in order to determine where a risk assessment may be required.

6.3 Risk Assessment Documentation

The findings of the risk assessment must be recorded using the Trust's online integrated risk management system (http://dbhdatixweb/datix/live/index.php). All staff who document risks using this system should receive appropriate training.

Documenting a risk using the Trust's online integrated risk management system requires the employee documenting the risk assessment to:

- describe the risk in full, covering the cause (situation giving rise to the risk), the event that may occur, and the effect of that event
- assign a 'risk owner' (the manager who is responsible for the area which the risk assessment affects)
- identify the appropriate review frequency (monthly for all risks rated 8 or above)
- describe any action already taken and control measures already in place
- determine the adequacy of existing control measures
- determine the likelihood of injury or harm arising, quantify the severity of the consequences of this harm, and assign a risk rating
- determine the target risk rating using the same principles

- identify potential additional control measures or actions, with timescales for implementation or details of process being followed.
- identify any specific legal duty or requirement which is relevant to the risk
- identify any reported incidents that relate to the risk
- provide sufficient information to enable the risk owner to monitor and manage the risk appropriately.

7. RISK ASSESSMENT PROCESS

The risk assessment process can be broken down into steps as follows:

(a) Identify potential hazards or risks - Carry out a pre-assessment walkthrough or review of the activity to identify hazards or potential risks. Be systematic, list all credible/foreseeable hazards and consider all possibilities.

(b) Plan the assessment - Assessments should be planned and prioritised for a specific area or activity and should cover likely risk issues including:

- work activities
- property and equipment
- known hazards
- accident and incident reports
- known 'near misses'
- risks to achievement of specified objectives or targets

(c) Define the nature of the risk – Once identified, the risk should be defined. What might occur, or is occurring, and what adverse consequences might this cause?

(d) Identify the people at risk - Identify all those who might be at risk including staff, contractors, patients, and the public.

(e) Analyse exposure - Identify under what conditions, when and how exposure to the risks takes place.

(f) Detail and evaluate the existing controls in place - Evaluate how the risk is being controlled, taking into consideration statutory compliance requirements and whether the controls are effective in practice.

(g) Quantify the risk – Determine the likelihood and consequences of the risk being realised using the Risk Matrix shown at **Appendix 2.** Use these scores to allocate a risk rating.

(h) Identify further controls - Identify further control measures or actions required to reduce the risk, and prioritise these.

(i) Develop action plan - An action plan should be drawn up to implement any further control measures required. This should identify who is responsible for actions, and timescales for completion. This plan should be monitored at the identified appropriate level, dependent on the risk rating. Where actions require escalation in order to gain approval, this should be undertaken.

(j) Quantify the target residual risk - The target residual risk is the lowest level which the department anticipates being able to reduce the risk to, following completion of the action plan. The target residual risk should be quantified, and a timescale set for achieving this reduction.

NB: In some cases, the target residual risk may be the same as the current risk rating. In these cases, no action is required, although existing control measures must be maintained.

(k) Record the findings - The significant findings of the assessment together with any actions identified should be recorded using the Trust's online integrated risk management system. The assessment should be approved by the risk owner, and conveyed to all staff.

(l) Review the assessment - This is required on a regular basis (monthly for all risks rated 8 or above) and under the following circumstances:

- If new equipment is introduced
- If new substances or premises are used
- If new clinical techniques are introduced which impact on staff rosters or patient handling duties
- If other processes or operational parameters change significantly
- Following an accident
- If there is reason to suspect that the assessment is no longer valid
- If there has been a significant change in matters to which the assessment relates

(m) Inform staff - Staff should be informed of:

- Any risks to their health and safety identified by the assessment
- Control measures in place
- Any emergency measures identified
- Planned action to be taken

8. REVIEW AND MONITORING OF RISKS

(a) The responsibility for the risk assessment lies with the manager who is responsible for the area which the risk assessment affects (e.g. on a ward, the ward manager/sister).

(b) Following completion of the online risk assessment, the head of department will approve the assessment on the Trust's online integrated risk management system, to confirm

agreement with both the risk assessment and action plan.

(c) The head of department will ensure an action plan is developed where appropriate, and appoint a lead person for each action point together with a completion date. Once finalised, the risk assessment and action plan will be notified to all persons who could be affected by the outcome of the risk assessment.

(d) A programme of monthly review must be established for risks rated 8 or above, to ensure that all agreed actions are carried out within timescales. This will be carried out by the appropriate Care Group or directorate management team within the Care Group / directorate governance arrangements.

(e) All risk assessments rated lower than 8 should be reviewed on an annual basis as a minimum, or as described below.

(f) Risks rated 15 or above should be escalated for inclusion in the Corporate Risk Register in addition to the process outlined above. Risks on the Corporate Risk Register are reviewed monthly by the Management Board.

(g) In addition to the above, risk assessments should be reviewed if they meet the criteria outlined under paragraph 7(l) above.

9. TRAINING/ SUPPORT

The effective implementation of this policy will facilitate the delivery of a quality service, alongside employee training and support to provide an improved awareness of the measures needed to prevent, control and contain risk.

An assessment of the risk management training needs of all staff will be documented within the Trust's Training Review which will be reviewed on an annual basis and action plans developed. This assessment will be linked to incidents, claims, complaints, risk assessments, external assurance and performance indicators.

The Trust's training prospectus will include details of all risk management courses. Local risk management training needs identified by individual areas will be discussed with the risk management department.

The Training Department will maintain records of actual and expected completion of statutory and essential to role training, including corporate induction, and will address and rectify inadequate attendance. Care Groups and departments will address and rectify inadequate attendance at local mandatory training courses.

The Trust will:

- Ensure all employees and stakeholders have access to a copy of this policy
- Provide new employees with corporate induction.
- Provide risk management awareness training to board members, (both Executive and Non-executive Directors) manager and Care Group management teams on an annual basis.

Those carrying out assessments should be competent to do so and should have attended the Trust's internal training. The assessor should have an understanding of the workplace, an ability to make sound judgements, and knowledge of the best practicable means to reduce those risks identified. Competency does not require a particular level of qualification but may be defined as a combination of knowledge, skills, experience and personal qualities, including the ability to recognise the extent and limitation of one's own competence.

The Health and Safety Advisor, Trust Board Secretary and Deputy Director of Quality & Governance are available to provide support and advice to employees experiencing difficulties in assessing risk.

10. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Risk escalation in the Trust has been supported by initial internal audit reviews to date and the risk management system will continue to be reviewed by the internal auditors.

What is being monitored?	Who will carry out the monitoring?	How often	How reviewed / Where reported to?
Correct completion of risk assessments.	Risk lead for ward/department	Annually	Audit / Deputy Director of Quality & Governance
Completion of action plan with each risk assessment where further action is necessary.	Risk lead for ward/department	Annually	Audit / Deputy Director of Quality & Governance
Ward/department level risk register monitored monthly by ward/ department manager.	Risk lead for ward/department	Annually	Audit / Deputy Director of Quality & Governance
Care Group / Directorate level risk register monitored monthly at appropriate forum.	Risk lead for Care Group/Directorate	Annually	Meeting minutes / Deputy Director of Quality & Governance
Corporate Risk Register monitored monthly by the Management Board.	Head of Risk & Legal Services	Annually	Meeting minutes / Trust Board Secretary

11. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

A copy of the EIA is available on request from the HR Department.

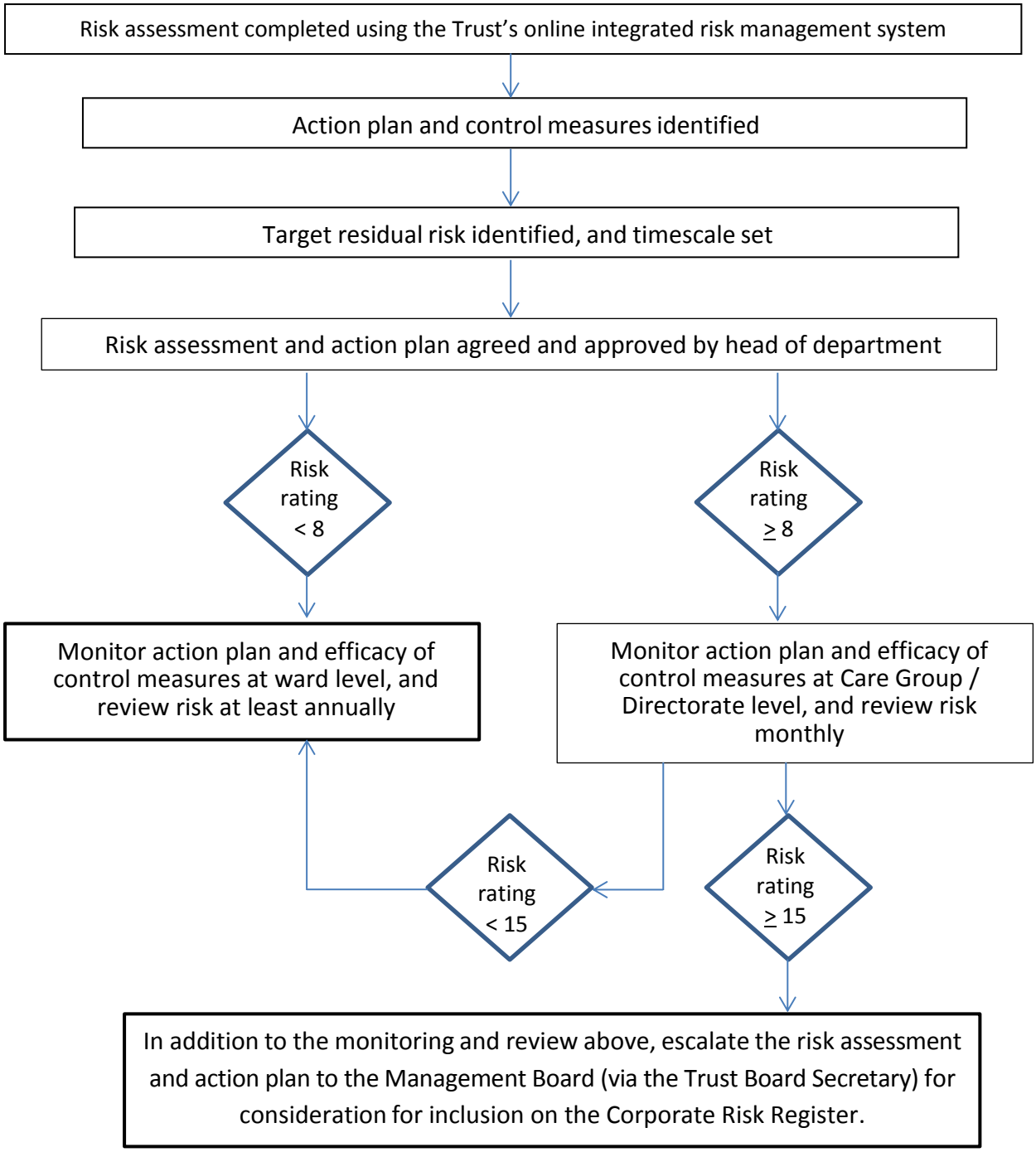
12. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Claims Handling Policy CORP/RISK 5
- Policy for the Reporting and Management of Incidents and Near Misses. CORP/RISK 13
- Serious Incidents Policy CORP/RISK 15
- Maternity Service Risk Management Strategy CORP/RISK 16
- Learning from Incidents, Complaints and Claims CORP/RISK 20
- Complaints, Concerns, Comments and Compliments Resolution and Learning CORP/COMM 4
- Whistleblowing Policy - Voicing Your Concerns CORP/EMP 14
- Health and Safety Policy CORP/HSFS 1
- Security Policy CORP/HSFS 15

13. REFERENCES

- Control of Asbestos Regulations 2012
- Control of Lead at Work Regulations 2002
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Data Protection Act 1998
- Health and Safety at Work Act 1974
- Health and Safety (Display Screen Equipment) Regulations 1992
- Ionising Radiation Regulations 1999
- Management of Health and Safety at Work Regulations 1999 (SI No 3242).
- Management of health and safety at work - Approved Code of practice and Guidance (L21 - HSE)
- Manual Handling Operations Regulations 1992
- Noise at Work Regulations 2005
- Personal Protective Equipment at Work Regulations 1992

APPENDIX 1 – FLOWCHART FOR MONITORING AND REVIEW OF RISK ASSESSMENTS



APPENDIX 2 – RISK MATRIX

Table 1 - Consequence Score

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1 - Negligible	**2 - Minor**	**3 - Moderate**	**4 - Major**	**5 - Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity /disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality / complaints / audit	Peripheral element of treatment or service suboptimal. Informal complaint/ inquiry.	Overall treatment or service suboptimal. Formal complaint - local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints /independent review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources / organisational development /staffing /competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective /service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training.	Non-delivery of key objective /service due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis.

Statutory duty/ inspections	No or minimal impact or breach of guidance / statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendation / improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity/ reputation	Rumours. Potential for public concern.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House). Total loss of public confidence.
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget. Schedule slippage.	5–10% over project budget. Schedule slippage.	10–25% over project budget. Schedule slippage. Key objectives not met.	>25% over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget. Claim less than £10k.	Loss of 0.25–0.5% of budget. Claim(s) between £10k and £100k.	Uncertain delivery of key objective /Loss of 0.5–1% of budget Claim(s) between £100k and £1m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >1% of budget. Failure to meet specification /slippage. Loss of contract / payment by results. Claim(s) >£1m.
Service / business interruption	Loss /interruption of >1 hour.	Loss /interruption of >8 hours.	Loss /interruption of >1 day.	Loss /interruption of >1 week.	Permanent loss of service or facility.
Environmental impact	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic impact on environment.

Table 2 - Likelihood Score

The frequency-based score is appropriate in most circumstances and should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor & Frequency	**Rare** - This will probably never happen /recur.	**Unlikely** - Do not expect it to happen / recur but it is possible it may do so.	**Possible** - Might happen or recur occasionally.	**Likely** - Will probably happen / recur but it is not a persisting Issue.	**Almost Certain** - Will undoubtedly happen / recur, possibly frequently.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**29 August 2017**
Author:	**Matthew Kane, Trust Board Secretary**		
For:	**For approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The purpose of this report is to advise of use of the Trust Seal in accordance with section 14: Custody of Seal and Sealing of Documents of the Standing Orders of the Board of Directors:

Seal No.	Description	Signed	Date of sealing
86	Lease relating to Sunshine Day Nursery, Bassetlaw Hospital, Worksop, S81 0BD	Richard Parker Chief Executive	5 July 2017
		Jon Sargeant Director of Finance	

Recommendation(s)

The Board is requested to approve use of the Trust Seal.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Finance & Performance Committee – Chair's Log**		
Report to	**Board of Directors**	**Date**	**29 August 2017**
Author	**Neil Rhodes, Chair of Finance & Performance Committee**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
All papers and presentations were received prior to the meeting in a timely manner – which was appreciated. It was a very full meeting and the 9.15 – 1300 window is tight for so much business. **Assurance area – Performance** A strong presentation was received from Lesley Hammond ED Care Group Manager as part of a deep dive into four hour access performance in the Emergency Department. The presentation is available to any Board member who would like it via Matthew Kane. It paints a picture of good performance, which has enabled us to access the proportion of STP monies allocated against this area, in relation to having patient streaming in place and achieving set targets. The real challenge will be lifting the bar to 95% of patients hitting the sub four hour mark in the final quarter of the year. The meeting had a detailed consideration of the other principal performance issues and were reassured as to the broad performance of the Trust. A separate overview report will be presented at Board. No individual items were identified for escalation. David Purdue and Neil Rhodes were actioned to meet with Ruth Bruce, Head of Performance, to agree a revised format for the performance report for the next meeting. It is intended that it will broadly follow the format of the Finance Report, with analysis and comment, supported by embedded charts from the Single Oversight Framework measures (style agreed at the meeting) relevant to the key areas under review.

Assurance area – Workforce Management

Workforce management information was considered on this occasion as part of the overall Finance report.

It was agreed that Karen Barnard and Neil Rhodes would meet and design a format for a paper to support a permanent Workforce Management agenda item, covering –

- The profile of vacant posts
- Agency spend
- Staff sickness

All of these, it was agreed, are significant contributors to the financial pressures.

Assurance area – Overall Financial Picture

A separate financial highlight report has been prepared for the Board meeting. There are no individual areas escalated for attention.

An excellent presentation was received from Julie Robinson, manager of the Overseas Visitors Team. The presentation and lengthy questioning underlined the importance of pursuing this area of work. In addition to identifying cost leakage with some degree of accuracy, the team are beginning to achieve cost recovery. Cultural change is needed in some areas to ensure full cooperation with the team and the Committee agreed to canvass executive support for that. We were particularly impressed by the compassionate, proportionate and sensible approach being adopted, in line with our 'We Care' principles. This has seen the identification of instances not just of health tourism, but more importantly of modern slavery, prostitution and people trafficking.

A paper from the Director of Estates set out progress in the conversation with our preferred bidder for the outsourcing of catering. Contract formulation on the back of bid clarification continues and progress is scheduled to see the final contract at F+P next month, before a recommendation is made to the Board.

Assurance area – Closing the Financial Gap

In my last report and at the subsequent Board meeting we considered slippage in the CIPs, with the financial gap exacerbated by escalating agency spend. Agency spend has been significantly reduced compared to last month (down to £1.4m from £1.8m) and – as discussed above – will now become a permanent agenda item.

Focus on underperforming CIPs has tightened with the introduction of the CEO-led performance process and we need to give this a small amount of time to bear fruit. Importantly, Board members should be aware that we are now at the pivot point for the year where the back-loaded change plans should (and MUST) begin to deliver. They will be the subject of increased scrutiny moving forwards.

In real terms the picture is slightly better than last month although it appears £400k worse as we have been asked not to show the additional STP monies received against the plan.

F+P will ensure there is increased focus on closing the financial gap in the months ahead

Assurance area – Risk Management

The Risk Register was considered, both throughout the meeting and as a separate item at the end. We noted revisions, scoring and the addition of a new risk in relation to fire safety.

Key questions posed by the report
• Is the Board assured in respect of the key areas considered in this report?
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That Board receives the report for assurance.

DBH Quality & Effectiveness Committee (QEC) 22 8 17
- Chair's report to Board 29 8 17

Escalation

No items for escalation to the Board.

Planning process

Debrief/ planning meeting held after first meeting, and agenda review meeting prior to this QEC.

Meeting process

We welcomed our two Governor Members and confirmed their role. Governor questions were discussed at the end of the meeting.
The meeting process was as outlined in June QEC Chair's report, with an enhanced focus on the degree to which we feel assured after considering the papers, and implementing our reflection that posing fewer assurance questions may work better. We reprised our commitment to focus on discussion (rather than presenting), on exception reporting, and on assurance on progress with delivering outcomes as well as activity (outputs).

We reviewed our agreement on the scope and structure of Assurance reports (and data reports), and confirmed this as:

- What are the data telling us (where are we now)? How are we triangulating data to give a richer picture of what is happening (e.g. staff and quality data)?
- What are our good practices and achievements?
- What are the causes for concern (what are the problem issues, "the red areas" etc.)?
- Where there are concerns, are we assured on having action plans to address these/ improve and to monitor these?
- What assurances are there on progress with mitigatory actions on the causes of concern, and on next steps?
- What is the future trajectory, better or worse?
- It was also agreed that the period covered by an Assurance Report would be specified in the cover sheet.

We received minutes from the PEEC but noted that this was a duplication of the governance process: the committee is reporting to the CGC, which will receive its minutes and assurance report. Assurance on patient experience will be reviewed 6 monthly at QEC.

Meeting outputs and outcomes

Strategic thematic discussion. QEC considered a very thought-provoking and well structured presentation on the topic of: Patient Experience and Engagement. An

excellent and thought-provoking initial presentation from Moira Hardy posed 4 assurance questions and was structured around:

- What do we do already?
- What do we need to do or do better?

It was agreed to focus on Questions 3 and 4 of this, and that the process of reviewing the questions and the evidence had prompted a recognition of the lack of consistency in how we gather and use our data, and the relative paucity of use of soft intelligence. The PE team have now devised a draft template for data collection at Care Group level and it is hoped that this will go a long way to addressing this gap. This template is to be considered at the PEEC Friday 25 August and thereafter will be formally circulated to QEC.

The preparation of the presentation and the discussion also highlighted the relative gap in information around how we correlate staff experience and patient experience data. We have both but have not much brought them together, and we also know from research that there is a strong correlation between the two. QEC therefore requested further work in this area to be brought back.

There was also discussion around how all of this would feed into developing a composite measure of patient experience to which we committed in our most recent Quality Accounts. One example would be a kind of Balanced Scorecard. Linn Phipps summarised ideas for this as including:

- Soft metrics
- Hard metrics
- Local measures
- National targets and surveys
- CQC Insights
- Correlations e.g. staff and patient experience
- Patient stories
- Assurance/governance processes demonstrating improvement
- Learning within and across Care Groups
- Areas of focus
- Innovation

QEC will be kept updated on progress with developing a new composite measure of PE.

<u>Post meeting note:</u> Moira and Linn have agreed to collaborate and co-produce Linn's Board workshop 26 September on new ways of working at the Committee and agendas as questions, using this PE topic as the worked example. Therefore greater detail will be shared and discussed at the Board workshop.

Assurance reports

Clinical Governance Assurance Report

A wide ranging report with assurance around the many actions being taken in response to issues identified, such as Infection Control. The discussion on these supported the Committee in clarifying what we mean by assurance:

- That problems and challenges are known and identified from the data and intelligence
- That there is an action plan to address problems and risks
- That progress is monitored against the action plan and spot checks take place
- That soft issues and harder-to-measure/long-term issues are addressed eg culture change
- That there is sufficient pace with progress
- That we are clear on who does what in the assurance governance "tree" and focus appropriately on exception reporting

Item escalated to QEC(escalated from CGC):

- Trust call answering: a range of mitigations was described and assurance on these considered.
- The issue of temporary medical records was also escalated but is being dealt with via RFID (radio-frequency identification) and is on the risk register.

CQC Inspection Update

QEC agreed that the overarching purpose of this report, which contains a number of strands, is as an Assurance Report on Readiness for CQC Inspection and on Planning to Maintain/Improve our scores.
Concerns were raised about those areas with deteriorating metrics.

Nursing Workforce and Ward Quality Metrics report.

A range of actions is in hand, although national pressures were noted.
QEC noted that there is a degree of duplication between what the Board and QEC receive, which could usefully be addressed.

Workforce and Education Assurance report

The report cover provided a very helpful Executive Summary and the report provided a comprehensive review of the purpose of WEC, how it is working and how it plans to work. QEC discussed how we next focus on assurances on W&E, on how QEC should review relevant sections of the BIR and how we should provide assurance on metrics. Alan Armstrong drew particular attention to the need to focus on demonstration of outcomes as well as outputs. It was agreed that areas for future attention and focus would be assurance on leadership development work.
WEC ToR: agreed in principle subject to addition of a governance accountability tree, deletion of agreeing strategies (as this is a Board responsibility), and of Karen Barnard and Martin McAreavey working together to finalise a clause on scope.

RCOG Action Plan:

The cover sheet reminded QEC of the remit of the external report.
Sewa Singh summarised the 3 key issues now as:

- Service redesign
- Team work
- Strengthening clinical governance in specialities.

The report to QEC had been designed to address a key assurance question:
How assured are we [QEC] that the Action Plan will deliver significant improvements in a timely manner?

QEC commended the enormous amount of work that had been done to move this forward and accelerate pace. The Action Plan was now well populated and the greater part of the actions had been completed. Going forward, QEC felt it appropriate that detailed review of Action Plan progress should lie with CGC. However, QEC noted that successful outcomes on some areas – such as cultural change – would be relatively log term and harder to measure. QEC identified areas where it would wish to continue to receive assurance through Exception Reports: Action Plan items1/28-29, 12,16,17,18,20-21-23, 30 (the latter being Service User involvement).

Sewa Singh is proposing a baseline and 6-monthly surveys of staff and patient experience as a new and "soft" measure of improvement.

Board Assurance Framework CRR
QEC adopted the Risk Review Template suggested by Linn Phipps and agreed that the QEC Planning Group would select a key risk for future "interrogation".

Annual Revalidation Assurance report
Looking back, it was recognised that the national process had not been very demanding. Sewa Singh identified the opportunity for the next phase to help to drive care quality improvement. QEC identified the assurance issue as being assured on the consistent achievement of a high quality revalidation process, which would use incident etc data to drive the 1:1 process. Currently there are gaps in our data systems, which make this difficult.

National Quality Board Framework
We need to shape an assurance question around its new metrics.

Identification of new risks: none

Meeting reflections – what have we learnt?
Need to consider whether one or two other senior managers should participate in QEC.
Need to implement our intent to actually rate the degree of assurance we fell at the end of each item.

Future discussion items identified for Work plan:

- BIR – quality section – scope and QEC role?
- Quality metrics including use of NCB metrics?
- How/on what do we provide assurance to the Board, eg patient experience, metrics?
- Research – October QEC to devise assurance question(s), for December QEC.
- Risk interrogation – which? Date?
- CQC/progress on maternity (RCOG report) – further assurance eg on pace and longer-term items such as quality.

Linn Phipps
Chair Quality & Effectiveness Committee
25 8 17

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**CQC Inisghts report**		
Report to	**Board of Directors**	**Date**	**29 August 2017**
Author	**Mr Sewa Singh – Medical Director**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		✓

Executive summary containing key messages and issues
This paper provides a briefing on the Care Quality Commission (CQC) provision of their quality monitoring tool, CQC Insights. This will be made available to the Trust on a monthly basis and will be used as a risk monitoring tool and information pack for any inspector to refer to when considering inspecting the Trust, through the Quality Surveillance Groups held regionally and also during the planning of an inspection to focus on particular core services. It is the latest iteration of tools following the historical CQC Quality Risk Profile (QRP) and Intelligent Monitoring Report (IMR). This report complements the NHSI Single Oversight Framework, DBTH Clinical Governance Objectives, DBTH Quality Assessment Tool and Quality Metrics and DBTH Accountability Framework and external accreditation schemes.
Key questions posed by the report
Using the information from CQC Insights, how can the Trust improve its quality performance to demonstrate that the Trust is Well Led?
How this report contributes to the delivery of the strategic objectives
As the CQC is one of the key regulatory bodies for healthcare, then all of the strategic aims are linked to how we monitor and improve our services for our patients. 1 We will work with patients to continue to develop accessible, high quality and responsive services. 2 - We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary. 3 - We will increase partnership working to benefit people and communities. 4 - We will support the development of enhanced community based services, prevention and self-care. 5 - As a Teaching Hospital we are committed to continuously developing the skills, innovation

and leadership of our staff to provide high quality, efficient and effective care.

How this report impacts on current risks or highlights new risks

The risks identified from the CQC Insight report highlight a range of process measures, and outcome measures, linked to similar information reports used by NHS Improvement and benchmarked against other NHS organisations. The core service areas profiled to be at risk and therefore more likely to be inspected are:

- Maternity and Gynaecology
- Urgent and Emergency Care
- Outpatients and Radiology

In addition to these areas, the Children and Young People core service has a higher likelihood of inspection due to the Regulation 28 Coroner letter and service adjustments made due to staffing resources at Bassetlaw.

Recommendation(s) and next steps

The Board of Directors is asked to NOTE the report and support the monitoring of Quality using the CQC Insights report with other quality monitoring tools and processes described in the report.

CQC INSIGHTS REPORT

1. Introduction

The report is produce monthly by the CQC and published on a secure portal. The data is not available to the public, nor directly to the CCG's, but many organisations intend to share the information with their CCG's as part of openness and transparency.

2. CQC Insight Report Structure

The report contains 4 main sections and several more subsections which are illustrated in the bullet list below:

- **Facts Figures and ratings**
    - Trust Activity and profile
    - Historical CQC inspection ratings for core services and overall
        - Links to improving or deteriorating performance for core service analysis
    - Core service activity breakdown
        - Enforcement notices
        - Outstanding practice
- **Trust and core service analysis**
    - Overview of indicators
    - Trust Composite indicator
    - Trust wide indicators, including comparative data for previous year, any change and national comparison
    - Core service indicators
- **Featured Data Sources**
    - Incident reporting though NRLS
    - Safety Thermometer
    - Mortality and Maternity outlier alerts
    - Mortality
        - HSMR and SHMI trends
    - National audits
        - Summary performance and detail of recent audits
    - A&E waiting time performance
    - Access and flow – under development
    - Patient Surveys
    - Staff Surveys
- **Definitions**
    - Key
    - Planner – schedule for data refresh

The most significant and helpful parts of the report are the Trust and Core Service Analysis section and Featured Data Sources. These indicator sets provide a range of process measures for patient care, but also for staff, organisation leadership and the systems in place to manage the available resources. There are also some clinical outcome indicators which provide an oversight of some clinical outcomes, but do not fully illustrate all of the care provided and clinical activity, but what is available through existing returns and reports made by the Trust.

These benchmark indicators then provide a means to identify risks and aid the CQC inspection priorities.

The benefits of this for the Trust include the ability to monitor the Trusts services, bringing some transparency that has not always been possible for some indicators, such as the national audit reports that are not always reported in to the Trust directly. It links with other monitoring processes, such as the NHSI Single Oversight Framework and external accreditation processes. It complements the Trusts accountability framework and clinical governance objectives, along with the quality assurance tool and quality metrics.

Whilst the Insight report is useful in tracking the Trust's progress, it does have limitations in that it attempts to turn subjective feedback into objective measures. This does not always correlate with care quality and triangulation of a wide range of metrics is required in order to obtain an accurate reflection of the care quality in a Trust. The report includes a range of soft measures that have been turned into objective metrics in order to facilitate comparison and benchmarking. Interpreting and comparing these measures in isolation should be done with caution.

3. Conclusion

The monthly CQC Insight report will complement existing systems, aid the organisation in prioritising the focus on quality and provide opportunities for improvement. The core service areas profiled to be at risk and therefore more likely to be inspected are:

- Maternity and Gynaecology
- Urgent and Emergency Care
- Outpatients and Radiology

In addition to these areas, the Children and Young People core service has a higher likelihood of inspection due to the Regulation 28 Coroner letter and service adjustments made due to staffing resources at Bassetlaw.

4. Next Steps

- Monthly analysis of the Insight report will be made and significant changes will be reported to the Board, with routine monitoring reports to the Executive Team and Clinical Governance Committee.
- Develop action plans to tackle all risk identified from the Insight report and mirror data collection that is generated from Trust systems, cross referencing with the clinical governance objectives and single oversight framework.
- Share the Insight report with the senior management teams so that core service and corporate department leads can take ownership of their indicators.

25 July 2017

CQC Insight for Acute NHS Trusts

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please email NHS-IH.CQCInsight@cqc.org.uk with any feedback and questions

What we've updated in June…

Facts and figures

Refreshed data streams:

- Trust: Bed Occupancy, NHS Improvement (Projected Surplus and Financial Special Measures) and Workforce Statistics.
- Critical Care: HES and Bed Occupancy.
- CYP: Workforce Statistics.
- EoLC: Workforce Statistics.
- Maternity: Bed Occupancy and Workforce Statistics.
- Medicine: Workforce Statistics.
- Surgery: Workforce Statistics.
- U&E: A&E Quality Indicators.

Featured data sources

Refreshed pages:

- Trust: Staff FFT

Trust and core service analysis

Refreshed data streams:

- Trust: CAS, C.DIFF, DQMI, Delayed Transfers of Care, Enhanced Monitoring, HCW Seasonal Influenza Vaccination Programme, MRSA, National Inpatient Survey, STEIS Never Events and Whistleblowing.
- Critical Care: Bed Occupancy and STEIS Never Events.
- CYP: Bed Occupancy, Paediatric Diabetes Audit and STEIS Never Events.
- Maternity: STEIS Never Events.
- Medicine: National Lung Cancer Audit, RTT, Safety Thermometer (Falls, Pressure Ulcers and UTIs) and STEIS Never Events.
- Outpatients: Diagnostic Waiting Times, RTT and STEIS Never Events.
- Surgery: National Vascular Registry, RTT, Safety Thermometer (Falls, Pressure Ulcers and UTIs) and STEIS Never Events.
- U&E: A&E Quality Indicators, A&E SitReps, Ambulance Turnaround and STEIS Never Events.

New data streams:

- National Paediatric Diabetes Audit 2015/16
- Severe Sepsis and Septic Shock Audit 2016/17

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Table of contents

Click on a button to see the content for that page

Facts, figures and ratings

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

TRUST | LOCATION | URGENT & EMERGENCY | MEDICAL CARE | SURGERY | CRITICAL CARE | MATERNITY | CHILDREN & YOUNG PEOPLE | END OF LIFE CARE | OUTPATIENTS | RATINGS

- Activity levels at trust, location and core service level
- Capacity (staffing, beds)
- Financial information
- Population served
- Ratings overview - latest ratings with indication of changes in intelligence

Trust and core service analysis

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

OVERVIEW | TRUST COMPOSITE INDICATOR | TRUST WIDE | URGENT & EMERGENCY | MEDICAL CARE | SURGERY | CRITICAL CARE | MATERNITY | CHILDREN & YOUNG PEOPLE | END OF LIFE CARE | OUTPATIENTS

- Intelligence overview of key messages
- Trust composite indicator
- Indicator detail pages - trust wide and for each core service

Featured data sources

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

INCIDENTS | SAFETY THERMOMETER | MATERNITY & MORTALITY OUTLIERS | MORTALITY | NATIONAL CLINICAL AUDITS | A&E WAITING TIMES | ACCESS AND FLOW | PATIENT SURVEYS | STAFF SURVEYS

- Incident reporting (NRLS)
- Safety thermometer
- Maternity and Mortality Outliers
- Mortality (SHMI and HSMR)
- National Clinical Audits (HQIP)
- A&E waits, delayed transfers and referral to treatment (under development)
- Surveys - NHS Staff Survey, Staff friends and family and Inpatient Survey

Definitions

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

KEY | PLANNER

- Key of symbols and colours
- Data definitions and download

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Trust level

Trust level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Date of last inspection: 08/06/2015	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015

Trust organisation history

Under development

Registered locations

- Montagu Hospital, Mexborough
- Bassetlaw District General Hospital
- Doncaster Royal Infirmary
- Retford Hospital

Population estimate: 418,201

These experimental population estimates have been calculated by PHE derived from HES admissions and small area population estimates for 2013. Estimates are only presented for non-specialist trusts.

Activity	Previous	Latest	Change	National comparison
Inpatient admissions	113,549 Apr 15 - Mar 16	114,397 Apr 16 - Mar 17	(+1%)	
Outpatient attendances	552,902 Apr 15 - Mar 16	561,467 Apr 16 - Mar 17	(+2%)	
A&E attendances	157,689 Apr 15 - Mar 16	153,555 Apr 16 - Mar 17	(-3%)	
Number of deliveries	4,765 Apr 15 - Mar 16	4,284 Apr 16 - Mar 17	(-10%)	
Number of deaths	1,890 Apr 15 - Mar 16	1,924 Apr 16 - Mar 17	(+2%)	

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Number of general and acute beds	896 Jan 16 - Mar 16	849 Jan 17 - Mar 17	(-5%)	
Number of maternity beds	85 Jan 16 - Mar 16	84 Jan 17 - Mar 17	(-1%)	
Number of critical care beds	32 May 16	29 May 17	(-9%)	
Number of bed days	326,140 Apr 15 - Mar 16	318,714 Apr 16 - Mar 17	(-2%)	
Number of staff (WTE):	Not applicable	5,455		
Medical	Not applicable	534 Mar 17		
Nursing	Not applicable	1,399 Mar 17		
Other(s)	Not applicable	3,522 Mar 17		
Care hours	Data not yet available	Data not yet available		

Finance and governance	Previous	Latest	Change	National comparison
Projected surplus [£000s] (deficit)		(36,357)	NA	
Turnover [£000s]		357,571	NA	
NHSI financial special measures		No	NA	
NHSI Single Oversight Framework segmentation	NA	Providers receiving mandated support.	NA	

Source(s): Hospital Episode Statistics; NHS England - Bed occupancy; NHS Digital - Workforce statistics; NHS Improvement

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Trust level inpatient admissions

Trust level rating:

Date of last inspection: 08/06/2015

Safe	Effective	Caring	Responsive	Well led	Overall
RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015

Trust organisation history

Under development

Registered locations

- Montagu Hospital, Mexborough
- Bassetlaw District General Hospital
- Doncaster Royal Infirmary
- Retford Hospital

Population estimate: 418,201

These experimental population estimates have been calculated by PHE derived from HES admissions and small area population estimates for 2013. Estimates are only presented for non-specialist trusts.

	Inpatient admissions	Previous	Latest	Change	National comparison
	Inpatient admissions (total)	113,549	114,397	(1%)	
Service	Children	5,235	5,085	(-3%)	
	Medicine	51,468	51,387	(0%)	
	Surgery	42,739	41,690	(-2%)	
Condition (Top 3)	Gastroenterology and hepatology	18,831	18,209	(-3%)	
	Miscellaneous	14,782	15,044	(+2%)	
	Respiratory medicine	8,771	9,486	(+8%)	
Age group (%)	Under 1	1.6%	1.6%	(0%)	
	1 to 3	1.7%	1.6%	(0%)	
	4 to 15	4.0%	3.8%	(0%)	
	16 to 17	0.8%	0.8%	(0%)	
	18 to 74	64.3%	64.4%	(0%)	
	75 and over	27.5%	27.8%	(0%)	
Ethnicity (%)	White	93.4%	92.5%	(-1%)	
	Not known	2.3%	2.8%	(0%)	
	Not stated	1.9%	2.2%	(0%)	
	Asian	0.9%	1.0%	(0%)	
	Other	0.7%	0.7%	(0%)	
	Mixed	0.4%	0.5%	(0%)	
	Black	0.4%	0.4%	(0%)	
		Apr 15 - Mar 16	Apr 16 - Mar 17		

Source(s): Hospital Episode Statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Locations

Location level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Overall	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Bassetlaw District General Hospi...	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Doncaster Royal Infirmary	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Montagu Hospital, Mexborough	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Retford Hospital	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015

Activity	Bassetlaw District General Hospital	Doncaster Royal Infirmary	Montagu Hospital, Mexborough	Retford Hospital	
Inpatient admissions Apr 16 - Mar 17	24,988	81,208	7,699		
Outpatients attendances Apr 16 - Mar 17	122,009	355,610	74,004	9,844	
Number of deaths (under development)					

Location level facilities	Bassetlaw District General Hospital	Doncaster Royal Infirmary	Montagu Hospital, Mexborough	Retford Hospital	
Neonatal unit type	SCU	LNU	-	-	

Source(s): Hospital Episode Statistics; National Neonatal Audit Programme

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Urgent and emergency care

Location ratings for urgent and emergency care:

	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Doncaster Royal Infirmary	RI 23/10/2015	G 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Montagu Hospital, Mexborough	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Retford Hospital	NA	NA	NA	NA	NA	NA

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where urgent and emergency care service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary
- Montagu Hospital, Mexborough

Activity	Previous	Latest	Change	National comparison
A&E attendances (total)	157,689 Apr 15 - Mar 16	153,555 Apr 16 - Mar 17	(-3%)	
Children attending A&E (total)	35,376 Apr 15 - Mar 16	33,303 Apr 16 - Mar 17	(-6%)	
Attendees arriving by ambulance (total)	42,887	43,574	(+2%)	
% of total attendances	27.2% Apr 15 - Mar 16	28.4% Apr 16 - Mar 17	(+1%)	
Number of A&E attendances admitted	28,955	29,082	(0%)	
% of total attendances	18.4% Apr 15 - Mar 16	18.9% Apr 16 - Mar 17	(+1%)	
Patients left without being seen (%)	1.2% Mar 16	1.2% Mar 17	(0%)	
Reattendances within 7 days (%)	7.3% Mar 16	6.7% Mar 17	(-1%)	

Source(s): Hospital Episode Statistics; NHS Digital - A&E Quality

Capacity	Previous	Latest	Change	National comparison
National Guardian Freedom to Speak Up				
Under development				

Source(s):

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Medical care

Location ratings for medicine:	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Doncaster Royal Infirmary	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Montagu Hospital, Mexborough	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Retford Hospital	NA	NA	NA	NA	NA	NA

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where medicine service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary
- Montagu Hospital, Mexborough

Activity	Previous	Latest	Change	National comparison
Admissions (total)	51,468	51,387	(0%)	
Elective admissions	2,051	1,414	(-31%)	
Emergency admissions	23,032	22,637	(-2%)	
Day case	26,385	27,336	(+4%)	
By specialty (top 3):				
General Medicine	23,865	26,851	(+13%)	
Clinical Haematology	5,126	5,644	(+10%)	
Medical Ophthalmology	6,159	5,600	(-9%)	
	Apr 15 - Mar 16	Apr 16 - Mar 17		
Average length of stay (days)	6.2 Apr 15 - Mar 16	6.4 Apr 16 - Mar 17	(2%)	

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Medical wards (number)	Data not yet available	Data not yet available		
Medical beds (number)	Data not yet available	Data not yet available		
Medical consultants (WTE)	Not applicable	85 Mar 17		

Source(s): NHS Digital - Workforce statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Surgery

Location ratings for surgery:	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Doncaster Royal Infirmary	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Montagu Hospital, Mexborough	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Retford Hospital	NA	NA	NA	NA	NA	NA

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where surgery service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary
- Montagu Hospital, Mexborough

Activity	Previous	Latest	Change	National comparison
Elective admissions (number)	8,094 Apr 15 - Mar 16	7,675 Apr 16 - Mar 17	(-5%)	
Emergency admissions (number)	11,497 Apr 15 - Mar 16	12,049 Apr 16 - Mar 17	(+5%)	
Day admissions (number)	23,148 Apr 15 - Mar 16	21,966 Apr 16 - Mar 17	(-5%)	
Operations (number)	Data not yet available	Data not yet available		

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Operating theatres (number)	Data not yet available	Data not yet available		
Number of wards (number)	Data not yet available	Data not yet available		
Inpatient beds (number)	Data not yet available	Data not yet available		
Day case beds (number)	Data not yet available	Data not yet available		
Consultant surgeons (WTE)	Not applicable	98 Mar 17		

Source(s): NHS Digital - Workforce statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Critical care

Location ratings for critical care:	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Doncaster Royal Infirmary	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA
Retford Hospital	NA	NA	NA	NA	NA	NA

Is there a critical care outreach team?

Data not available

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where critical care service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary

Activity	Previous	Latest	Change	National comparison
Discharges (number)	917 Apr 15 - Mar 16	1,085 Apr 16 - Mar 17	(+18%)	
Deaths (number)	155 Apr 15 - Mar 16	194 Apr 16 - Mar 17	(+25%)	

Source(s): Hospital Episode Statistics

Capacity	Previous	Latest	Change	National comparison
Beds (total)	Data not yet available	Data not yet available		
Level 1	Data not yet available	Data not yet available		
Level 2	Data not yet available	Data not yet available		
Level 3	Data not yet available	Data not yet available		
Consultants (WTE)	Data not yet available	Data not yet available		
Registered nurses (WTE)	Data not yet available	Data not yet available		

Source(s): NHS Digital - Workforce statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Maternity

Location ratings for maternity:	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Doncaster Royal Infirmary	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015
Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA
Retford Hospital	NA	NA	NA	NA	NA	NA

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where maternity service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary

Activity	Previous	Latest	Change	National comparison
Deliveries (number)	4,765 Apr 15 - Mar 16	4,284 Apr 16 - Mar 17	(-10%)	
Caesarean sections rate (%)	25.6% Apr 15 - Mar 16	27.5% Apr 16 - Mar 17	(+2%)	
Instrumental delivery rate (%)	10.2% Apr 15 - Mar 16	9.2% Apr 16 - Mar 17	(-1%)	
Non-interventional delivery rate (%)	64.2% Apr 15 - Mar 16	63.3% Apr 16 - Mar 17	(-1%)	

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Antenatal beds (number)	Data not yet available	Data not yet available		
Beds on labour suites (number)	Data not yet available	Data not yet available		
Postnatal beds (number)	Data not yet available	Data not yet available		
Midwives (WTE)	Not applicable	162 Mar 17	NA	
Consultant obstetricians/gynaecologists (WTE)	Not applicable	5 Mar 17		

Source(s): NHS Digital - Workforce statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Children and young people

Location ratings for children and young people:

	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Doncaster Royal Infirmary	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA
Retford Hospital	NA	NA	NA	NA	NA	NA

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where children and young people service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary

Activity	Previous	Latest	Change	National comparison
Admissions (total)	9,215	8,917	(-3%)	
Under 1	1,797	1,812	(+1%)	
1 to 3	1,975	1,845	(-7%)	
4 to 15	4,526	4,357	(-4%)	
16 to 17	917 Apr 15 - Mar 16	903 Apr 16 - Mar 17	(-2%)	

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Wards (number)	Data not yet available	Data not yet available		
Beds (number)	Data not yet available	Data not yet available		
Paediatric consultants (WTE)	Not applicable	14 Mar 17		
Paediatric nurses (WTE)	Not applicable	59 Mar 17	NA	
Neonatal cots (total)	Data not yet available	Data not yet available		
Level 1	Data not yet available	Data not yet available		
Level 2	Data not yet available	Data not yet available		
Level 3	Data not yet available	Data not yet available		

Source(s): NHS Digital - Workforce statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > End of life care

Location ratings for end of life care:	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi...	G 23/10/2015	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Doncaster Royal Infirmary	G 23/10/2015	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015
Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA
Retford Hospital	NA	NA	NA	NA	NA	NA

Service availability

Data not yet available

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where end of life care service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary

Activity	Previous	Latest	Change	National comparison
In-hospital deaths (number)	1,890 Apr 15 - Mar 16	1,924 Apr 16 - Mar 17	(+2%)	
Referrals to specialist palliative care team (number)	Data not yet available	Data not yet available		
Cancer referrals (number)	Data not yet available	Data not yet available		
Non-cancer referrals (number)	Data not yet available	Data not yet available		

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Specialist palliative care consultants (WTE)	Not applicable	3 Mar 17		
Specialist palliative care nurses (WTE)	Data not yet available	Data not yet available		

Source(s): NHS Digital - Workforce statistics

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Facts and figures > Core services > Outpatients

Location ratings for outpatients:	Safe	Effective	Caring	Responsive	Well led	Overall
Bassetlaw District General Hospi... (15/20/2310)	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015
Doncaster Royal Infirmary (15/20/2310)	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015
Montagu Hospital, Mexborough (15/20/2310)	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015
Retford Hospital (15/20/2310)	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where outpatient service has been rated

- Bassetlaw District General Hospi...
- Doncaster Royal Infirmary
- Montagu Hospital, Mexborough
- Retford Hospital

Activity	Previous	Latest	Change	National comparison
Number of attendances (total)	552,902	561,467	(+2%)	
Ophthalmology	73,155	72,101	(-1%)	
Dermatology	38,877	38,129	(-2%)	
Medical specialties	135,377	140,175	(+4%)	
Surgical specialties	223,459	224,268	(0%)	
Oncology				
Other(s)	81,419 Apr 15 - Mar 16	86,794 Apr 16 - Mar 17	(+7%)	
Number of outpatient clinics held per week	Data not yet available	Data not yet available		

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Under development				

Source(s):

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Ratings overview

National Guardian Freedom to Speak Up

Insight Acute NHS

CareQuality Commission

This page displays the latest ratings and the direction of travel for core service and trust level key question intelligence indicators. Click on the arrows to see the indicator detail.

Key messages

Intelligence indicates that

- Overall performance for this trust is about the same
- Safe, Well led, Responsive, Caring, Effective performance is stable
- Maternity and gynaecology performance is improving
- Outpatients and diagnostic imaging, Medical care, Urgent and emergency care, Crtical care, Surgery performance is stable

		Safe	Effective	Caring	Responsive	Well led	Overall	
	Overall	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	
Urgent and emergency care	Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	→
	Doncaster Royal Infirmary	RI 23/10/2015	G 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	
	Montagu Hospital, Mexborough	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
Medical care	Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	→
	Doncaster Royal Infirmary	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Montagu Hospital, Mexborough	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
Surgery	Bassetlaw District General Hospi...	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	→
	Doncaster Royal Infirmary	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Montagu Hospital, Mexborough	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
Critical care	Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	→
	Doncaster Royal Infirmary	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
Maternity	Bassetlaw District General Hospi...	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	↑
	Doncaster Royal Infirmary	RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	
	Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
Children and young people	Bassetlaw District General Hospi...	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	NA
	Doncaster Royal Infirmary	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
End of life care	Bassetlaw District General Hospi...	G 23/10/2015	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	NA
	Doncaster Royal Infirmary	G 23/10/2015	RI 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	G 23/10/2015	
	Montagu Hospital, Mexborough	NA	NA	NA	NA	NA	NA	
	Retford Hospital	NA	NA	NA	NA	NA	NA	
Outpatients	Bassetlaw District General Hospi...	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015	→
	Doncaster Royal Infirmary	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015	
	Montagu Hospital, Mexborough	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015	
	Retford Hospital	RI 23/10/2015	NA	G 23/10/2015	G 23/10/2015	RI 23/10/2015	RI 23/10/2015	

Source(s): CQC ratings data

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Overview

Trust level rating:

Date of last inspection: 08/06/2015

Safe	Effective	Caring	Responsive	Well led	Overall
RI 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015	G 23/10/2015	RI 23/10/2015

Trust composite of key indicators Apr-16 to Jul-17

- The current composite indicator score is similar to other acute trusts that were more likely to be rated as requires improvement
- This trust's composite score is within the middle 50% of acute trusts

Outliers, trust wide and core service indicators

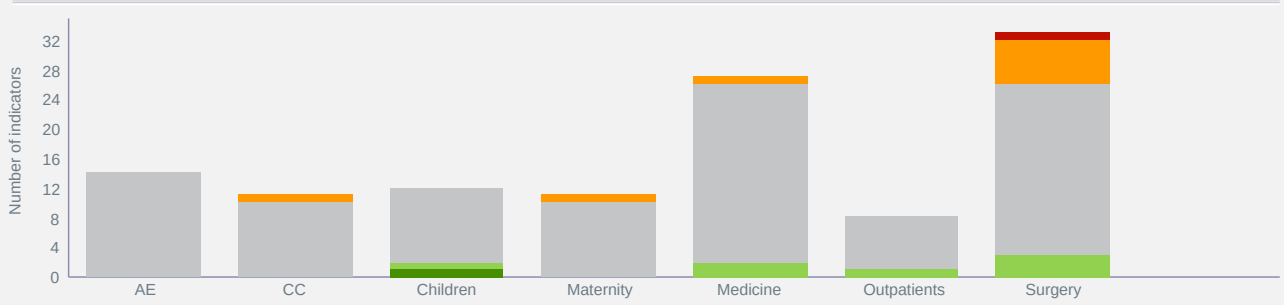
- There are currently 0 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 0 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Of the 77 trust wide indicators, 1 (1%) are categorised as much better, 2 (3%) as better, 2 (3%) as worse and 0 (0%) as much worse. 37 indicators have been compared to data from 12 months previous, of which 1 (3%) have shown an improvement and 5 (14%) have shown a decline

Much better compared nationally	Much worse compared nationally	Improved	Declined
• Sick days for medical and dental staff (%)		• Flu vaccination uptake (%)	• Confidence and trust in the nurses • Patient-led assessment of environment for dementia care (%) • Patient-led assessment of food (%) • Patient-led assessment of privacy, dignity, and well being (%) • Staff appraised in last 12 months (%)

For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of Indicators for each core service and the number within each category:

National comparisons of indicators by core service (much better to much worse)



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Trust composite of key indicators

National Guardian Freedom to Speak Up

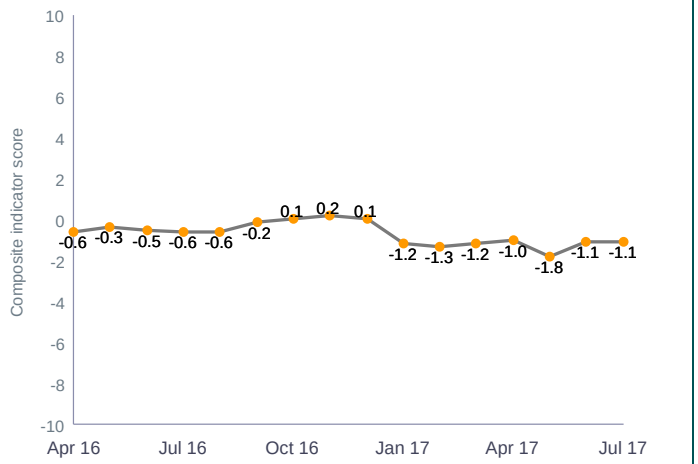
Insight Acute NHS

CareQuality Commission

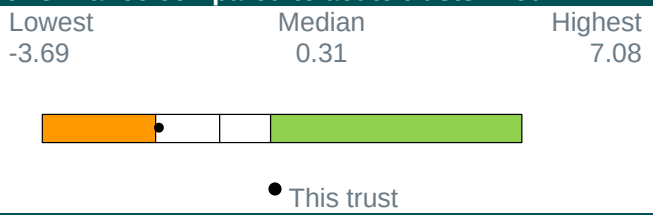
The trust composite is a pilot indicator created from 12 specific indicators within Insight. The composite indicator score helps to assess a trust's overall performance but it is not a rating nor a judgement. The composite should be used alongside other evidence in monitoring trusts.

- The latest trust rating is requires improvement published on 23/10/2015 (last inspection date 08/06/2015)
- The current composite indicator score is similar to other acute trusts that were more likely to be rated as requires improvement
- This trust's composite score is within the middle 50% of acute trusts

Trust composite indicator score Apr-16 to Jul-17



Performance compared to acute trusts in Jul-17



Indicator	Performance			National comparison
	Previous	Latest	Change	
Support from immediate managers (1-5) NHS England - NHS Staff Survey (29 Mar 2017)	3.69 Sep 15 - Dec 15	3.61 Sep 16 - Dec 16	→	S
In-hospital mortality: Infectious diseases HES - Mortality (09 Sep 2016)	115.4 Apr 14 - Mar 15	125.1 Apr 15 - Mar 16	→	S
Patient-led assessment of privacy, dignity, and well being (%) Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (10 Aug 2016)	84.6% Feb 15 - Jun 15	76.1% Feb 16 - Jun 16	↓	S
Communication between senior management and staff (%) NHS England - NHS Staff Survey (24 Mar 2017)	33.7% Sep 15 - Dec 15	29.1% Sep 16 - Dec 16	→	S
Fairness and effectiveness of reporting (1-5) NHS England - NHS Staff Survey (29 Mar 2017)	3.71 Sep 15 - Dec 15	3.64 Sep 16 - Dec 16	→	S
Cancelled operations as a percentage of elective activity (%) Department of Health (DH) - Cancelled Operations (QMCO) (17 May 2017)	2.1% Jan 16 - Mar 16	1.3% Jan 17 - Mar 17	→	S
Confidence and trust in the doctors CQC - Inpatient survey (30 May 2017)	8.8 Jun 15 - Aug 15	8.9 Jun 16 - Aug 16	→	S
Treatment with respect and dignity CQC - Inpatient survey (30 May 2017)	9.1 Jun 15 - Aug 15	9.0 Jun 16 - Aug 16	→	S
Patients spending less than 4 hours in major A&E (%) NHS England - Monthly A&E SitReps (18 Jul 2017)	91.5% May 16	89.2% May 17	→	S
Advice at the start of labour Care Quality Commission - Maternity survey (30 Sep 2016)	8.9 Feb 13	8.9 Feb 15	→	S
Ambulances remaining at hospital for more than 60 minutes (%) NHS Ambulance Service - Ambulance Turnaround Times (26 Jun 2017)	2.7% May 16	2.5% May 17	→	S
Flu vaccination uptake (%) Department of Health - HCW Seasonal Influenza Vaccination Programme (07 Jun 2017)	64.7% Sep 15 - Feb 16	77.7% Sep 16 - Feb 17	↑	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

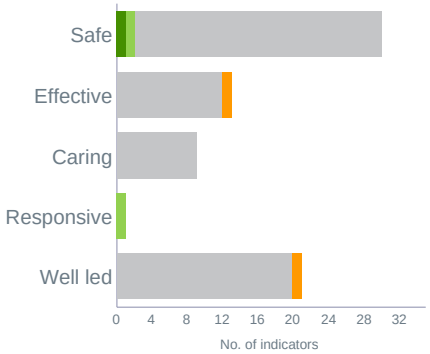
Trust and core service analysis > Trust-wide indicators

National Guardian Freedom to Speak Up

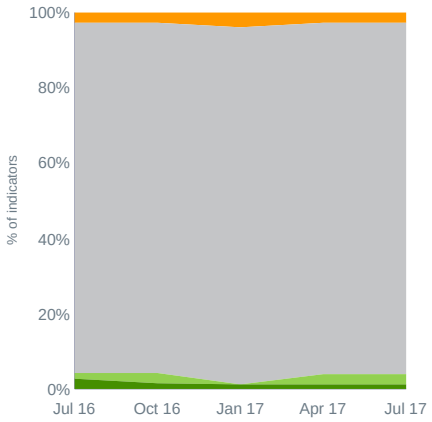
Insight Acute NHS

CareQuality Commission

What's the current performance of trust wide indicators?



How has the trust-wide indicator performance changed over time?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S1	**Clostridium difficile alert in three months?** Public health - C. Difficile (27 May 2017)		NA	No Jan 17 - Mar 17	NA	S
	S1	**Clostridium difficile infections (trust-apportioned)** Public health - C. Difficile (27 May 2017)	-	NA	26 Apr 16 - Mar 17	NA	S
	S1	**E. coli rate (for cases of hospital-onset E. coli)** Public Health England - Hospital onset E. Coli (06 Dec 2016)	-	NA	26.4 Apr 15 - Mar 16	NA	
	S1	**Flu vaccination uptake (%)** Department of Health - HCW Seasonal Influenza Vaccination Programme (07 Jun 2017)	67.3%	64.7% Sep 15 - Feb 16	77.7% Sep 16 - Feb 17	↑	S
	S1	**MRSA alert in three months?** Public health - MRSA (01 Jun 2017)		NA	No Jan 17 - Mar 17	NA	S
	S1	**MRSA infections (trust-apportioned)** Public health - MRSA (01 Jun 2017)	-	NA	3 Apr 16 - Mar 17	NA	S
	S1	**Patient-led assessment of cleanliness of environment (%)** Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (10 Aug 2016)	98.2%	98.4% Feb 15 - Jun 15	96.9% Feb 16 - Jun 16	→	S
	S1	**Patient-led assessment of environment for dementia care (%)** Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (11 Aug 2016)	75.1%	72.2% Feb 15 - Jun 15	65.8% Feb 16 - Jun 16	↓	S
	S1	**Patient-led assessment of facilities (%)** Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (10 Aug 2016)	93.3%	89.8% Feb 15 - Jun 15	92.4% Feb 16 - Jun 16	→	S
	S2	**Ratio of band 6 nurses to band 5 nurses** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.47	-	0.39 Feb 16 - Jan 17	Under dev	S
	S2	**Ratio of band 7 nurses to band 5/6 nurses** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.19	-	0.16 Feb 16 - Jan 17	Under dev	S
	S2	**Ratio of consultant to non-consultant doctors** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.72	-	0.98 Feb 16 - Jan 17	Under dev	B
	S2	**Ratio of occupied beds to medical and dental staff** Electronic Staff Record - ESR Data Warehouse (25 Apr 2017)	4.47	-	7.09 Feb 16 - Jan 17	Under dev	S
	S2	**Ratio of occupied beds to nursing staff** Electronic Staff Record - ESR Data Warehouse (25 Apr 2017)	2.17	-	2.47 Feb 16 - Jan 17	Under dev	S
	S2	**Ratio of occupied beds to other clinical staff** Electronic Staff Record - ESR Data Warehouse (25 Apr 2017)	1.93	-	2.06 Feb 16 - Jan 17	Under dev	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Trust-wide indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	S2	**Sick days for medical and dental staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	1.14%	NA	1.25% Feb 16 - Jan 17	NA	MB
	S2	**Sick days for non-clinical staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	4.25%	NA	5.13% Feb 16 - Jan 17	NA	S
	S2	**Sick days for nursing and midwifery staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	4.29%	NA	4.72% Feb 16 - Jan 17	NA	S
	S2	**Sick days for other clinical staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	4.76%	NA	4.56% Feb 16 - Jan 17	NA	S
	S2	**Ward staff who are registered nurses (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	66.3%	NA	60.8% Feb 16 - Jan 17	NA	S
	S5	**Never event alert in the last three months?** NHS Improvement - STEIS (24 Jul 2017)		NA	No Apr 17 - Jun 17	NA	S
	S5	**Never Events (total events with rule-based risk assessment)** NHS Improvement - STEIS (24 Jul 2017)	-	1 Jul 15 - Jun 16	1 Jul 16 - Jun 17	→	S
	S5	**Never Events (total events with statistical comparison to bed days)** NHS Improvement - STEIS (24 Jul 2017)	-	1 Jul 15 - Jun 16	1 Jul 16 - Jun 17	→	S
	S5	**NRLS - Proportion of reported patient safety incidents that are harmful (%)** NHS Improvement - NRLS (24 Jul 2017)	23.9%	18.9% May 15 - Apr 16	18.4% May 16 - Apr 17	→	S
	S6	**CAS alerts closed late in preceeding 12 months** Medicines and Healthcare products Regulatory Agency (MHRA) - Central Alerting System (27 Jun 2017)		NA	< 25% of alerts closed late Jun 16 - May 17	NA	S
	S6	**CAS alerts not closed by the trust in the preceding 12 months** Medicines and Healthcare products Regulatory Agency (MHRA) - Central Alerting System (27 Jun 2017)		NA	0 alerts still open Jun 16 - May 17	NA	S
	S6	**CAS alerts not closed by the trust more than 12 months before** Medicines and Healthcare products Regulatory Agency (MHRA) - Central Alerting System (27 Jun 2017)		NA	0 alerts still open Jan 12 - May 16	NA	S
	S6	**Fairness and effectiveness of reporting (1-5)** NHS England - NHS Staff Survey (29 Mar 2017)	-	3.71 Sep 15 - Dec 15	3.64 Sep 16 - Dec 16	→	S
	S6	**NRLS - Consistency of reporting** National Reporting Learning System (NRLS) - National Reporting Learning System (NRLS) (30 Mar 2017)		6 months of reporting Apr 15 - Sep 15	6 months of reporting Apr 16 - Sep 16	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Trust-wide indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	S6	**NRLS - Potential under-reporting of patient safety incidents** NHS Improvement - NRLS (24 Jul 2017)	1.00	1.07 May 15 - Apr 16	0.96 May 16 - Apr 17	→	s
	S6	**NRLS - Potential under-reporting of patient safety incidents resulting in death or severe harm** NHS Improvement - NRLS (24 Jul 2017)	1.00	1.10 May 15 - Apr 16	1.12 May 16 - Apr 17	→	s
Effective	E1	**Help with eating** CQC - Inpatient survey (30 May 2017)	-	7.3 Jun 15 - Aug 15	7.2 Jun 16 - Aug 16	→	s
	E1	**Patient-led assessment of food (%)** Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (17 Jul 2017)	87.9%	88.9% Feb 15 - Jun 15	73.0% Feb 16 - Jun 16	↓	w
	E2	**Deaths in Low-Risk Diagnosis Groups** Dr Foster Intelligence (13 Jul 2017)	100.0		0.5 Jan 16 - Dec 16	NA	s
	E2	**Deaths in Low-Risk Diagnosis Groups** Dr Foster Intelligence (24 Jul 2017)	0.55	0.56 Jan 15 - Dec 15	0.53 Jan 16 - Dec 16	→	s
	E2	**Hospital Standardised Mortality Ratio (HSMR)** Dr Foster Intelligence (13 Jul 2017)	100.0	94.4 Jan 15 - Dec 15	93.7 Jan 16 - Dec 16	→	s
	E2	**Hospital Standardised Mortality Ratio (Weekday)** Dr Foster Intelligence (13 Jul 2017)	100.0	94.0 Jan 15 - Dec 15	92.8 Jan 16 - Dec 16	→	s
	E2	**Hospital Standardised Mortality Ratio (Weekend)** Dr Foster Intelligence (13 Jul 2017)	100.0	96.8 Jan 15 - Dec 15	95.9 Jan 16 - Dec 16	→	s
	E2	**Summary Hospital-level Mortality Indicator (SHMI)** NHS Digital (13 Jul 2017)	1.00	1.00 Jan 15 - Dec 15	1.04 Jan 16 - Dec 16	→	s
	E3	**Active professional registration (medical and dental) (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	98.9%	NA	99.2% Jan 17	NA	s
	E3	**Active professional registration (nursing and midwifery) (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	98.2%	NA	99.8% Jan 17	NA	s
	E3	**Overall trainee satisfaction (trust score compared to doctors scores)** General Medical Council - National Training Surveys (24 Jul 2017)		In middle 50% of scores Mar 16 - May 16	In middle 50% of scores Mar 17 - May 17	→	s
	E3	**Staff appraised in last 12 months (%)** NHS England - NHS Staff Survey (24 Mar 2017)	-	88.1% Sep 15 - Dec 15	81.7% Sep 16 - Dec 16	↓	s
	E3	**Support from immediate managers (1-5)** NHS England - NHS Staff Survey (29 Mar 2017)	-	3.69 Sep 15 - Dec 15	3.61 Sep 16 - Dec 16	→	s

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Trust-wide indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Caring	C1	**Confidence and trust in the doctors** CQC - Inpatient survey (30 May 2017)	-	8.8 Jun 15 - Aug 15	8.9 Jun 16 - Aug 16	→	S
	C1	**Confidence and trust in the nurses** CQC - Inpatient survey (30 May 2017)	-	9.0 Jun 15 - Aug 15	8.8 Jun 16 - Aug 16	↓	S
	C1	**Emotional support from hospital staff** CQC - Inpatient survey (30 May 2017)	-	7.6 Jun 15 - Aug 15	7.1 Jun 16 - Aug 16	→	S
	C1	**Overall experience as an inpatient** CQC - Inpatient survey (30 May 2017)	-	8.2 Jun 15 - Aug 15	8.1 Jun 16 - Aug 16	→	S
	C1	**Patients recommending the trust - Inpatients (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	96.0% Feb 16 - Apr 16	97.3% Feb 17 - Apr 17	→	
	C1	**Speaking to staff about worries and fears** CQC - Inpatient survey (30 May 2017)	-	6.1 Jun 15 - Aug 15	5.6 Jun 16 - Aug 16	→	S
	C2	**Involvement in decisions** CQC - Inpatient survey (30 May 2017)	-	7.5 Jun 15 - Aug 15	7.2 Jun 16 - Aug 16	→	S
	C3	**Pain control by staff** CQC - Inpatient survey (30 May 2017)	-	8.0 Jun 15 - Aug 15	7.9 Jun 16 - Aug 16	→	S
	C3	**Patient-led assessment of privacy, dignity, and well being (%)** Information Centre for Health & Social Care (IC) - Patient-led assessments of the care environment (10 Aug 2016)	83.5%	84.6% Feb 15 - Jun 15	76.1% Feb 16 - Jun 16	↓	S
	C3	**Treatment with respect and dignity** CQC - Inpatient survey (30 May 2017)	-	9.1 Jun 15 - Aug 15	9.0 Jun 16 - Aug 16	→	S
Responsive	R3	**Ratio between delayed transfers and bed occupancy** NHS England - Delayed Transfers of Care (30 May 2017)	0.03	NA	0.01 Jan 17 - Mar 17	Under dev	B
Well led	W3	**Communication between senior management and staff (%)** NHS England - NHS Staff Survey (24 Mar 2017)	-	33.7% Sep 15 - Dec 15	29.1% Sep 16 - Dec 16	→	S
	W3	**Sick days due to back problems (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.25%	NA	0.33% Feb 16 - Jan 17	NA	S
	W3	**Sick days due to stress (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.77%	NA	1.14% Feb 16 - Jan 17	NA	S
	W3	**Stability of Medical and Dental staff** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.92	-	0.85 Feb 16 - Jan 17	Under dev	S
	W3	**Stability of non clinical staff** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.88	-	0.88 Feb 16 - Jan 17	Under dev	S
	W3	**Stability of Nursing and Midwifery staff** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.88	-	0.88 Feb 16 - Jan 17	Under dev	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Trust-wide indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	W3	**Stability of other clinical staff** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.87	-	0.88 Feb 16 - Jan 17	Under dev	S
	W3	**Staff experiencing harassment, bullying or abuse from staff (%)** NHS England - NHS Staff Survey (24 Mar 2017)	-	22.7% Sep 15 - Dec 15	23.7% Sep 16 - Dec 16	→	S
	W3	**Staff experiencing physical violence from staff (%)** NHS England - NHS Staff Survey (24 Mar 2017)	-	1.7% Sep 15 - Dec 15	2.1% Sep 16 - Dec 16	→	S
	W3	**Staff recommendation of the trust for work or care (1-5)** NHS England - NHS Staff Survey (29 Mar 2017)	-	3.72 Sep 15 - Dec 15	3.55 Sep 16 - Dec 16	→	S
	W3	**Turnover rate for medical and dental staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	8.1%	NA	12.4% Feb 16 - Jan 17	NA	S
	W3	**Turnover rate for other clinical staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	13.2%	NA	13.3% Feb 16 - Jan 17	NA	S
	W3	**Turnover rate for other non-clinical staff (%)** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	12.4%	NA	12.8% Feb 16 - Jan 17	NA	S
	W3	**Whistleblowing alerts** CQC - Whistleblowing (03 Jul 2017)		NA	Zero Jun 17	NA	S
	W4	**Identified level of potential support needs by the provider segmentation** NHS Improvement - Single Oversight Framework (SOF) (24 Jul 2017)		NA	Providers receiving mandated support. Jul 17	NA	W
	W5	**GMC - Enhanced monitoring** General Medical Council - Enhanced Monitoring (21 Jun 2017)		NA	No concerns Jun 17	NA	S
	W6	**Data Quality Maturity Index Score (%)** NHS Digital - Data Quality Maturity Index (05 Jun 2017)	96.6%	NA	98.4% Oct 16 - Dec 16	NA	S
	W6	**Digital maturity capabilities score (%)** NHS England - Digital Maturity Self Assessments (01 Jun 2017)	43.5%	NA	40.0% Nov 15 - Jan 16	NA	S
	W6	**Digital maturity infrastructure score (%)** NHS England - Digital Maturity Self Assessments (01 Jun 2017)	67.5%	NA	75.0% Nov 15 - Jan 16	NA	S
	W6	**Digital maturity readiness score (%)** NHS England - Digital Maturity Self Assessments (01 Jun 2017)	74.7%	NA	73.0% Nov 15 - Jan 16	NA	S
	W7	**Inpatient response rate (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	28.6% May 15 - Apr 16	29.9% May 16 - Apr 17	→	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

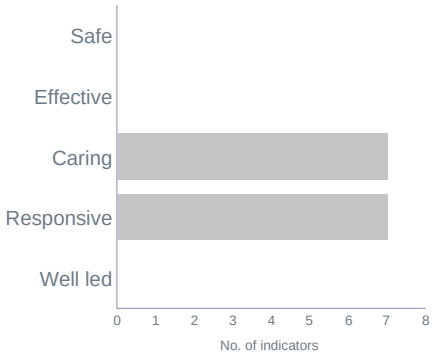
Trust and core service analysis > Trust-wide indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	W7	**Overall engagement (1-5)** NHS England - NHS Staff Survey (04 Apr 2017)	-	3.78 Sep 15 - Dec 15	3.66 Sep 16 - Dec 16	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Urgent and emergency care indicators

What's the current performance of urgent and emergency care indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S5	**Never events in urgent and emergency care** NHS Improvement - STEIS (28 Jun 2017)	-	0 Jun 15 - May 16	1 Jun 16 - May 17	↓	
Caring	C1	**Confidence and trust in the doctors and nurses** Care Quality Commission - A&E survey (22 Jul 2016)	-	8.3 Jan 12 - Mar 12	8.1 Jan 14 - Mar 14	→	S
	C1	**Knowing who to contact after leaving hospital** Care Quality Commission - A&E survey (22 Jul 2016)	-	7.6 Jan 12 - Mar 12	7.2 Jan 14 - Mar 14	→	S
	C1	**Patients recommending the trust - A&E (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	87.4% Feb 16 - Apr 16	89.8% Feb 17 - Apr 17	→	
	C3	**Getting help when needed** Care Quality Commission - A&E survey (22 Jul 2016)	-	7.6 Jan 12 - Mar 12	7.6 Jan 14 - Mar 14	→	S
	C3	**Pain control by staff** Care Quality Commission - A&E survey (22 Jul 2016)	-	NA	7.2 Jan 14 - Mar 14	NA	S
	C3	**Privacy during examination or treatment** Care Quality Commission - A&E survey (22 Jul 2016)	-	9.2 Jan 12 - Mar 12	9.1 Jan 14 - Mar 14	→	S
	C3	**Reassurance by staff when distressed** Care Quality Commission - A&E survey (22 Jul 2016)	-	NA	6.0 Jan 14 - Mar 14	NA	S
	C3	**Treatment with respect and dignity** Care Quality Commission - A&E survey (22 Jul 2016)	-	8.8 Jan 12 - Mar 12	8.7 Jan 14 - Mar 14	→	S
Responsive	R3	**A&E Attendees spending more than 12 hours from decision to admit to admission** NHS England - Monthly A&E SitReps (18 Jul 2017)	1.0	0.0 May 16	0.0 May 17	→	S
	R3	**Admissions waiting 4-12 hours from the decision to admit (%)** NHS England - Monthly A&E SitReps (18 Jul 2017)	11%	13% May 16	5% May 17	↑	S
	R3	**Ambulances remaining at hospital for more than 60 minutes (%)** NHS Ambulance Service - Ambulance Turnaround Times (26 Jun 2017)	5.4%	2.7% May 16	2.5% May 17	→	S
	R3	**Patients spending less than 4 hours in (any type of) A&E (%)** NHS England - Monthly A&E SitReps (18 Jul 2017)	88.1%	93.1% May 16	91.4% May 17	→	S
	R3	**Patients spending less than 4 hours in major A&E (%)** NHS England - Monthly A&E SitReps (18 Jul 2017)	84.6%	91.5% May 16	89.2% May 17	→	S
	R3	**Patients spending less than 4 hours in type 3 A&E, including MIUs (%)** NHS England - Monthly A&E SitReps (18 Jul 2017)	99.2%	100.0% May 16	100.0% May 17	→	S
	R3	**Time from arrival by ambulance to initial assessment** HSCIC - A&E Quality Indicators (29 Jun 2017)	-	NA	5 Mar 17	Under dev	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

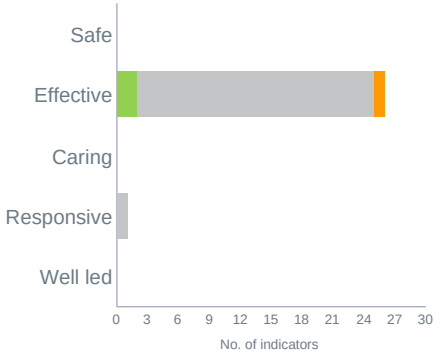
Trust and core service analysis > Urgent and emergency care indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	R3	**Time to treatment (minutes)** HSCIC - A&E Quality Indicators (29 Jun 2017)	-	NA	51.0 Mar 17	Under dev	
	R3	**Waiting time from arrival to examination by doctor or nurse** Care Quality Commission - A&E survey (22 Jul 2016)	-	6.9 Jan 12 - Mar 12	6.1 Jan 14 - Mar 14	↓	≤

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Medical care indicators

What's the current performance of medicine indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S5	**Falls with harm in medical wards (per 100 patients sampled)** Safety thermometer - Safety thermometer (28 Jun 2017)	-	0.6 Jan 16 - Mar 16	0.5 Jan 17 - Mar 17		
	S5	**Never events in medical care** NHS Improvement - STEIS (28 Jun 2017)	-	0 Jun 15 - May 16	0 Jun 16 - May 17	→	
	S5	**New pressure ulcers in medical wards (per 100 patients sampled)** Safety thermometer - Safety thermometer (28 Jun 2017)	-	1.0 Jan 16 - Mar 16	1.5 Jan 17 - Mar 17		
	S5	**New UTIs in catheterised patients on medical wards (per 100 patients sampled)** Safety thermometer - Safety thermometer (28 Jun 2017)	-	0.2 Jan 16 - Mar 16	0.5 Jan 17 - Mar 17		
Effective	E1	**Crude proportion of fit patients with advanced Non Small Cell Lung Cancer (NSCLC) receiving chemotherapy (%)** Royal College of Physicians - National Lung Cancer Audit (21 Jun 2017)	64.0%	1.4% Jan 14 - Dec 14	72.9% Jan 15 - Dec 15	↑	S
	E1	**Crude proportion of patients with histologically confirmed Non Small Cell Lung Cancer (NSCLC) receiving surgery (%)** Royal College of Physicians - National Lung Cancer Audit (21 Jun 2017)	24.0%	0.0% Jan 14 - Dec 14	24.1% Jan 15 - Dec 15	↑	B
	E1	**Crude proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (%)** Royal College of Physicians - National Lung Cancer Audit (21 Jun 2017)	69.0%	0.0% Jan 14 - Dec 14	70.2% Jan 15 - Dec 15	↑	S
	E1	**Patients who received all the secondary prevention medications for which they were eligible (%)** University College London - Myocardial Ischaemia National Audit Project (06 Mar 2015)	88.4%	92.4% Apr 12 - Mar 13	91.8% Apr 13 - Mar 14	→	S
	E1	**SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator** Royal College of Physicians - Sentinel Stroke National Audit Programme (SSNAP) (20 Jul 2017)		Level C Jan 16 - Mar 16	Level D Dec 16 - Mar 17	↓	W
	E2	**Emergency readmissions: Acute and unspecified renal failure** Hospital Episode Statistics (09 Feb 2017)	100	109.2 Sep 14 - Aug 15	102.0 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Acute bronchitis** Hospital Episode Statistics (09 Feb 2017)	100	95.1 Sep 14 - Aug 15	97.9 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Acute cerebrovascular disease** Hospital Episode Statistics (09 Feb 2017)	100	82.7 Sep 14 - Aug 15	84.3 Sep 15 - Aug 16	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Medical care indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**Emergency readmissions: Acute myocardial infarction** Hospital Episode Statistics (09 Feb 2017)	100	95.1 Sep 14 - Aug 15	107.8 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Chronic obstructive pulmonary disease and bronchiectasis** Hospital Episode Statistics (09 Feb 2017)	100	99.3 Sep 14 - Aug 15	97.0 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Fluid and electrolyte disorders** Hospital Episode Statistics (09 Feb 2017)	100	72.9 Sep 14 - Aug 15	72.8 Sep 15 - Aug 16	→	B
	E2	**Emergency readmissions: Fracture of neck of femur (hip)** Hospital Episode Statistics (09 Feb 2017)	100	103.1 Sep 14 - Aug 15	89.4 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Pneumonia** Hospital Episode Statistics (09 Feb 2017)	100	98.4 Sep 14 - Aug 15	113.3 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Septicaemia (except in labour)** Hospital Episode Statistics (09 Feb 2017)	100	113.3 Sep 14 - Aug 15	79.2 Sep 15 - Aug 16	→	S
	E2	**Emergency readmissions: Urinary tract infections** Hospital Episode Statistics (09 Feb 2017)	100	87.2 Sep 14 - Aug 15	102.6 Sep 15 - Aug 16	→	S
	E2	**In-hospital mortality: Acute and unspecified renal failure** Hospital Episode Statistics (12 Jun 2017)	100	104.8 Jan 15 - Dec 15	124.5 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Acute bronchitis** Hospital Episode Statistics (12 Jun 2017)	100	88.7 Jan 15 - Dec 15	65.6 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Acute cerebrovascular disease** Hospital Episode Statistics (12 Jun 2017)	100	108.6 Jan 15 - Dec 15	102.2 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Acute myocardial infarction** Hospital Episode Statistics (12 Jun 2017)	100	100.5 Jan 15 - Dec 15	77.9 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Chronic obstructive pulmonary disease and bronchiectasis** Hospital Episode Statistics (12 Jun 2017)	100	98.7 Jan 15 - Dec 15	99.2 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Fluid and electrolyte disorders** Hospital Episode Statistics (12 Jun 2017)	100	108.6 Jan 15 - Dec 15	65.1 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Fracture of neck of femur (hip)** Hospital Episode Statistics (12 Jun 2017)	100	92.0 Jan 15 - Dec 15	121.0 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Pneumonia** Hospital Episode Statistics (12 Jun 2017)	100	99.8 Jan 15 - Dec 15	102.7 Jan 16 - Dec 16	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

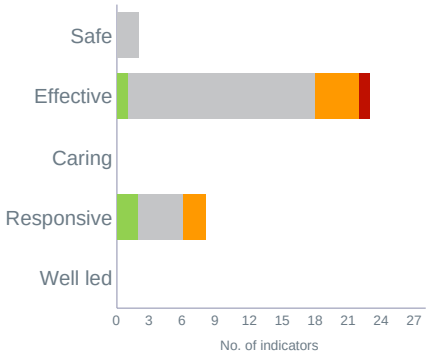
Trust and core service analysis > Medical care indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**In-hospital mortality: Septicaemia (except in labour)** Hospital Episode Statistics (12 Jun 2017)	100	125.1 Jan 15 - Dec 15	135.1 Jan 16 - Dec 16	→	S
	E2	**In-hospital mortality: Urinary tract infections** Hospital Episode Statistics (12 Jun 2017)	100	87.3 Jan 15 - Dec 15	92.2 Jan 16 - Dec 16	→	S
	E2	**One year relative survival rate (%)** Royal College of Physicians - National Lung Cancer Audit (21 Jun 2017)	38.0%	NA	36.1% Jan 15 - Dec 15	NA	S
Caring	C1	**Patients recommending the trust - Medical care inpatients (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	94.1% Feb 16 - Apr 16	96.2% Feb 17 - Apr 17	→	
Responsive	R3	**Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%)** NHS England - Referral to Treatment Waiting Times (21 Jul 2017)	90.0%	91.3% May 16	86.2% May 17	↓	S
Well led	W7	**Response rate - Medical inpatients (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	23.4% May 15 - Apr 16	23.1% May 16 - Apr 17	→	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Surgery indicators

What's the current performance of surgery indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S5	**Crude percentage of patients documented as not developing a pressure ulcer(%)** Royal College of Physicians - National Hip Fracture Database - Bassetlaw District General Hospital (06 Dec 2016)	94.2%	-	98.1% Jan 15 - Dec 15	NA	S
	S5	**Crude percentage of patients documented as not developing a pressure ulcer(%)** Royal College of Physicians - National Hip Fracture Database - Doncaster Royal Infirmary (06 Dec 2016)	94.2%	-	98.0% Jan 15 - Dec 15	NA	S
	S5	**Falls with harm in surgical wards (per 100 patients sampled)** Safety thermometer - Safety thermometer (28 Jun 2017)	-	0.6 Jan 16 - Mar 16	0.0 Jan 17 - Mar 17		
	S5	**Never events in Surgery** NHS Improvement - STEIS (28 Jun 2017) National Guardian Freedom to Speak Up	-	1 Jun 15 - May 16	0 Jun 16 - May 17	↑	
	S5	**New pressure ulcers in surgical wards (per 100 patients sampled)** Safety thermometer - Safety thermometer (28 Jun 2017)	-	0.4 Jan 16 - Mar 16	0.6 Jan 17 - Mar 17		
	S5	**New UTIs in catheterised patients on surgical wards (per 100 patients sampled)** Safety thermometer - Safety thermometer (28 Jun 2017)	-	0.1 Jan 16 - Mar 16	0.2 Jan 17 - Mar 17		
Effective	E1	**Crude proportion of cases with access to theatres within clinically appropriate time frames (%)** Royal College of Anaethetists - National Emergency Laparotomy Audit - Doncaster Royal Infirmary (14 Feb 2017)	82.0%	NA	84.0% Dec 14 - Nov 15	NA	S
	E1	**Crude proportion of cases with pre-operative documentation of risk of death (%)** Royal College of Anaethetists - National Emergency Laparotomy Audit - Doncaster Royal Infirmary (14 Feb 2017)	64.0%	NA	62.0% Dec 14 - Nov 15	NA	W
	E1	**Crude proportion of high-risk cases (>5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (%)** Royal College of Anaethetists - National Emergency Laparotomy Audit - Doncaster Royal Infirmary (14 Feb 2017)	74.0%	NA	73.0% Dec 14 - Nov 15	NA	W
	E1	**Crude proportion of patients having perioperative medical assessment(%)** Royal College of Physicians - National Hip Fracture Database - Bassetlaw District General Hospital (06 Dec 2016)	86.2%	-	96.5% Jan 15 - Dec 15	NA	B

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Surgery indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E1	**Crude proportion of patients having perioperative medical assessment(%)** Royal College of Physicians - National Hip Fracture Database - Doncaster Royal Infirmary (06 Dec 2016)	86.2%	-	92.8% Jan 15 - Dec 15	NA	S
	E2	**Abdominal aortic aneurysm risk-adjusted post-operative in-hospital mortality rate(%)** Vascular Services Quality Improvement Programme - National Vascular Registry (09 Jun 2017)	1.5%	-	0.7% Jan 13 - Dec 15	NA	S
	E2	**Carotid Endarterectomy risk-adjusted 30-day mortality and stroke rate(%)** Vascular Services Quality Improvement Programme - National Vascular Registry (09 Jun 2017)	2.1%	-	1.5% Jan 13 - Dec 15	NA	S
	E2	**PROMs: Groin Hernia Surgery EQ-5D score (14-15) - Finalised** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (30 Sep 2016)		NA	Lower 95% Apr 14 - Mar 15	NA	W
	E2	**PROMs: Groin Hernia Surgery EQ-5D score (15-16) - Provisional (finalised in August)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (15 May 2017)		NA	Nil significance Apr 15 - Mar 16	NA	S
	E2	**PROMs: Primary Hip Replacement EQ-5D score (15-16) - Provisional (finalised in August)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (15 May 2017)		NA	Lower 95% Apr 15 - Mar 16	NA	W
	E2	**PROMs: Primary Hip Replacement EQ-5D score (14-15) - Finalised** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (30 Sep 2016)		NA	Nil significance Apr 14 - Mar 15	NA	S
	E2	**PROMs: Primary Hip Replacement Oxford score (14-15) - Finalised** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (30 Sep 2016)		NA	Nil significance Apr 14 - Mar 15	NA	S
	E2	**PROMs: Primary Hip Replacement Oxford score (15-16) - Provisional (finalised in August)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (15 May 2017)		NA	Lower 99.8% Apr 15 - Mar 16	NA	MW
	E2	**PROMs: Primary Knee Replacement EQ-5D score (14-15) - Finalised** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (30 Sep 2016)		NA	Nil significance Apr 14 - Mar 15	NA	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Surgery indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**PROMs: Primary Knee Replacement EQ-5D score (15-16) - Provisional (finalised in August)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (15 May 2017)		NA	Nil significance Apr 15 - Mar 16	NA	S
	E2	**PROMs: Primary Knee Replacement Oxford score (14-15) - Finalised** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (30 Sep 2016)		NA	Nil significance Apr 14 - Mar 15	NA	S
	E2	**PROMs: Primary Knee Replacement Oxford score (15-16) - Provisional (finalised in August)** Information Centre for Health & Social Care (IC) - Patient reported outcome measures (PROMS) (15 May 2017)		NA	Nil significance Apr 15 - Mar 16	NA	S
	E2	**Risk-adjusted 30-day mortality (%)** Royal College of Anaethetists - National Emergency Laparotomy Audit - Doncaster Royal Infirmary (14 Feb 2017)	11.4%	NA	7.9% Dec 13 - Nov 15	NA	S
	E2	**Risk-adjusted 30-day mortality rate(%)** Royal College of Physicians - National Hip Fracture Database - Bassetlaw District General Hospital (06 Dec 2016)	7.3%	-	4.5% Jan 15 - Dec 15	NA	S
	E2	**Risk-adjusted 30-day mortality rate(%)** Royal College of Physicians - National Hip Fracture Database - Doncaster Royal Infirmary (06 Dec 2016)	7.3%	-	8.3% Jan 15 - Dec 15	NA	S
	E2	**Risk-adjusted 30-day unplanned readmission rate (%)** NHS Digital - National Bowel Cancer Audit (21 Feb 2017)	10.1%	NA	13.4% Apr 14 - Mar 15	NA	S
	E2	**Risk-adjusted 90-day post-operative mortality rate(%)** NHS Digital - National Bowel Cancer Audit (21 Feb 2017)	3.8%	4.5% Apr 13 - Mar 14	6.1% Apr 14 - Mar 15	→	S
	E2	**Risk-adjusted 90-day post-operative mortality rate(%)** Health and Social Care Information Centre - National Oesophago-gastric Cancer Audit (04 Nov 2016)	3.9%	-	10.8% Apr 13 - Mar 15	NA	S
Caring	C1	**Patients recommending the trust - Surgery inpatients (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	96.7% Feb 16 - Apr 16	97.9% Feb 17 - Apr 17	→	
Responsive	R3	**Cancelled operations as a percentage of elective activity (%)** Department of Health (DH) - Cancelled Operations (QMCO) (17 May 2017)	1.1%	2.1% Jan 16 - Mar 16	1.3% Jan 17 - Mar 17	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

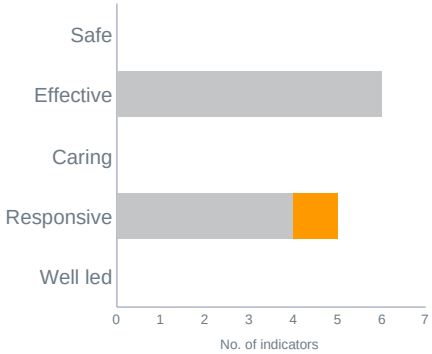
Trust and core service analysis > Surgery indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	R3	**Cancelled operations not treated within 28 days of non-clinical cancellation (%)** Department of Health (DH) - Cancelled Operations (QMCO) (17 May 2017)	7.9%	2.8% Jan 16 - Mar 16	1.4% Jan 17 - Mar 17	→	S
	R3	**Crude overall hospital length of stay** Royal College of Physicians - National Hip Fracture Database - Bassetlaw District General Hospital (06 Dec 2016)	20.7	-	15.1 Jan 15 - Dec 15	NA	B
	R3	**Crude overall hospital length of stay** Royal College of Physicians - National Hip Fracture Database - Doncaster Royal Infirmary (06 Dec 2016)	20.7	-	22.0 Jan 15 - Dec 15	NA	S
	R3	**Crude proportion of highest-risk cases (>10% predicted mortality) admitted to critical care post-operatively (%)** Royal College of Anaethetists - National Emergency Laparotomy Audit - Doncaster Royal Infirmary (14 Feb 2017)	85.0%	NA	63.0% Dec 14 - Nov 15	NA	W
	R3	**Crude proportion of patients having surgery on the day or day after admission(%)** Royal College of Physicians - National Hip Fracture Database - Bassetlaw District General Hospital (06 Dec 2016)	72.8%	-	82.5% Jan 15 - Dec 15	NA	B
	R3	**Crude proportion of patients having surgery on the day or day after admission(%)** Royal College of Physicians - National Hip Fracture Database - Doncaster Royal Infirmary (06 Dec 2016)	72.8%	-	68.3% Jan 15 - Dec 15	NA	W
	R3	**Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%)** NHS England - Referral to Treatment Waiting Times (21 Jul 2017)	70.5%	75.4% May 16	64.5% May 17	↓	S
Well led	W7	**Response rate - Surgery inpatients (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	39.7% May 15 - Apr 16	45.5% May 16 - Apr 17	↑	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Critical care indicators

What's the current performance of critical care indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S5	**Never events in critical care** NHS Improvement - STEIS (28 Jun 2017) **National Guardian** Freedom to Speak Up	-	0 Jun 15 - May 16	0 Jun 16 - May 17	→	
Effective	E2	**Risk-adjusted hospital mortality ratio** Intensive Care National Audit and Research Centre - ICNARC - Bassetlaw Hospital, Department of Critical Care (26 Apr 2017)	1.00	0.86 Apr 14 - Mar 15	1.10 Apr 15 - Mar 16	→	S
	E2	**Risk-adjusted hospital mortality ratio** Intensive Care National Audit and Research Centre - ICNARC - Doncaster Royal Infirmary, Department of Critical Care (26 Apr 2017)	1.00	1.03 Apr 14 - Mar 15	1.07 Apr 15 - Mar 16	→	S
	E2	**Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)** Intensive Care National Audit and Research Centre - ICNARC - Bassetlaw Hospital, Department of Critical Care (26 Apr 2017)	1.00	0.60 Apr 14 - Mar 15	0.90 Apr 15 - Mar 16	→	S
	E2	**Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)** Intensive Care National Audit and Research Centre - ICNARC - Doncaster Royal Infirmary, Department of Critical Care (26 Apr 2017)	1.00	1.09 Apr 14 - Mar 15	0.93 Apr 15 - Mar 16	→	S
	E4	**Crude proportion of out of hours discharges to the ward (not delayed) (%)** Intensive Care National Audit and Research Centre - ICNARC - Bassetlaw Hospital, Department of Critical Care (26 Apr 2017)	2.5%	2.1% Apr 14 - Mar 15	3.8% Apr 15 - Mar 16	→	S
	E4	**Crude proportion of out of hours discharges to the ward (not delayed) (%)** Intensive Care National Audit and Research Centre - ICNARC - Doncaster Royal Infirmary, Department of Critical Care (26 Apr 2017)	2.5%	1.2% Apr 14 - Mar 15	1.4% Apr 15 - Mar 16	→	S
Responsive	R1	**Crude proportion of non-clinical transfers (%)** Intensive Care National Audit and Research Centre - ICNARC - Bassetlaw Hospital, Department of Critical Care (26 Apr 2017)	0.41%	2.67% Apr 14 - Mar 15	5.95% Apr 15 - Mar 16	↓	W
	R1	**Crude proportion of non-clinical transfers (%)** Intensive Care National Audit and Research Centre - ICNARC - Doncaster Royal Infirmary, Department of Critical Care (26 Apr 2017)	0.41%	0.11% Apr 14 - Mar 15	0.12% Apr 15 - Mar 16	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

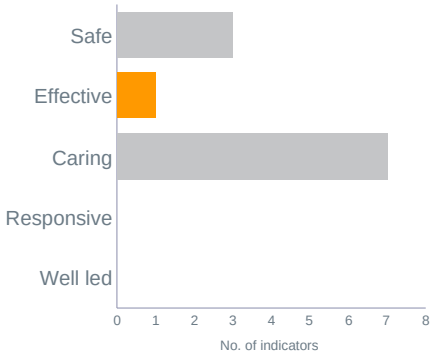
Trust and core service analysis > Critical care indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	R3	**Crude delayed discharge (bed-days occupied by patients with discharge delayed >8 hours) (%)** Intensive Care National Audit and Research Centre - ICNARC - Bassetlaw Hospital, Department of Critical Care (26 Apr 2017)	5.3%	2.1% Apr 14 - Mar 15	2.3% Apr 15 - Mar 16	→	S
	R3	**Crude delayed discharge (bed-days occupied by patients with discharge delayed >8 hours) (%)** Intensive Care National Audit and Research Centre - ICNARC - Doncaster Royal Infirmary, Department of Critical Care (26 Apr 2017)	5.3%	7.9% Apr 14 - Mar 15	6.3% Apr 15 - Mar 16	→	S
	R3	**Full bed occupancy levels for adult critical care beds** NHS England - Critical Care Bed Capacity (12 Jul 2017)		0-1 month of full occupancy Mar 16 - May 16	0-1 month of full occupancy Mar 17 - May 17	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Maternity indicators

What's the current performance of maternity indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S1	**Cleanliness of toilets and bathrooms** Care Quality Commission - Maternity survey (30 Sep 2016)	-	7.9 Feb 13	8.7 Feb 15	↑	S
	S2	**Ratio of band 7 midwives to band 5/6 midwives** Electronic Staff Record - ESR Data Warehouse (21 Apr 2017)	0.24	-	0.23 Feb 16 - Jan 17	Under dev	S
	S2	**Ratio of births to midwifery staff** Electronic Staff Record - ESR Data Warehouse (25 Apr 2017)	26.78	-	28.79 Feb 16 - Jan 17	Under dev	S
	S5	**Never events in maternity** NHS Improvement - STEIS (28 Jun 2017) **National Guardian** Freedom to Speak Up	-	0 Jun 15 - May 16	0 Jun 16 - May 17	→	
Effective	E2	**Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)** University of Leicester - MBRRACE-UK Perinatal Mortality Surveillance Report (24 Jan 2017)	5.0	NA	5.1 Jan 14 - Dec 14	NA	W
Caring	C1	**Being left alone** Care Quality Commission - Maternity survey (30 Sep 2016)	-	7.7 Feb 13	7.6 Feb 15	→	S
	C1	**Patients recommending the trust - Antenatal (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	96.5% Feb 16 - Apr 16	98.6% Feb 17 - Apr 17	→	
	C1	**Patients recommending the trust - Maternity delivery (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	93.3% Feb 16 - Apr 16	98.6% Feb 17 - Apr 17	↑	
	C1	**Patients recommending the trust - Postnatal community (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	97.7% Feb 16 - Apr 16	98.4% Feb 17 - Apr 17	→	
	C1	**Patients recommending the trust - Postnatal ward (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	91.8% Feb 16 - Apr 16	97.0% Feb 17 - Apr 17	↑	
	C1	**Raising concerns** Care Quality Commission - Maternity survey (30 Sep 2016)	-	8.5 Feb 13	8.7 Feb 15	→	S
	C1	**Staff introduction** Care Quality Commission - Maternity survey (30 Sep 2016)	-	8.7 Feb 13	9.2 Feb 15	→	S
	C2	**Advice at the start of labour** Care Quality Commission - Maternity survey (30 Sep 2016)	-	8.9 Feb 13	8.9 Feb 15	→	S
	C2	**Information or explanations given after birth** Care Quality Commission - Maternity survey (30 Sep 2016)	-	7.3 Feb 13	7.9 Feb 15	→	S
	C2	**Moving during labour** Care Quality Commission - Maternity survey (30 Sep 2016)	-	NA	7.8 Feb 15	NA	S
	C3	**Treatment with respect and dignity** Care Quality Commission - Maternity survey (30 Sep 2016)	-	9.0 Feb 13	9.5 Feb 15	↑	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Children and young people indicators

National Guardian Freedom to Speak Up

Insight Acute NHS

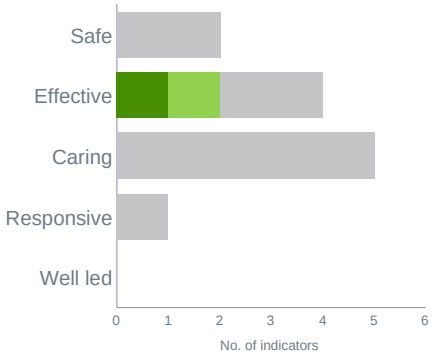
CareQuality Commission

FACTS, FIGURES & RATINGS | TRUST AND CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

25 July 2017

OVERVIEW | TRUST COMPOSITE INDICATOR | TRUST WIDE | URGENT & EMERGENCY | MEDICAL CARE | SURGERY | CRITICAL CARE | MATERNITY | **CHILDREN & YOUNG PEOPLE** | END OF LIFE CARE | OUTPATIENTS

What's the current performance of children and young people indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S1	**How clean do you think the hospital room or ward was that your child was in?** CQC - Childrens Survey (09 Jan 2017)	-	NA	8.9 Aug 14	NA	S
	S3	**Were the different members of staff caring for and treating your child aware of their medical history?** CQC - Childrens Survey (09 Jan 2017)	-	NA	7.7 Aug 14	NA	S
	S5	**Never events in children and young people** NHS Improvement - STEIS (28 Jun 2017)	-	0 Jun 15 - May 16	0 Jun 16 - May 17	→	
Effective	E1	**Case-mix adjusted mean HbA1c level; blood glucose management** Royal College of Paediatrics and Child Health - National Paediatric Diabetes Audit - Bassetlaw District General Hospital (19 May 2017)	68.3	NA	62.1 Apr 15 - Mar 16	NA	MB
	E1	**Case-mix adjusted mean HbA1c level; blood glucose management** Royal College of Paediatrics and Child Health - National Paediatric Diabetes Audit - Doncaster Royal Infirmary (19 May 2017)	68.3	NA	65.3 Apr 15 - Mar 16	NA	B
	E1	**Did the ward where your child stayed have appropriate equipment or adaptations?** CQC - Childrens Survey (09 Jan 2017)	-	NA	9.0 Aug 14	NA	S
	E3	**Did you feel that staff looking after your child knew how to care for their individual or special needs?** CQC - Childrens Survey (09 Jan 2017)	-	NA	8.1 Aug 14	NA	S
Caring	C1	**Did new members of staff treating your child introduce themselves?** CQC - Childrens Survey (09 Jan 2017)	-	NA	8.7 Aug 14	NA	S
	C1	**Did you have confidence and trust in the members of staff treating your child?** CQC - Childrens Survey (09 Jan 2017)	-	NA	8.5 Aug 14	NA	S
	C1	**Overall Experience** CQC - Childrens Survey (09 Jan 2017)	-	NA	8.1 Aug 14	NA	S
	C2	**Did members of staff treating your child communicate with them in a way that your child could understand?** CQC - Childrens Survey (09 Jan 2017)	-	NA	7.9 Aug 14	NA	S
	C3	**Do you think the hospital staff did everything they could to help ease your child's pain?** CQC - Childrens Survey (09 Jan 2017)	-	NA	8.5 Aug 14	NA	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

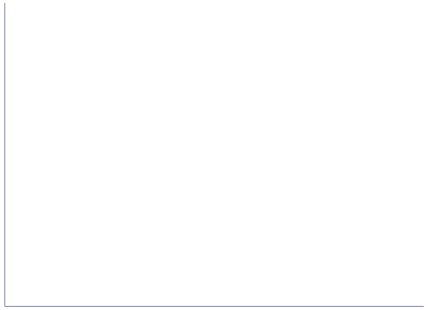
Trust and core service analysis > Children and young people indicators

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Responsive	R3	**Full bed occupancy levels for neonatal intensive care beds** NHS England - Critical Care Bed Capacity (12 Jul 2017)		0-1 month of full occupancy Mar 16 - May 16	0-1 month of full occupancy Mar 17 - May 17	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > End of life care indicators

What's the current performance of end of life care indicators?



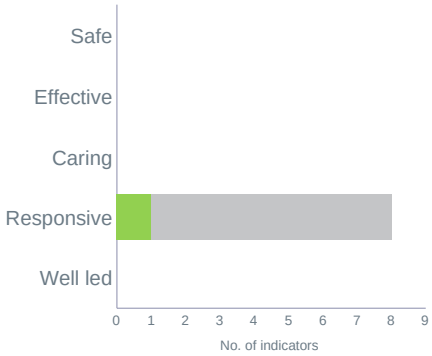
Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	

Under development

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Trust and core service analysis > Outpatients indicators

What's the current performance of outpatients indicators?



Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S5	**Never events in outpatients and diagnostic imaging** NHS Improvement - STEIS (28 Jun 2017) **National Guardian** Freedom to Speak Up	-	0 Jun 15 - May 16	0 Jun 16 - May 17	→	
Caring	C1	**Patients recommending the trust - Outpatients (%)** NHS England - Friends and Family Test (20 Jul 2017)	-	96.7% Feb 16 - Apr 16	97.5% Feb 17 - Apr 17	→	
Responsive	R3	**Cancer - First treatment in 31 days of decision to treat (%)** NHS England - Cancer waiting times (18 May 2017)	97.5%	98.1% Jan 16 - Mar 16	99.3% Jan 17 - Mar 17	→	B
	R3	**Cancer - First treatment in 62 days of urgent GP/dentist referral (%)** NHS England - Cancer waiting times (18 May 2017)	81.2%	85.2% Jan 16 - Mar 16	86.8% Jan 17 - Mar 17	→	S
	R3	**Cancer - First treatment in 62 days of urgent national screening referral (%)** NHS England - Cancer waiting times (18 May 2017)	91.2%	91.3% Jan 16 - Mar 16	88.0% Jan 17 - Mar 17	→	S
	R3	**Cancer - Seen by specialist in 14 days of urgent GP/dentist referral (%)** NHS England - Cancer waiting times (18 May 2017)	94.7%	94.9% Jan 16 - Mar 16	89.0% Jan 17 - Mar 17	↓	S
	R3	**Outpatient DNAs (%)** HES - Outpatients (24 Jul 2017)	7.4%	8.8% Mar 16	9.1% Mar 17	→	S
	R3	**Patients waiting over 6 weeks for diagnostic test (%)** NHS England - Diagnostics Waiting Times (19 May 2017)	1.1%	1.7% Mar 16	2.6% Mar 17	→	S
	R3	**Referral to treatment, on incomplete pathways, within 18 weeks (%)** NHS England - Referral to Treatment Waiting Times (21 Jul 2017)	90.0%	93.1% May 16	90.6% May 17	→	S
	R3	**Referral to treatment, on non-admitted pathways, within 18 weeks (%)** NHS England - Referral to Treatment Waiting Times (21 Jul 2017)	90.7%	88.5% May 16	89.2% May 17	→	S

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

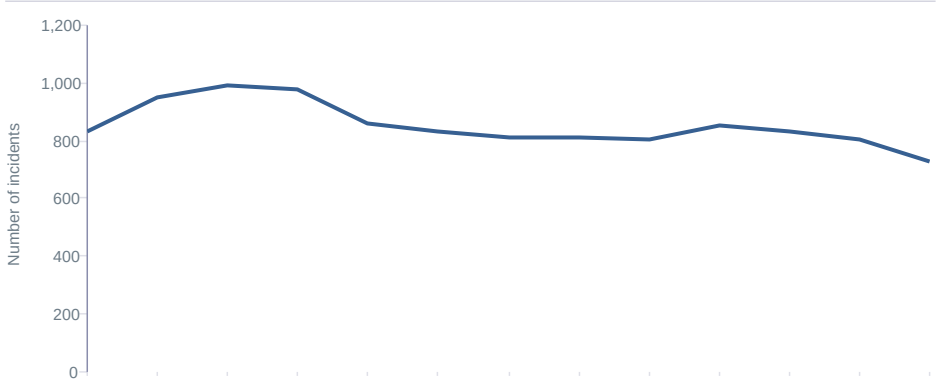
Featured data sources > Incidents

Key messages

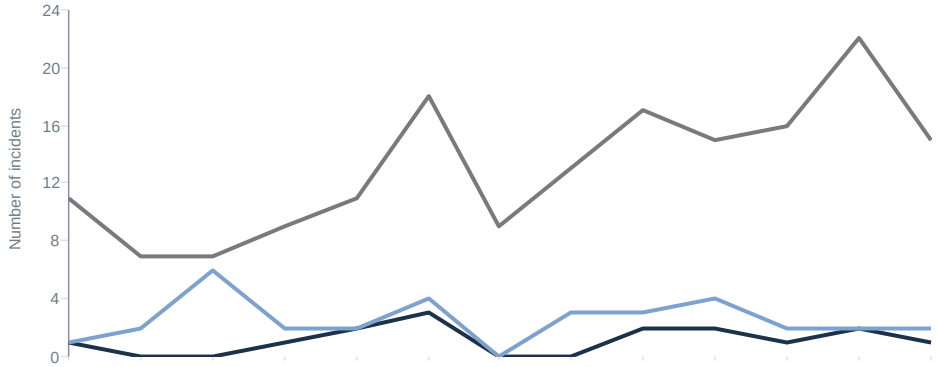
• The median time taken to report incidents was 18 days for this organisation compared to 26 for all trusts between Apr 16 and Sep 16

This trust
Highest 25% of reporters
Middle 50% of reporters
Lowest 25% of reporters
Median

All reported incidents

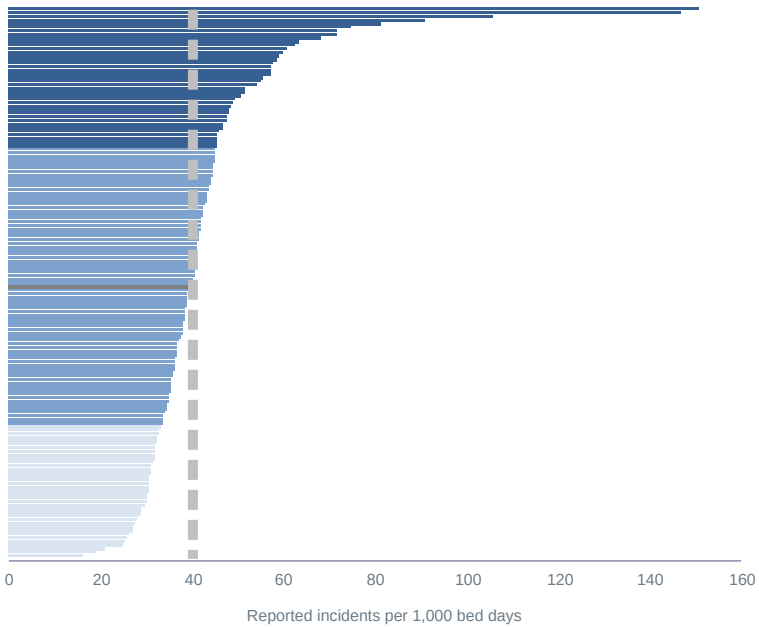


Reported incidents that resulted in moderate, severe harm or death



Year-month	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04
1. Death	1	0	0	1	2	3	0	0	2	2	1	2	1
2. Severe	1	2	6	2	2	4	0	3	3	4	2	2	2
3. Moderate	11	7	7	9	11	18	9	13	17	15	16	22	15
4. Low	141	174	182	161	147	126	128	139	139	129	129	98	124
5. No Harm	679	767	794	801	700	681	673	654	642	702	685	681	587
6. Total	833	950	989	974	862	832	810	809	803	852	833	805	729

Comparative reporting rate for incidents in acute trusts



Indicator	Trend	Performance
NRLS - Proportion of reported patient safety incidents that are harmful (%)	→	S
NRLS - Potential under-reporting of patient safety incidents resulting in death or severe harm	→	S
NRLS - Potential under-reporting of patient safety incidents	→	S

Source: NRLS (Apr 16 - Sep 16)

Key messages

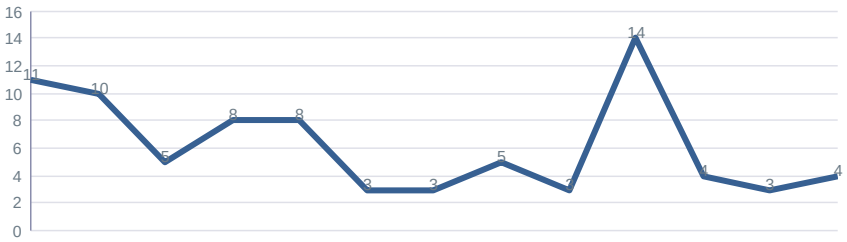
• The ward with the highest rate of pressure ulcers is DEPT CRITICAL CARE with 2.45 per 100 patients sampled

• The ward with the highest rate of falls is WARD A5 with 1.00 per 100 patients sampled

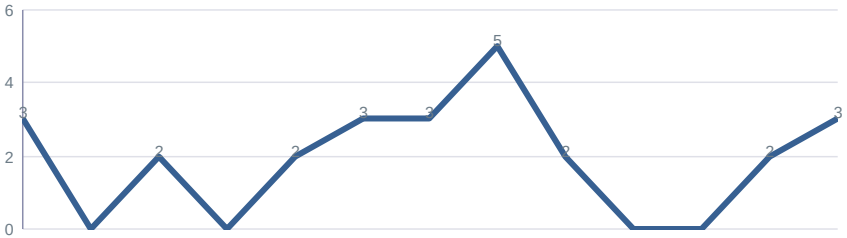
• The ward with the highest rate of catheter acquired UTIs is WARD 18 HAEM with 1.95 per 100 patients sampled

Indicator Summary: Under development

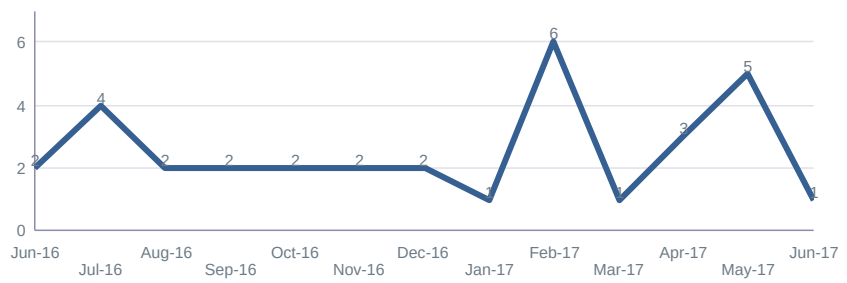
Sampled patients with new pressure ulcers



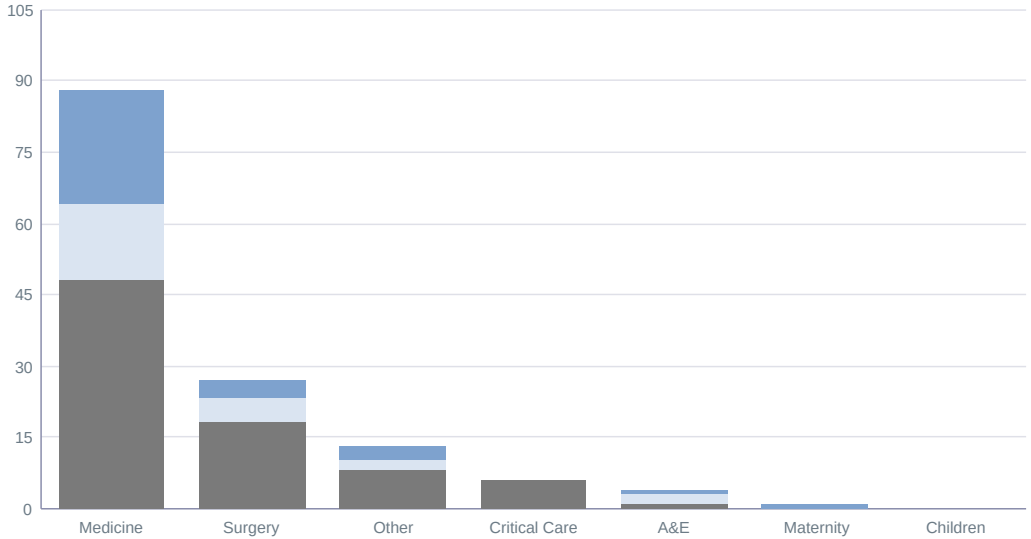
Sampled patients experiencing a fall



Sampled patients with catheter acquired UTI



Incidents recorded in samples by core service



1 Pressure ulcers, includes levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Core service	PUs[1]	Falls[2]	UTIs[3]	Patients surveyed
Medicine	48 (0.98)	16 (0.33)	24 (0.49)	4,880
Surgery	18 (0.68)	5 (0.19)	4 (0.15)	2,663
Other	8 (1.16)	2 (0.29)	3 (0.44)	687
Critical Care	6 (1.49)	0 (0.00)	0 (0.00)	404
A&E	1 (0.44)	2 (0.88)	1 (0.44)	226
Maternity	0 (0.00)	0 (0.00)	1 (0.12)	840
Children	0 (0.00)	0 (0.00)	0 (0.00)	498

Source: Safety Thermometer

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Maternity and mortality outliers

Key messages

- There are currently 0 active mortality alerts for this trust.
- There are currently 0 active maternity alerts for this trust.

Number of outlier alerts for this trust as at 5 July 17

	Active alerts			Closed cases	Total
	Cases under consideration by Outliers Panel	Cases where action plans are being followed up by local inspection team	Cases for review by inspection team		
Mortality	0	0	0	4	4
Maternity	0	0	0	2	2

Mortality outliers – Active alerts

Cases under consideration by Outliers panel

- There are currently no active mortality alerts

Cases where action plans are being followed up by local inspection team

- There are currently no mortality alerts where action plans are being followed up by the local inspection team

Cases for review by inspection team

- There are currently no mortality alerts for review by inspection team

Maternity outliers – Active alerts

Cases under consideration by Outliers panel

- There are currently no maternity alerts under consideration by Outliers panel

Cases where action plans are being followed up by local inspection team

- There are currently no maternity alerts where action plans are being followed up by the local inspection team

Cases for review by inspection team

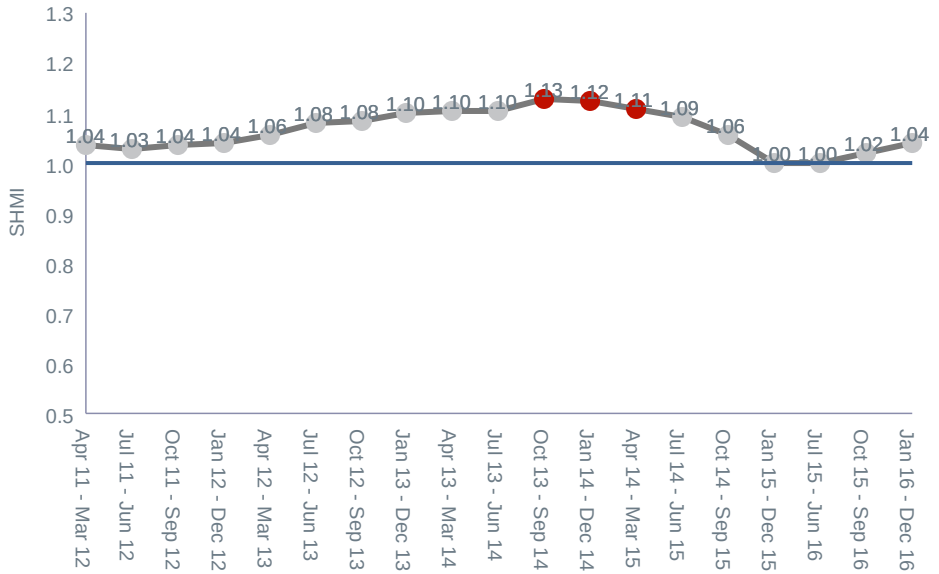
- There are currently no maternity alerts for review by inspection team

Key messages

- For the 12-month period from Jan 16 - Dec 16, SHMI was as expected.
- For the 12-month period from Jan 16 - Dec 16, HSMR was as expected.

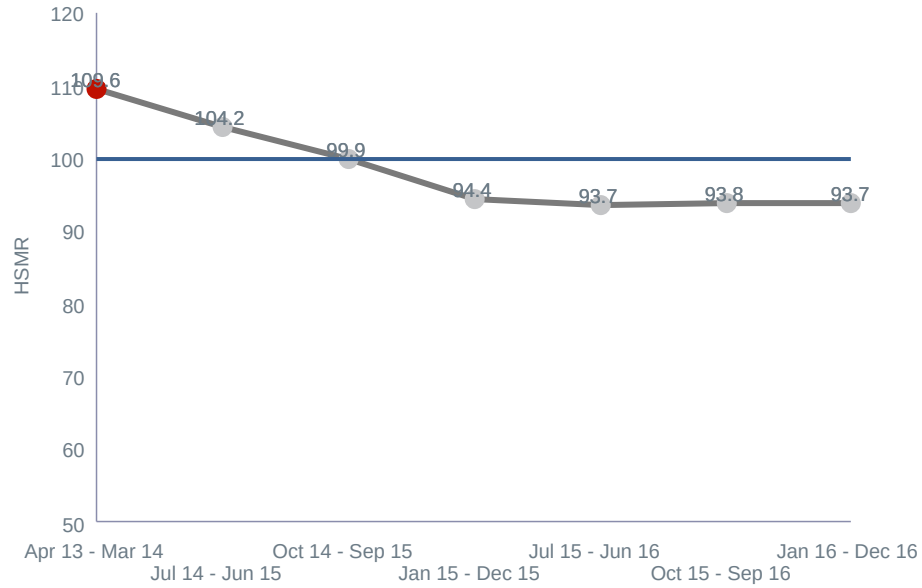
Summary Hospital-level Mortality indicator (SHMI)

For the 12-month period from Jan 16 - Dec 16, SHMI was as expected with a value of 1.04 (compared to 1.0 for England) and 2,900 deaths compared to an expected 2,798 deaths..



Hospital Standardised Mortality Ratio (HSMR)

For the 12-month period from Jan 16 - Dec 16, HSMR was as expected with a value of 93.74 (compared to 100 for England) and 1,764 deaths compared to an expected 1,882 deaths. Weekend HSMR is within expected range for this time period.



Note: From the period July 2014 to June 2015 onwards, HSMR indicators have been updated by DFI on a quarterly, rather than annual, basis.

England standardised mortality ratio

This trust

Higher than expected

Within expected range

Lower than expected

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > National clinical audits

National clinical audits are priority information to inform discussions about quality improvement. The table below provides a high-level summary 'at a glance' of the key clinically relevant indicators which best reflect trust performance. Click on the links to see extra site and ward-level audit results to inform monitoring conversations.

- Audit results should be followed-up during engagement meetings:
  - Better or worse than expected performance should be used to drive quality improvement
  - Where performance is much worse than expected we would expect this to prompt an investigation by the trust
- National clinical audits are reported here only if the trust participated
- More audits will be added each quarter and inspectors will soon receive information on audit outliers and audit data quality concerns

Core Service	Audit Name	Level	Date last refreshed	Insight indicator national comparison				
				Much Worse	Worse	About the same	Better	Much Better
Critical care	ICNARC	Bassetlaw District General Hospital*	04/17	0	1	4	0	0
Critical care	ICNARC	Doncaster Royal Infirmary*	04/17	0	0	5	0	0
Maternity	MBRRACE-UK	Trust	01/17	0	1	0	0	0
Surgery	National Bowel Cancer Audit	Trust	02/17	0	0	2	0	0
Surgery	National Emergency Laparotomy Audit	Doncaster Royal Infirmary	02/17	0	3	2	0	0
Surgery	National Hip Fracture Database	Bassetlaw District General Hospital	12/16	0	0	2	3	0
Surgery	National Hip Fracture Database	Doncaster Royal Infirmary	12/16	0	1	4	0	0
Medical care	National Lung Cancer Audit	Trust	06/17	0	0	2	1	0
Surgery	National Oesophago-gastric Cancer Audit	Trust	11/16	0	0	1	0	0
Surgery	National Vascular Registry	Trust	06/17	0	0	2	0	0

*May be an aggregate of more than one ward's results

Do you have a query or suggestion for national clinical audits? **Contact us.**

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

	Metric	CQC Key Question	2015 Report[1]	2016 Report[2]	National Aggregate (England and Wales)	National Aspirational Standard	Comparison to other hospitals
All patients 403 cases	Crude proportion of patients seen by a Cancer Nurse Specialist	Responsive	72.0%	**50.0%**	**n/a**	90%~	Does not meet the audit aspirational standard of 90%
	One year relative survival rate	Effective	Not available	**36.1% (OR 0.91)**	**38.0%**	none	Not significantly different from the national level
NSCLC 224 cases	Crude proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery	Effective	0.0% (OR 0.00)	**24.1% (OR 1.51)**	**24.0%**	none	Significantly better than the national level
NSCLC 59 cases	Crude proportion of fit patients with advanced Non-Small Cell Lung Cancer (NSCLC) receiving chemotherapy	Effective	1.0% (OR 0.01)	**72.9% (OR 1.34)**	**64.0%**	60%*	Not significantly different from the national level
SCLC 47 cases	Crude proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy	Effective	0.0% (OR 0.00)	**70.2% (OR 0.80)**	**69.0%**	70%*	Not significantly different from the national level

All trusts in England participate in the audit, and data is submitted for approximately 100% of patients. Case ascertainment is therefore not presented separately.

Royal College of Physicians | National Lung Cancer Audit

Anticipated date of next update is 01/2018

[1] Jan 14- Dec 14
[2] Jan 15- Dec 15

OR: Odds ratio

~Audit recommendation based on NICE guideline
*Audit standard based on NICE guideline

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

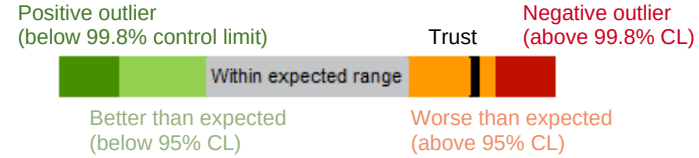
Featured data sources > National audits > Hip fracture audit

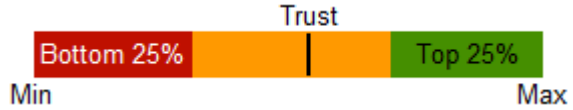
Doncaster Royal Infirmary

	Metric	CQC Key Question	2015[1] Report	2016[2] Report	National Aggregate (England and Wales)	National Aspirational Standard	Comparison to other hospitals
388 cases	Case ascertainment All eligible patients	Well Led	98.4%	**95.1%**	**90.7%**	none	44.6 89.7 94.4 106.3
388 cases	Crude proportion of patients having surgery on the day or day after admission	Effective	63.1%	**68.3%**	**72.8%**	85%*	33.3 68.5 79.5 92.8
388 cases	Crude perioperative medical assessment rate	Effective	86.1%	**92.8%**	**86.2%**	100%*	0.3 84.6 96.1 99.9
388 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	98.7%	**98%**	**94.2%**	none	3.1 94.6 98.7 100
388 cases	Crude overall hospital length of stay	Responsive	24.2 days	**22 days**	**20.7 days**	none	10.2 16.4 23.7 38.8
388 cases	Risk-adjusted 30-day mortality rate	Effective	8%	**8.3%**	**7.3%****	none	Within expected limits

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

Key:





[1] Jan 14- Dec 14
[2] Jan 15- Dec 15

*Audit recommendation based on NICE guideline
**England only

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

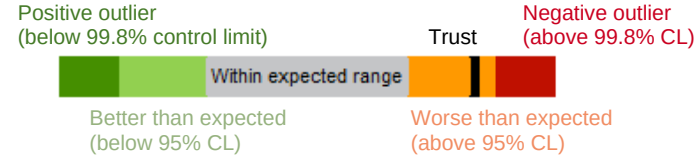
Featured data sources > National audits > Hip fracture audit

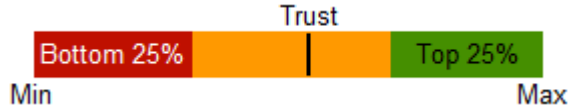
Bassetlaw Hospital

	Metric	CQC Key Question	2015[1] Report	2016[2] Report	National Aggregate (England and Wales)	National Aspirational Standard	Comparison to other hospitals
171 cases	Case ascertainment All eligible patients	Well Led	76.5%	**91.8%**	**90.7%**	none	44.6 89.7 94.4 106.3
171 cases	Crude proportion of patients having surgery on the day or day after admission	Effective	79.5%	**82.5%**	**72.8%**	85%*	33.3 68.5 79.5 92.8
171 cases	Crude perioperative medical assessment rate	Effective	94.9%	**96.5%**	**86.2%**	100%*	0.3 84.6 96.1 99.9
171 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	94.4%	**98.1%**	**94.2%**	none	3.1 94.6 98.7 100
171 cases	Crude overall hospital length of stay	Responsive	15.4 days	**15.1 days**	**20.7 days**	none	10.2 16.4 23.7 38.8
171 cases	Risk-adjusted 30-day mortality rate	Effective	9.6%	**4.5%**	**7.3%****	none	Within expected limits

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

Key:





[1] Jan 14- Dec 14
[2] Jan 15- Dec 15

*Audit recommendation based on NICE guideline
**England only

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

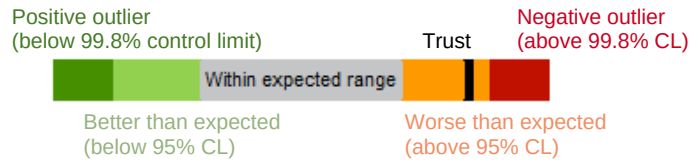
Featured data sources > National audits > Bowel cancer audit

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

	Metric	CQC Key Question	2015 Report	2016 Report	National Aggregate (England and Wales)	National Aspirational Standard	Comparison to other hospitals
196 operations	Case ascertainment	Well Led	107.2%[1]	**74.2%[4]**	**93%**	none	Fair (50-80%)
128 operations	Crude post-operative length of stay >5 days after major resection	Responsive	54.1%[1]	**87.5%[4]**	**69%**	none	Worse than national aggregate
128 operations	Risk-adjusted 90-day post-operative mortality rate	Effective	4.5%[1]	**6.1%[4]**	**3.8%**	none	0 Within expected range 19
N/A	Risk-adjusted 2-year post-operative mortality rate	Effective	23.6%[2]	**18.3%[5]**	**20.9%**	none	0 Within expected range 45
120 operations	Risk-adjusted 30-day unplanned readmission rate	Effective	Not Reported[1]	**13.4%[4]**	**10.1% ***	none	0 Within expected range 40
154 operations	Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	Effective	52.8%[3]	**52.1%[6]**	**50% ***	none	0 Within Expected Range 90

National Bowel Cancer Audit 2016

Key:



Anticipated date of next update is 07/2017

[1] Apr 13- Mar 14
[2] Apr 11- Mar 12
[3] Apr 10- Mar 13
[4] Apr 14- Mar 15
[5] Apr 12- Mar 13
[6] Apr 11- Mar 14

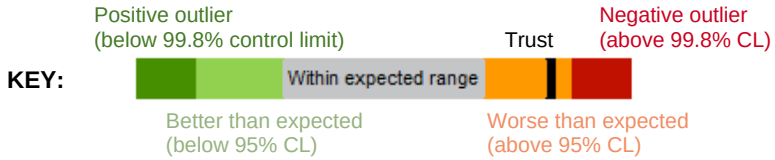
*England only

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > National audits > Intensive care audit

Doncaster Royal Infirmary, Department of Critical Care

	Metric	CQC Key Question	2014/15[1] Report	2015/16[2] Report	National Aggregate (England, Wales & N. Ireland)	National Aspirational Standard	Comparison to other hospitals
	Case Ascertainment All eligible patients	Well Led	Not reported for this audit			none	n/a
857 admissions	Crude non-clinical transfers	Responsive	0.1%	**0.1%**	**0.4%**	0%*	0.0 Within expected limits 8.0
560 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	1.2%	**1.4%**	**2.5%**	0%*	0.0 Within expected limits 15.0
7320 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	7.9%	**6.3%**	**5.3%**	0%*	Not in the worst 5% of units
820 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1	**1.1**	**1**	none	0.5 Within expected limits 2.0
571 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	1.1	**0.9**	**1**	none	0.3 Within expected limits 3.37



Anticipated date of next update is 11/2017

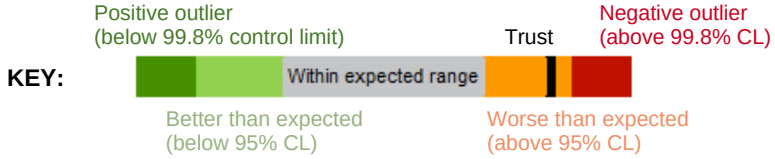
[1] Apr 14- Mar 15
[2] Apr 15- Mar 16

* FICM/ICS guideline

Bassetlaw Hospital, Department of Critical Care

	Metric	CQC Key Question	2014/15[1] Report	2015/16[2] Report	National Aggregate (England, Wales & N. Ireland)	National Aspirational Standard	Comparison to other hospitals
	Case Ascertainment All eligible patients	Well Led	Not reported for this audit			none	n/a
252 admissions	Crude non-clinical transfers	Responsive	2.7%	6%	0.4%	0%*	0.0 Worse than expected 8.0
160 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	2.1%	3.8%	2.5%	0%*	0.0 Within expected limits 17.9191
2196 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	2.1%	2.3%	5.3%	0%*	Not in the worst 5% of units
247 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	0.9	1.1	1	none	0.5 Within expected limits 2.0
150 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	0.6	0.9	1	none	0.04632 Within expected limits 3.37

icnarc | intensive care national audit & research centre



Anticipated date of next update is 11/2017

[1] Apr 14- Mar 15
[2] Apr 15- Mar 16

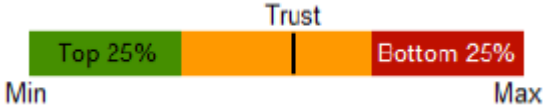
* FICM/ICS guideline

Yorkshire and the Humber Strategic Clinical Network

		Metric	CQC Key Question	2015[1] Report	2016[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparative performance
Trust-level metrics	202 cases	Case ascertainment	Well Led	61 to 70%	**71 to 80%**	**79%***	none	Similar to national aggregate
	202 cases	Age and sex adjusted proportion of patients diagnosed after an emergency admission	Effective	11.6%	**14%**	**13.7%**	none	
	29 cases	Risk-adjusted 90-day post-operative mortality rate	Well Led	9.7%	**10.8%**	**3.9%**	none	
Strategic Clinical Network-level	2442 cases	Crude proportion of patients treated with curative intent in the Strategic Clinical Network	Effective	35.4%	**34.3%**	**37.6%**	none	Significantly lower than the national aggregate

National Oesophago-Gastric Cancer Audit 2016

Key:



[1] Apr 12- Mar 14
[2] Apr 13- Mar 15

*England only

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

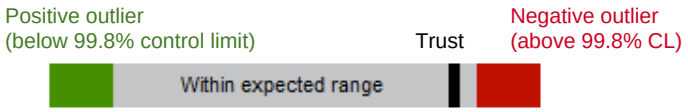
Featured data sources > National audits > National vascular registry

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

		Metric	CQC Key Question	2015 Report	2016 Report	National Aggregate (UK)	National Aspirational Standard	Comparative performance
Abdominal Aortic Aneurysm	72 cases	Case ascertainment	Well Led	95%[1]	**100%[3]**	**87%**	90%	Better than audit aspirational standard
		Risk-adjusted post-operative in-hospital mortality rate	Effective	0.8%[2]	**0.7%[4]**	**1.5%**	none	0 Within expected range 21
Carotid Endarterectomy	38 cases	Case Ascertainment All eligible patients	Well Led	93%[1]	**97%[3]**	**89%**	90%	Better than audit aspirational standard
		Crude median time from symptom to surgery	Responsive	13 days[1]	**13 days[3]**	**13 days**	14 days*	Better than audit aspirational standard
		Risk-adjusted 30-day mortality and stroke rate	Effective	1.4%[2]	**1.5%[4]**	**2.1%**	none	0 Within expected range 15

VSQIP VASCULAR SERVICES QUALITY IMPROVEMENT PROGRAMME

KEY:



Anticipated date of next update is 11/2017

[1] Jan 14- Dec 14
[2] Jan 12 - Dec 14

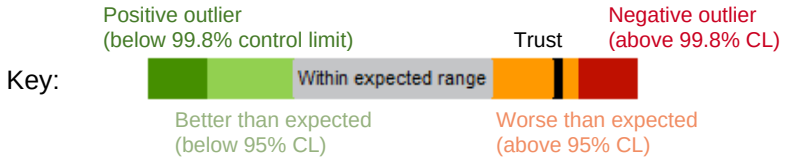
* NICE guideline

[3] Jan 15- Dec 15
[4] Jan 13- Dec 15

Doncaster Royal Infirmary

		Metric	CQC Key Question	Year 1[1]	Year 2[2]	National Aggregate (England & Wales)	National Standard	Hospital performance
	127 cases	Case Ascertainment	Well Led	n/a	**44%**	70%*	80%	Less than 50%
Proportion of patients for which each process of care was met	127 cases	Crude proportion of cases with pre-operative documentation of risk of death	Effective	n/a	**62%**	64%	80%	Between 50% and 80%
	93 cases	Crude proportion of cases with access to theatres within clinically appropriate time frames	Responsive	n/a	**84%**	82%	80%	Higher than 80%
	64 cases	Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	n/a	**73%**	74%	80%	Between 50% and 80%
	40 cases	Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively	Safe	n/a	**63%**	85%	80%	Between 50% and 80%
	229 cases	Risk adjusted 30-day mortality	Effective	n/a	**7.9%**[3]	11.4%	none	Within expected range

NELA National Emergency Laparotomy Audit



Anticipated date of next update is 07/17

[1] Dec 13 - Nov 14
[2] Dec 14 - Nov 15

*England only
[3]Based on Year 1 and Year 2 data

Bassetlaw Hospital

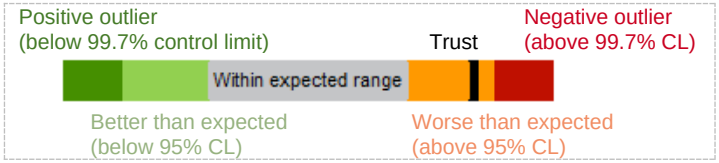
		Metric	CQC Key Question	2014/15[1] Report	2015/16[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
Process measures	25 cases	Crude proportion of patients receiving all key care processes annually	Effective	52.4%	**56.0%**	35.5%	n/a	 0% Better than expected 96%
Blood glucose diabetes control (HbA1c)	53 cases	**Organisation compared with nationally:** Case-mix adjusted mean HbA1c (mmol/mol)	Effective	Positive outlier	**62.1**	68.3	n/a	 61 Positive outlier 77
		Organisational performance compared between years: Median HbA1c (mmol/mol)	Effective	59.3	**60.7**	65.0	n/a	This metric is provided to compare year on year changes within the unit rather than comparison with national figures.

A change of more than 1 mmol/mol is deemed by the audit body to be indicative of a clinically significant change.

NPDA National Paediatric Diabetes Audit

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Higher values indicate poorer control.

Key:



[1] Apr 14 - Mar 15
[2] Apr 15 - Mar 16

Doncaster Royal Infirmary

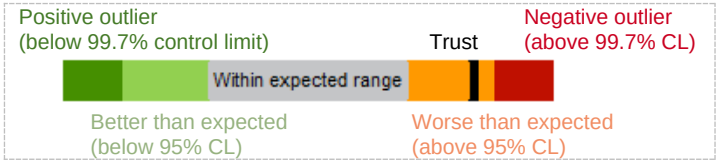
		Metric	CQC Key Question	2014/15[1] Report	2015/16[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
Process measures	85 cases	Crude proportion of patients receiving all key care processes annually	Effective	33.8%	**69.4%**	35.5%	n/a	 0% Positive outlier 96%
Blood glucose diabetes control (HbA1c)	164 cases	**Organisation compared with nationally:** Case-mix adjusted mean HbA1c (mmol/mol)	Effective	Positive outlier	**65.3**	68.3	n/a	 61 Better than expected 77
		Organisational performance compared between years: Median HbA1c (mmol/mol)	Effective	62.0	**62.5**	65.0	n/a	This metric is provided to compare year on year changes within the unit rather than comparison with national figures.

A change of more than 1 mmol/mol is deemed by the audit body to be indicative of a clinically significant change.

NPDA National Paediatric Diabetes Audit

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Higher values indicate poorer control.

Key:



[1] Apr 14 - Mar 15
[2] Apr 15 - Mar 16

Bassetlaw Hospital

Key messages

Comparing this provider to other trusts on the 2016/17 Severe Sepsis and Septic Shock Audit, performance was better in 5 metric(s), worse in 0 metric(s) and similar in 3 metric(s). In this context, 'similar' means that the trust's performance fell within the middle 50% of results. The national standard was met in 0 of 8 of the relevant metrics.

Metric	CQC Key Question	2013/14 Report	2016/17 Report	National Aggregate (UK)	National Standard	Comparison to other units
Number of records submitted to the audit			25	N/A		
Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival	Effective	N/A	96.0%	69.1%	100%*	
Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED	Effective	N/A	92.0%	64.6%	100%*	
Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to):Within one hour of arrival	Effective	N/A	38.1%	30.4%	100%*	

The Royal College of Emergency Medicine

Key: 

*NICE guidance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > National audits > Severe Sepsis and Septic Shock Audit

Metric	CQC Key Question	2013/14 Report	2016/17 Report	National Aggregate (UK)	National Standard	Comparison to other units
Standard 4: Serum lactate measured: Within one hour of arrival	Effective	N/A	**60.0%**	60.0%	100%*	0% 37% 72% 100%
Standard 5: Blood cultures obtained: Within one hour of arrival	Effective	N/A	**72.0%**	44.9%	100%*	0% 25% 62% 100%
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival	Effective	N/A	**65.2%**	43.2%	100%*	0% 25% 57% 96%
Standard 7: Antibiotics administered: Within one hour of arrival	Effective	N/A	**64.0%**	44.4%	100%*	0% 28% 58% 94%
Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival	Effective	N/A	**20.0%**	18.4%	100%*	0% 6% 38% 91%

The Royal College of Emergency Medicine

Key: Trust | Bottom 25% | Top 25% | Min | Max

*NICE guidance

Doncaster Royal Infirmary

Key messages

Comparing this provider to other trusts on the 2016/17 Severe Sepsis and Septic Shock Audit, performance was better in 1 metric(s), worse in 5 metric(s) and similar in 2 metric(s). In this context, 'similar' means that the trust's performance fell within the middle 50% of results. The national standard was met in 0 of 8 of the relevant metrics.

Metric	CQC Key Question	2013/14 Report	2016/17 Report	National Aggregate (UK)	National Standard	Comparison to other units
Number of records submitted to the audit		50	**102**	N/A		
Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival	Effective	N/A	**40.2%**	69.1%	100%*	
Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED	Effective	N/A	**77.5%**	64.6%	100%*	
Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to):Within one hour of arrival	Effective	10.0%	**7.4%**	30.4%	100%*	

The Royal College of Emergency Medicine

Key: 

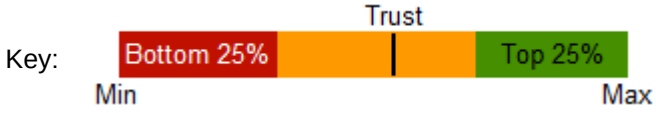
*NICE guidance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > National audits > Severe Sepsis and Septic Shock Audit

Metric	CQC Key Question	2013/14 Report	2016/17 Report	National Aggregate (UK)	National Standard	Comparison to other units
Standard 4: Serum lactate measured: Within one hour of arrival	Effective	76.0%	**25.5%**	60.0%	100%*	0% 37% 72% 100%
Standard 5: Blood cultures obtained: Within one hour of arrival	Effective	60.0%	**34.3%**	44.9%	100%*	0% 25% 62% 100%
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival	Effective	60.0%	**21.8%**	43.2%	100%*	0% 25% 57% 96%
Standard 7: Antibiotics administered: Within one hour of arrival	Effective	50.0%	**22.6%**	44.4%	100%*	0% 28% 58% 94%
Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival	Effective	N/A	**9.9%**	18.4%	100%*	0% 6% 38% 91%

The Royal College of Emergency Medicine



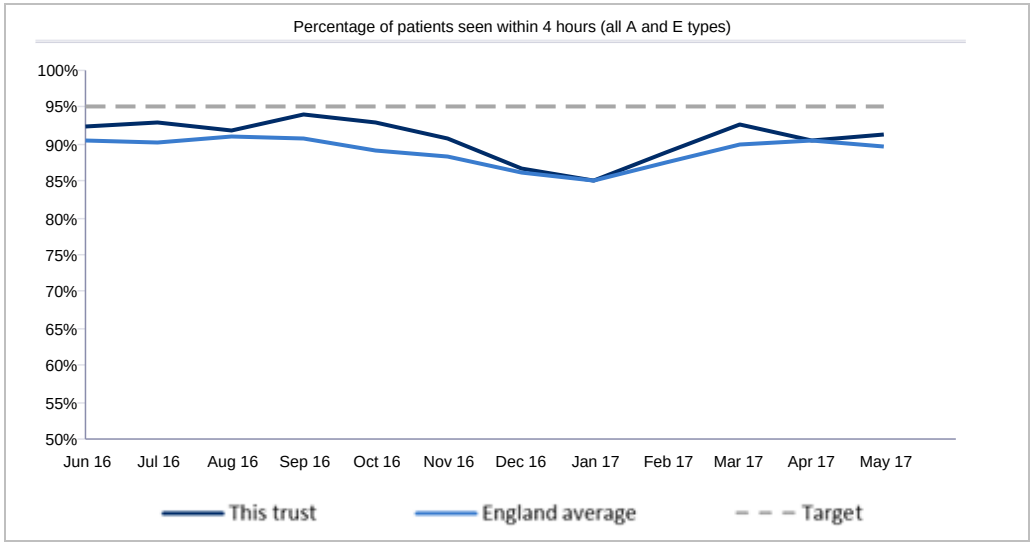
*NICE guidance

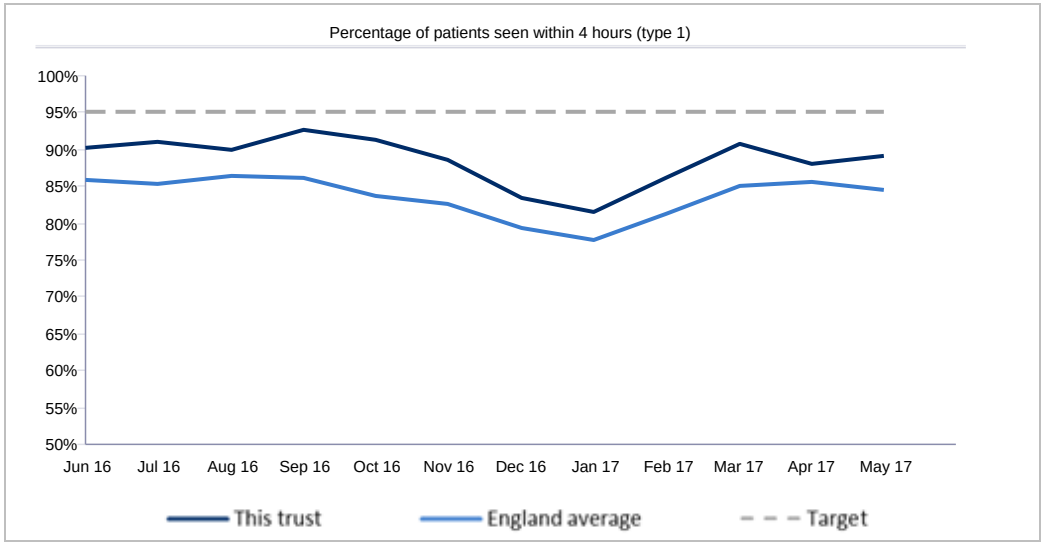
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

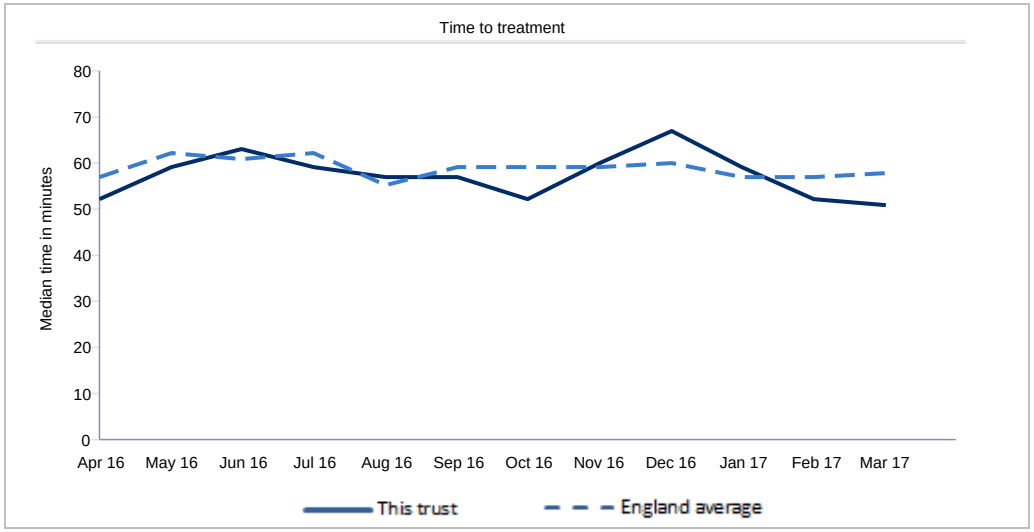
Featured data sources > A&E waiting times

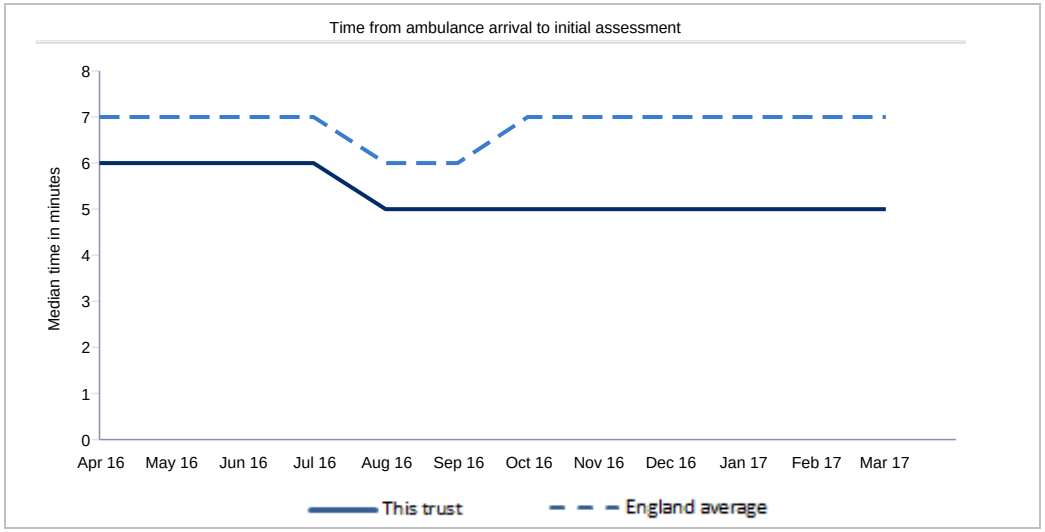
Key messages

- 91% Patients spending less than 4 hours in A&E (all types) in 12 months.
- 89% Patients spending less than 4 hours in A&E (type 1) in 12 months.









Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Access and flow> Bed occupancy

Under development

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Access and flow> Delayed transfers of care

Under development

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Patient surveys > Inpatient survey

Concern status: 2014 | 2015 | 2016

No concern
Concern
High concern

Click **here** to contact the Surveys Team to discuss survey data

Concerns live	Escalated to inspector	Action taken	Closed
Under development			

Concerns are flagged where a high proportion of people told us their experience of care was in line with the worst possible answer to a wide range of questions across the entire survey.

Feedback from adult inpatients (aged 16 or over) who spent at least one night in hospital during July 2016

Where has patient experience improved from 2015 to 2016?

1 area has improved

- ↑ Hospital changing admission date

Where has patient experience declined from 2015 to 2016?

5 areas have declined:

- ↓ Cleanliness of toilets and bathrooms
- ↓ Getting understandable answers to questions from nurses
- ↓ Bothered by noise at night from other patients
- ↓ Notice given about discharge
- ↓ Time between arrival and getting a bed on a ward

Where has patient experience continued to be better?

There were no areas better than expected in both years

Where has patient experience continued to be worse?

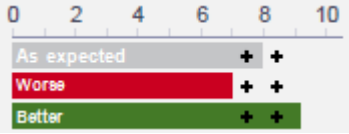
There were no areas worse than expected in both years

Source: Inpatient survey

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Patient surveys > Inpatient survey

Key:



- No significant change
- 2016 score is **significantly lower** than 2015 score
- 2016 score is **significantly higher** than 2015 score

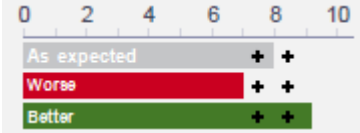
Question	2013	2014	2015	2016	2016 Threshold between 'As expected' and Worse	2016 Threshold between 'As expected' and Better	Trend
	Score out of 10						
Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.2	8.1	8.1	8.1	7.6	8.9	
Q4. Were you given enough privacy when being examined or treated in the A&E Department?	8.5	8.3	8.5	8.5	8.3	9.2	
Q6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	8.0	8.6	8.5	8.9	7.3	9.0	
Q7. Was your admission date changed by the hospital?	9.3	9.3	9.1	9.5	8.8	9.5	↑
Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.9	8.8	9.1	9.0	8.6	9.5	
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.2	7.2	7.8	6.9	6.4	8.7	↓
Q11. Did you ever share a sleeping area with patients of the opposite sex?	8.9	9.1	9.1	9.3	8.8	9.7	
Q14. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	8.5	9.0	8.7	8.6	7.7	9.8	
Q15. Were you ever bothered by noise at night from other patients?	5.8	6.5	6.9	6.2	5.3	7.1	↓
Q16. Were you ever bothered by noise at night from hospital staff?	7.5	7.7	7.8	7.6	7.4	8.6	
Q17. In your opinion, how clean was the hospital room or ward that you were in?	8.9	9.0	9.1	9.0	8.5	9.5	
Q18. How clean were the toilets and bathrooms that you used in hospital?	8.8	8.9	9.1	8.7	8.0	9.2	↓
Q19. Did you feel threatened during your stay in hospital by other patients or visitors?	9.8	9.8	9.5	9.7	9.5	9.9	
Q20. Did you get enough help from staff to wash or keep yourself clean?	-	-	-	7.9	7.6	8.8	NA
Q21. If you brought your own medication with you to hospital, were you able to take it when you needed to?	-	-	-	6.9	6.5	8.0	NA
Q22. How would you rate the hospital food?	5.8	6.0	6.2	5.9	4.8	6.6	
Q23. Were you offered a choice of food?	8.7	8.8	9.1	9.1	8.1	9.4	
Q24. Did you get enough help from staff to eat your meals?	6.8	7.5	7.3	7.2	6.4	8.3	
Q25. When you had important questions to ask a doctor, did you get answers that you could understand?	7.8	7.9	8.2	8.0	7.7	8.8	
Q26. Did you have confidence and trust in the doctors treating you?	8.5	8.5	8.8	8.9	8.6	9.4	
Q27. Did doctors talk in front of you as if you weren't there?	8.6	8.6	8.8	8.9	8.2	9.1	
Q28. When you had important questions to ask a nurse, did you get answers that you could understand?	8.2	8.5	8.6	8.0	7.7	8.9	↓

Source: Inpatient survey

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

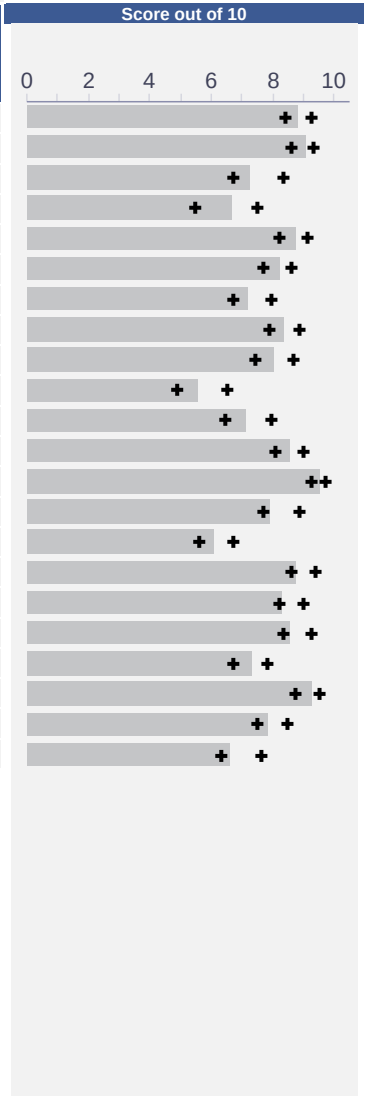
Featured data sources > Patient surveys > Inpatient survey

Key:



- No significant change
- 2016 score is **significantly lower** than 2015 score
- 2016 score is **significantly higher** than 2015 score

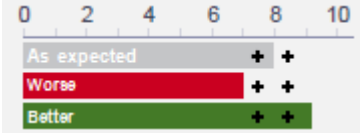
Question	2013	2014	2015	2016 Score out of 10	2016 Threshold between 'As expected' and Worse	2016 Threshold between 'As expected' and Better	Trend
Q29. Did you have confidence and trust in the nurses treating you?	8.5	8.8	9.0	8.8	8.4	9.3	
Q30. Did nurses talk in front of you as if you weren't there?	8.9	9.0	9.0	9.1	8.6	9.4	
Q31. In your opinion, were there enough nurses on duty to care for you in hospital?	6.6	7.1	7.6	7.3	6.7	8.3	
Q32. Did you know which nurse was in charge of looking after you?	-	-	-	6.7	5.5	7.5	NA
Q33. In your opinion, did the members of staff caring for you work well together?	-	-	9.0	8.7	8.2	9.1	
Q34. Did a member of staff say one thing and another say something different?	8.1	7.9	8.2	8.2	7.7	8.6	
Q35. Were you involved as much as you wanted to be in decisions about your care and treatment?	6.9	7.3	7.5	7.2	6.7	7.9	
Q36. Did you have confidence in the decisions made about your condition or treatment?	-	8.0	8.5	8.3	7.9	8.8	
Q37. How much information about your condition or treatment was given to you?	7.6	7.8	7.9	8.0	7.4	8.7	
Q38. Did you find someone on the hospital staff to talk to about your worries and fears?	5.6	5.8	6.1	5.6	4.9	6.5	
Q39. Do you feel you got enough emotional support from hospital staff during your stay?	7.2	7.2	7.6	7.1	6.5	7.9	
Q40. Were you given enough privacy when discussing your condition or treatment?	8.3	8.4	8.5	8.6	8.1	9.0	
Q41. Were you given enough privacy when being examined or treated?	9.5	9.4	9.5	9.6	9.3	9.7	
Q43. Do you think the hospital staff did everything they could to help control your pain?	7.7	7.8	8.0	7.9	7.7	8.9	
Q44. How many minutes after you used the call button did it usually take before you got the help you needed?	6.1	6.5	6.4	6.0	5.6	6.7	
Q46. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.7	8.8	9.1	8.7	8.6	9.4	
Q47. Beforehand, did a member of staff explain what would be done during the operation or procedure?	8.4	8.4	8.6	8.3	8.2	9.0	
Q48. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.4	8.7	8.8	8.6	8.4	9.2	
Q49. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	7.1	7.9	7.5	7.3	6.7	7.8	
Q51. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.4	9.4	9.2	9.3	8.8	9.5	
Q52. Afterwards, did a member of staff explain how the operation or procedure had gone?	7.0	7.9	8.1	7.8	7.5	8.5	
Q53. Did you feel you were involved in decisions about your discharge from hospital?	6.9	6.8	7.0	6.6	6.3	7.7	



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Patient surveys > Inpatient survey

Key:



- No significant change
- 2016 score is **significantly lower** than 2015 score
- 2016 score is **significantly higher** than 2015 score

Question	2013	2014	2015	2016	2016 Threshold between 'As expected' and Worse	2016 Threshold between 'As expected' and Better	Trend
	Score out of 10						
Q54. Were you given enough notice about when you were going to be discharged?	7.2	7.2	7.4	6.7	6.5	7.8	↓
Q56. Discharge delayed due to wait for medicines/to see doctor/for ambulance	6.8	6.3	6.7	6.3	5.4	7.2	→
Q57. How long was the delay?	7.7	7.5	7.8	7.7	6.8	8.4	→
Q59. Did you get enough support from health or social care professionals to help you recover and manage your condition?	-	-	6.9	7.0	6.1	7.3	→
Q60. When you left hospital, did you know what would happen next with your care?	-	-	-	6.8	6.3	7.4	NA
Q61. Were you given any written or printed information about what you should or should not do after leaving hospital?	6.7	6.4	6.6	6.0	5.6	7.2	→
Q62. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.1	8.5	8.2	8.2	7.8	8.8	→
Q63. Did a member of staff tell you about medication side effects to watch for when you went home?	5.3	5.4	5.1	4.5	3.9	5.6	→
Q64. Were you told how to take your medication in a way you could understand?	8.2	8.6	8.2	8.1	7.7	8.9	→
Q65. Were you given clear written or printed information about your medicines?	8.1	7.7	8.0	8.1	7.3	8.5	→
Q66. Did a member of staff tell you about any danger signals you should watch for after you went home?	5.1	5.9	5.7	5.3	4.5	6.2	→
Q67. Did hospital staff take your family or home situation into account when planning your discharge?	7.2	7.2	7.4	6.9	6.5	8.0	→
Q68. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	6.0	6.5	6.2	5.6	5.2	6.8	→
Q69. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.5	8.1	7.8	8.1	6.9	8.5	→
Q70. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.0	9.1	8.3	8.6	7.2	9.0	→
Q71. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.2	8.8	8.5	8.5	7.6	8.9	→
Q72. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.6	8.8	9.1	9.0	8.7	9.5	→
Q73. During your time in hospital did you feel well looked after by hospital staff?	-	8.6	8.9	8.8	8.5	9.3	→
Q74. Overall experience	7.8	7.9	8.2	8.1	7.7	8.6	→
Q75. During your hospital stay, were you ever asked to give your views on the quality of your care?	1.3	1.9	2.1	1.9	1.0	2.7	→
Q76. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.1	2.7	2.8	2.3	1.6	3.2	→

Source: Inpatient survey

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

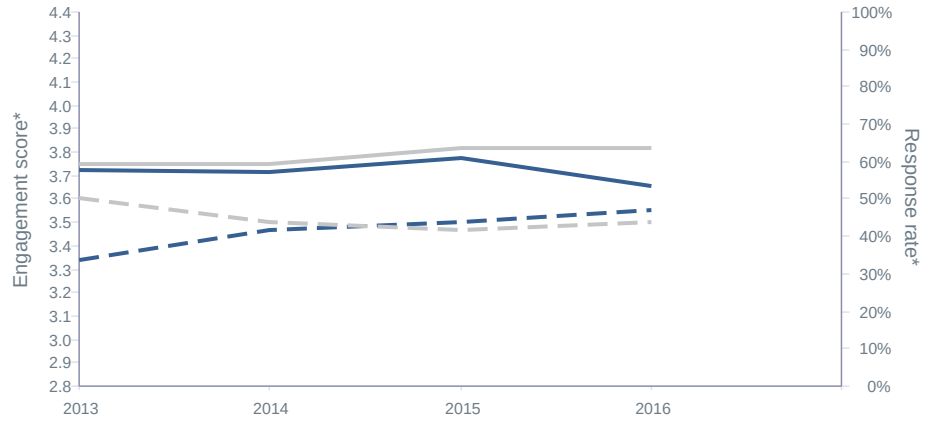
Featured data sources > Staff surveys > NHS Staff Survey

Key messages

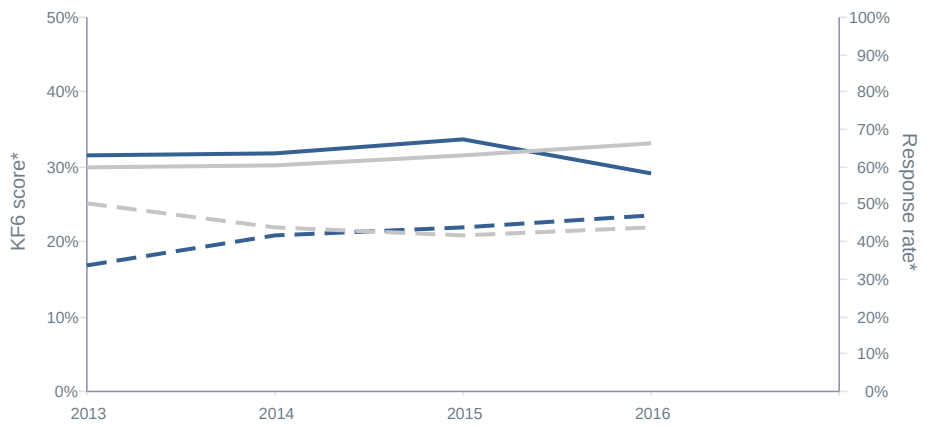
Comparing 2016 results for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust to all acute trusts:

- Engagement score was 'much lower'
- Recommendation rates were 'much lower'
- Communication was 'lower'
- Bullying and harassment was 'lower'

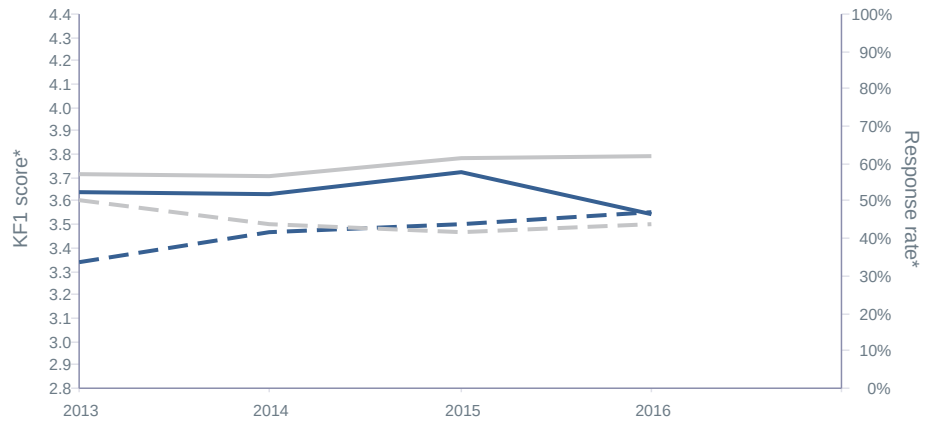
Overall engagement score



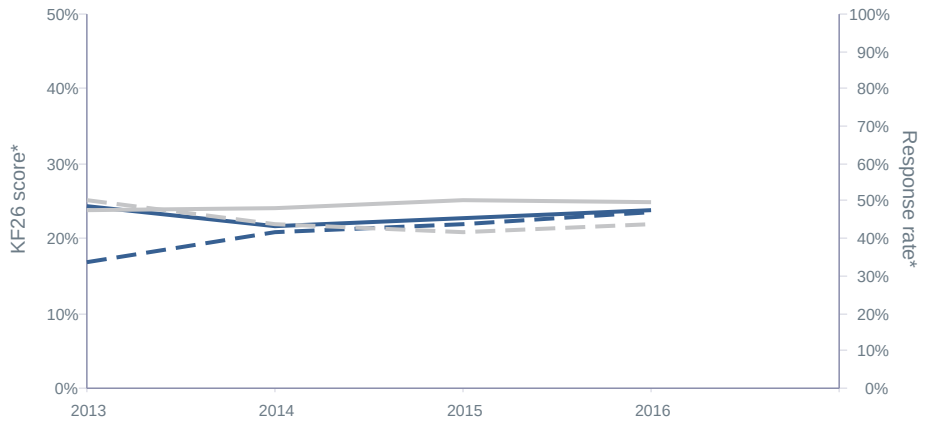
KF6. % staff reporting good communication



KF1. Staff recommendation of the organisation score



KF26. % staff experiencing harassment, bullying or abuse form other staff



Acute trusts | This trust | Response rate for acute trusts | Response rate for this trust

*Data up to 2014 is not weighted to reflect the different staff profiles of trusts.

Source: NHS Staff Survey http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

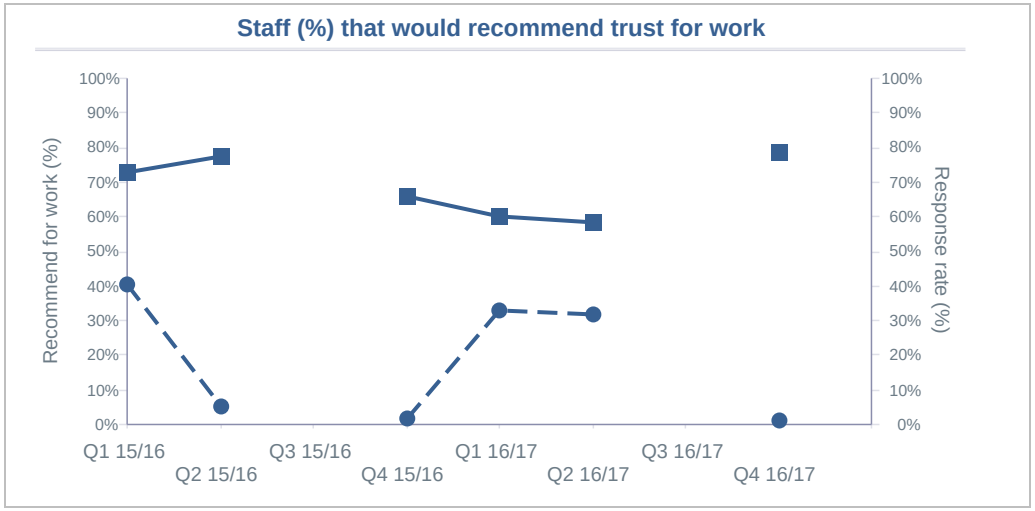
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

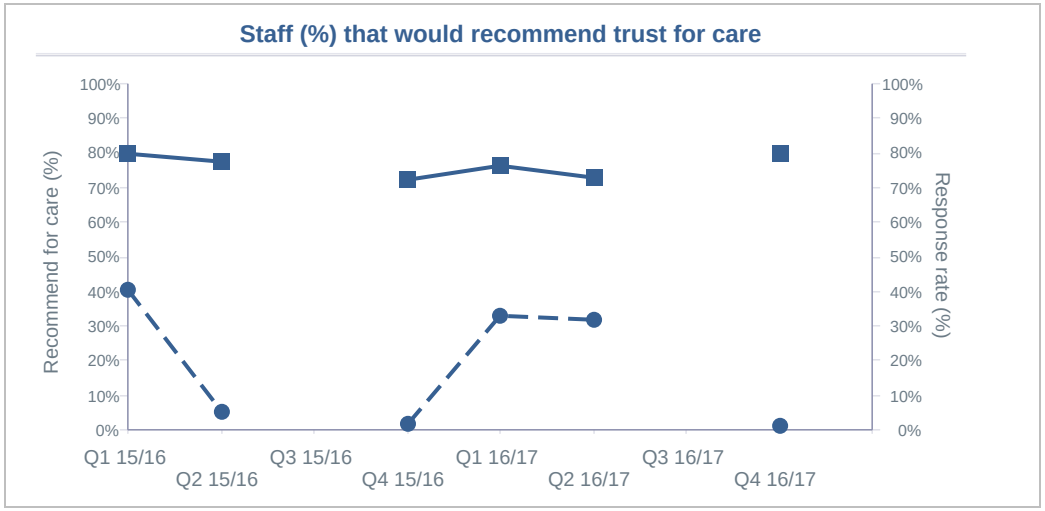
Featured data sources > Staff surveys > Staff Friends and Family Test

Key messages

• The percentage of staff that would recommend this trust as a place to work in Q4 16/17 increased when compared to the same time last year.

• The percentage of staff that would recommend this trust as a place to receive care in Q4 16/17 increased when compared to the same time last year





This trust

Response rate for this trust

Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

Source: Staff Friends and Family Test https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/data/

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Featured data sources > Staff surveys > Workforce race equality standard

Key messages

- In the latest survey the responses from BME staff and white staff were significantly different for KF26, KF21, Q17b
- The total response rate was lower than the minimum recommended response rate of 50%
- In the previous and latest survey this trust used a census which sends the survey to all staff in the trust

NHS Staff Survey Indicator		Proportion of respondents answering "Yes"		% difference between BME and white staff	
		BME staff	White staff		
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Trust**	**26.4%**	**26.9%**	●	**0.5%**
	England	27.4%	26.5%		-0.9%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months	**Trust**	**32.7%**	**23.1%**	●	**-9.7%**
	England	28.2%	24.1%		-4.1%
KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	**Trust**	**70.2%**	**84.9%**	●	**14.7%**
	England	72.7%	88.0%		15.4%
Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	**Trust**	**15.0%**	**5.6%**	●	**-9.4%**
	England	14.8%	6.1%		-8.7%

Key for % difference between BME and white staff	
●	Statistically significant
●	Not statistically significant
○	Statistical analysis of results was not undertaken due to the low number of BME respondents (<50)

		Previous	Latest
Sampling method	**Trust**	**Census**	**Census**
Total number of recipients *(ineligible staff removed)	**Trust**	**6,372**	**6,279**
Response rate from total recipients	**Trust**	**43.7%**	**46.8%**
	England	42.0%	43.7%

		BME		White		Total
Average number of respondents across the 4 WRES questions	**Trust**	**156**	**(6.2%)**	**2,371**	**(93.8%)**	**2,527**
	England	40,880	(16.2%)	210,966	(83.8%)	251,846

Trusts are encouraged to perform a census rather than a basic or extended sample in order to understand experiences for different staff groups. We encourage the trust to get more respondents to really understand issues affecting staff. It would also be helpful for inspection staff to follow up on what the trust is doing to understand the potential underlying causes and improve the experience for staff.

Source: NHS Staff Survey 2016

Performance level

- MB Much better
- B Better
- S About the same
- W Worse
- MW Much worse
- ! Non-submission
- No data

Performance change

- Improving
- About the same
- Declining

Ratings

- O Outstanding
- G Good
- RI Requires improvement
- I Inadequate
- NR* Inspected but not formally rated
- NA Not rated

Others

National Guardian Freedom to Speak Up — Data that is relevant for 'speaking up'

Understanding data

What do these boxes show?

The boxes represent all Acute NHS trusts from smallest to largest in five groups, or quintiles. The purple highlighted box shows you where this trust lies relative to the other trusts. If the smallest box is highlighted this trust is in the group of the smallest trust or lowest activity level, and if the second largest box is highlighted the trust is in the second largest group, or quintile, for higher activity levels.

What do N/A, *, and - mean when they are used for data values?

n/a Value is not applicable

- Data is not available for trust or time period.

***** Suppressed values between 1 and 5. We apply a strict statistical disclosure control in accordance with the HES protocol to all published data. This requires that small numbers are supressed to prevent individuals being identified and to ensure that patient confidentiality is maintained.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Planner

		Planned indicator refreshes				
		Monthly refreshes	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
	Facts and figures	• HES (inpatient spells, attendances, discharges, deaths, length of stay) • Workforce statistics • A&E Quality Indicators • Critical Care bed numbers	• NHSI segmentation • Bed occupancy (G&A and maternity) • HES Deliveries	• NHSI segmentation • Bed occupancy (G&A and maternity) • HES Deliveries	• NHSI segmentation • Bed occupancy (G&A and maternity) • HES Deliveries	• NHSI segmentation • Bed occupancy (G&A and maternity) • HES Deliveries
	Trust wide indicators	• RTT • Trust composite • NRLS • STEIS • Single Oversight Framework (SOF) segmentation	• Staff Survey* • HSMR/Deaths in low risk diagnosis groups • ESR • FFT • CAS • SHMI	• Inpatient Survey* • HSMR/Deaths in low risk diagnosis groups • ESR • FFT • CAS • SHMI	• N. Cancer Survey* • HSMR/Deaths in low risk diagnosis groups • ESR • FFT • CAS • SHMI	• HSMR/Deaths in low risk diagnosis groups • ESR • FFT • CAS • SHMI
Core service indicators	Urgent and emergency	• A&E response times • A&E Quality indicators • Ambulance handover timings • Never Events	• FFT		• A&E Survey*	
	Maternity	• Never events	• Maternity outliers • FFT		• Perinatal mortality (MBRRACE-UK)	• Maternity Survey*
	Outpatients	• RTT • Diagnostic waiting times • DNA rates • Never Events • HES	• Cancer waiting times			
	Surgery	• RTT • National Vascular Registry (mortality) • Additional mortality indicators (CCS groups) • Never Events	• FFT • PROMs • Cancelled operation rates • Additional mortality indicators (CCS groups)	• Inpatient Survey • Emergency laparotomy Audit • Additional mortality indicators (CCS groups) • Bowel Cancer Audit • Vascular Audit (NVR)	• Additional mortality indicators (CCS groups)	• Additional mortality indicators (CCS groups)
	Medicine (inc. older people)	• HES readmissions • RTT • Never events	• Mortality indicators • RTT • SSNAP (Stroke) indicator	• Lung Cancer audit	• Inpatient Falls (NAIF)	
	Critical care	• Never events	• Bed occupancy	• ICNARC		
	Children and young people	• Never events		• Paediatric Diabetes Audit	• CYP survey* • Neonatal Audit (NNAP) • Paediatric Intensive care (PICANET)	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Mixed Sex Accommodation**		
Report to	**Board of Directors**	**Date**	**29th August 2017**
Author	**Moira Hardy, Acting Director of Nursing Midwifery & Quality** **Lisette Caygill, Acting Deputy Director of Quality & Governance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✓
	Information		

Executive summary containing key messages and issues
The purpose of this paper is to provide a Declaration of Compliance with the requirement to eliminate mixed sex accommodation. This continues to be managed in line with national requirements, as it has in previous years.
Key questions posed by the report
Do reporting mechanisms give sufficient assurance of compliance with the requirement to eliminate mixed sex accommodation and that privacy and dignity for patients is optimised.
How this report contributes to the delivery of the strategic objectives
This report contributes to the strategic objective of providing accessible, high quality and responsive services by ensuring that patients' privacy is prioritised and that there are arrangements for patients' dignity to be optimised. This will be evidenced through monitoring good compliance seen through the patient surveys and placing value in the way that we demonstrate sensitivity when dealing with patients concerns. By working collaboratively with our patients in developing services and taking action to improve our services where further opportunities arise.
How this report impacts on current risks or highlights new risks
Potential for failure to manage our systems and process to benefit the needs of our patients, caused by ineffective patient experience considerations, leading to poor quality care and experience.
Recommendation(s) and next steps
The Board of Directors is asked to NOTE the content of this report.

Elimination of Mixed Sex Accommodation

Declaration of Compliance

Statement of Compliance

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust is pleased to confirm that we are compliant with the Government's requirements to eliminate mixed-sex accommodation, except when it is in the patient's overall best interests, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in critical care), or when patients actively choose to share (for instance in children's wards).

If our provision of care should fall short of the required standard, we will report it. We also have an audit mechanism to make sure that we do not misclassify any of our reports. We will publish the results of that audit through the Quality Report to the Board of Directors and to commissioners at the Clinical Quality Review Group.

What does this mean for patients?

Other than the circumstances set out above, patients who are admitted to Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust can expect the following in the inpatient wards:

- The room where your bed is will only have patients of the same sex as you
- Your toilet and bathroom will just be for your gender, and will be close to your bed area

It is possible that there will be both men and women patients on the ward, but the opposite gender will not share your sleeping or bathroom area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through opposite sex areas.

You may share some communal space, such as day rooms and dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to x-ray or the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need help to use the toilet or take a bath (e.g. you need a hoist or special bath) then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time.

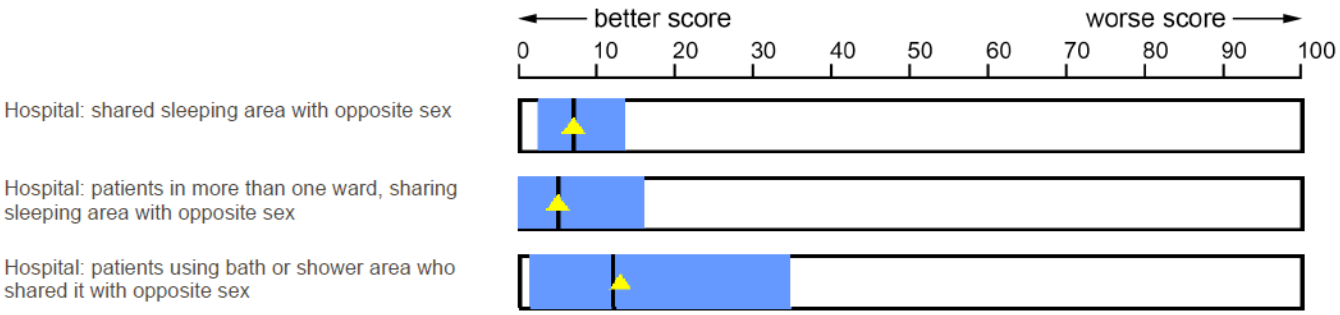
The NHS will not turn patients away just because a "right sex" bed is not immediately available.

Our commitment to you

We are committed to listening to what our patients tell us so that we can continually improve the services we provide.

We actively ask our patients in the patient surveys about their experience of bedroom and bathroom facilities to confirm to us that they have not shared accommodation with members of the opposite sex. When compared to the national benchmark group, our Inpatient Survey for 2016 showed results similar to other Trusts of our class, recognising the use of high dependency environments.

There have been no occasions where men and women shared accommodation except in the designated areas where this avoidable, such as critical care, for the past 5 years. There are processes to monitor and prevent breaches of the guidance.



Our plans for the future

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust will continue to improve the facilities for patients through ongoing investment and optimising the number of single rooms and also en-suite facilities as opportunities arise. We are also taking further steps to standardise clear signage using symbols and text to help patients access the correct facilities, in line with the requirements of the Patient Led Assessment of the Care Environment guidance.

What do you do if I think I am in mixed sex accommodation?

Please ask the nursing staff to explain where you are in relation to patients of the other gender. They will be able to show you and explain the bed and toilet facilities in use for you and other patients.

If you have further questions, then please ask to speak to the Matron or Head of Nursing responsible for the area in which you are receiving care or contact the Patient Experience Team office on 01302 642764. They will ensure that your concern is investigated by a member of the nursing management team and fed back to you.

ELIMINATING MIXED SEX ACCOMMODATION (EMSA) ACTION PLAN 2017/2018

Theme/Issue	Action Taken	Lead	Reporting/Expected Completion Date
Board of Directors responsibility			
Ensure the Board of Directors are kept appraised of any breaches of EMSA guidance thus ensuring they are able to sign the Trust statement of compliance	• Continue ward reporting on EMSA • Declaration of compliance August 2017	Ward Managers/ Heads of Nursing and Quality Director of Nursing, Midwifery and Quality	Weekly reporting Monthly reporting August 2017
Patient perception			
In 2016/17 there were no breaches of EMSA guidance. The 2016 Inpatient Survey showed 7% of patients shared a sleeping area.	• Ensure this question remains on patient experience surveys to ensure no increase in patient perception occurs. Report assurance to PEEC • Ensure that information is available at Ward level for all patients explaining the definition of "single sex accommodation" • Ensure patients in high dependency areas are informed of how their privacy and dignity will be maintained when sharing is clinically permitted.	Deputy Director of Quality and Governance Ward Managers Ward Managers	Quarterly reporting Ongoing process Ongoing process
Commissioner assurance			
Provide assurance to commissioners relating to EMSA	• Maintain EMSA breach reporting systems • Present results of any root cause analysis to CCG • Invite CCG to join "Quality Assurance Tool" assessments.	Deputy Director of Quality and Governance	Quarterly reporting By exception Annual cycle
Service changes			
Ensure all service specifications and service changes are assessed to ensure compliance with EMSA guidance	• Senior nurse/quality representative is core member of group who review all new service specifications • Estates department to seek assurance re EMSA compliance	Deputy Director of Nursing – Patient Experience & Quality Director of Estates	 As required

	when major projects are planned • Optimise signage to support patient recognition and access to toilet, shower and bathroom facilities	Patient Environment Group	Annual PLACE assessments and workplan

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Strategy & Improvement Update**		
Report to	**Board of Directors**	**Date**	**29th August 2017**
Author	**Marie Purdue, Deputy 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 the Strategic Plan Implementation Process – paragraph 2 b) Quality Improvement & Innovation Update – paragraph 3
Key questions posed by the report
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? Are the Board assured that the implementation and delivery process are sufficiently robust?
How this report contributes to the delivery of the strategic objectives
This report identifies the structures, processes and reporting mechanisms required to support the implementation of the strategy and all of the supporting objectives.
How this report impacts on current risks or highlights new risks
The main risk is that we will not have a credible and supported plan to deliver the transformation required at local or system level, to ensure we can sustain high quality services in line with our revised Strategic Direction. 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 content of this report.

1 Introduction

1.1. This paper seeks to provide:

a) Progress on the Strategic Plan Implementation Process – paragraph 2
b) Quality Improvement & Innovation Update – paragraph 3

2 Strategic Plan Implementation Process

2.1 Following the Board of Governors meeting in July, the Strategic Direction 2017-22 has been forwarded to NHSI.

2.2 A formal launch is planned for September, starting with Management Board on the 11th September to avoid the holiday season and achieve maximum coverage.

2.3 The launch is being supported by the Communications Team and includes, among others: formal communications to partners from CEO; workshops; inclusion in Foundations for Health and an information stand at the Annual Members Meeting.

2.4 The final drafts of the enabling strategies will be reviewed at Executive Team on 13th September to ensure alignment before agreement at QEC and F&P and ratification at the subsequent Trust Board.

2.5 Steering Groups have been developed to drive and oversee the strategy implementation in the following areas:

2.5.1 Urgent & Emergency Care (including Intermediate Care)
2.5.2 Elective Care (including Cancer Services)
2.5.3 Women's & Families

Progress has been made with the development of the Steering Groups. These will be clinically led and have Care Group senior management team, corporate departments and Executive membership. Terms of Reference have been drafted and circulated for comment and these will be agreed at the September Management Board. Chairs for the Urgent & Emergency and Elective Steering Groups are Care Group Directors, who will be supported by Strategy & Improvement with programme management and Qii input.

2.6 The work overseen by the Steering Groups will be managed using a Programme Management approach and will report into Management Board.

2.7 Decision making for the strategic changes will be through existing business planning structures, i.e. Corporate Investment Committee and Trust Board.

2.8 Strategic changes to services initiated in response to the place based Accountable Care Partnership transformation plan, or South Yorkshire & Bassetlaw Accountable Care System will be managed through these groups.

2.9 Work plans are being developed for discussion and agreement at the first steering group meetings and these will be used within the revised Care Group and Corporate Department business planning process. The business planning processes are currently being updated to reflect the new Strategic Direction.

3 Quality Improvement & Innovation

3.1 The Quality Improvement & Innovation (Qii) strategy and its associated action plan have been completed and have been shared at Clinical Governance Committee. It will be submitted to QEC in line with the process described in 2.5 above.

3.2 A Lead Consultant for Qii has been appointed and will work with the Qii Team on a number of areas including supporting the strategic change overseen by the Steering Groups.

3.3 The Team has introduced a Qii toolkit and are working with a number of clinical areas to trial this currently.

3.4 A development session on the Qii strategy was delivered to Board in July, and an awareness session will be delivered to Governors in due course.

4 Summary

4.1 Plans for implementation of the Strategic Direction are progressing well and will require ongoing support and development.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – July 2017**			
Report to	**Trust Board**	**Date**	**29.08.2017**	
Author	**Jon Sargeant - Director of Finance**			
Purpose	To update the Board on the financial position for the month of May 2017.			Tick one as appropriate
	Decision			
	Assurance			
	Information			✔

Executive summary containing key messages and issues
• In month position £2.384m deficit, £475k worse than plan • YTD position £10.380m deficit, £461k worse than plan • Total pay expenditure has dropped in July, but non pay spend and non delivery of CIP target continues to cause a pressure on the bottom line position
Key questions posed by the report
• How will the gap in the financial plan be closed • How will the gap in the CIP plan be closed
How this report contributes to the delivery of the strategic objectives
• Identify the most effective care possible • Assist in the control and reduction of the cost of healthcare • Aid focus on innovation for improvement • Assist in developing responsibly and delivering the right services with the right staff
How this report impacts on current risks or highlights new risks
• Identifies the size and scale of the gap in the financial and CIP plans for 2017/18
Recommendation(s) and next steps
• Develop action plans for closure of the gaps in the Financial and CIP plans

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P4 July 2017

29th August 2017

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE SCORECARD JUNE2017

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	1,965	56	A	9,961	42	A	16,489	16,070
Income	(31,228)	(879)	F	(122,234)	(2,442)	F	(361,298)	(361,298)
STF Incentive	(770)	0	F	(2,501)	0	F	(11,547)	(11,547)
STF Adjustment 16/17	(419)	(419)	F	(419)	(419)	F	0	(419)
Operating Expenditure	33,308	1,327	A	130,801	2,726	A	376,498	376,498
Pay	21,286	208	A	86,743	2,075	A	254,114	254,114
Non Pay	12,022	1,119	A	44,058	651	A	122,383	122,383
I&E Perf Exc 16/17 STF	**2,384**	**475**	**A**	**10,380**	**461**	**A**	**16,489**	**16,489**

F = Favourable A = Adverse

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

3. Statement of Financial Position

All figures £m	Opening Balance 01.04.17	Current Balance 31.07.17	Movement in year
Non Current Assets	***196,907***	***194,686***	***(2,221)***
Current Assets	*33,612*	*62,000*	*28,388*
Current Liabilities	*(31,967)*	*(69,284)*	*(37,317)*
Non Current liabilities	*(79,348)*	*(78,155)*	*1,193*
Total Assets Employed	***119,204***	***109,247***	***(9,957)***
Total Tax Payers Equity	***119,204***	***109,247***	***(9,957)***

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	280	(469)	A	842	(1,138)	A	11,675	
Drugs	12	12		12	12	F	65	
Clinical Supplies	106	19	F	179	(172)	A	1,156	
Non Clinical Supplies	0	0		0	0	A	10	
Non Pay Operating Expenses	42	3	F	88	(133)	A	1,224	
Income	6	(25)	A	34	(89)	A	369	
Total	**447**	**(460)**	**A**	**1,155**	**(1,521)**	**A**	**14,500**	

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	11,504	1,900	11,504	1,900	1,900
Capital Expenditure	635	243	1,403	780	6,481	7,842

5. Workforce

	Funded WTE	Actual WTE		Bank WTE	Agency WTE		Total in Post WTE	Under / (over)
Current Month	*6,031*	*5,583*		*182*	*142*		*5,907*	*124*
Previous Month	*6,031*	*5,577*		*170*	*284*		*6,031*	*0*
Movement	*0*	*(6)*	*0*	*(12)*	*142*	*0*	*124*	*124*

The high Agency WTE in month 3 related to the restatement of the year to date position.

1. Context/Background

The month 4 position for 2017/18 is a deficit of £9,960k, which is £42k behind the planned year to date deficit of £9,918k. However it must be noted that this reported position includes £419k of STF income relating to 2016/17 that cannot be counted towards the Trust's control total. The restated position which will be used by NHS Improvement to monitor the Trust's financial performance, is a deficit of £10,380k which is £461k worse than our control total target to date (£9,918k).

Income has over-performed against plan in July, but high agency expenditure has continued. The level of unidentified CIPs also continue to generate a significant overspend.

In month 3, £1.5m of balance sheet and reserve flexibilities were released into the position. In the month 4 year to date position, the benefit of this £1.5m remains, but no further reserves have been released.

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	-31,118	-32,417	-1,298	-122,293	-125,154	-2,861	-125,828	-125,346	482	-372,761	-373,180
2. Costs	31,981	33,308	1,327	128,074	130,801	2,726	129,184	126,659	-2,525	376,414	376,414
3.Capital Charges	1,047	1,074	27	4,137	4,314	177	4,701	4,647	-54	12,836	12,836
Total Position Before Impairments	**1,910**	**1,965**	**56**	**9,918**	**9,961**	**42**	**8,057**	**5,960**	**-2,097**	**16,489**	**16,070**
4.Impairments	0	0	0	0	0	0	0	0	0	0	0
Total Position After Impairments	**1,910**	**1,965**	**56**	**9,918**	**9,961**	**42**	**8,057**	**5,960**	**-2,097**	**16,489**	**16,070**
Remove STF relating to 16/17	0	419	419	0	419	419	0	0	0	0	419
Position to compare to control total	**1,910**	**2,384**	**475**	**9,918**	**10,380**	**461**	**8,057**	**5,960**	**-2,097**	**16,489**	**16,489**

I&E position	In Month Plan	In Month Actual	In Month Variance	2017/18 Plan
Position before STF	2,680	3,154	475	28,036
STF funding	-770	-770	0	-11,547
STF funding relating to 16/17	0	-419	-419	0
Reported position	1,910	1,965	56	16,489

During July, income has been £1,298k better than expected, this includes £419k relating to STF funding for 2016/17 which will be removed from the control total position. Other areas include £436k of income relating to R&D which is offset in the expenditure position. During July, Care Group expenditure was £2m higher than budgeted levels. Within this figure there is an overspend of £436k relating to R&D as mentioned above, £158k of overspend on pay budgets and £460k of unachieved CIP savings. There is also £153k of new Medinet costs with an offsetting impact within income.

The cumulative income position at the end of Month 4 is £2,861k favourable.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Commissioner Income	-302,225	-25,454	-25,988	-534	-100,482	-101,962	-1,480
Drugs	-22,601	-1,856	-1,849	7	-7,148	-7,891	-744
STF	-11,547	-770	-1,189	-419	-2,501	-2,920	-419
Trading Income	-36,471	-3,038	-3,391	-353	-12,163	-12,381	-219
Grand Total	**-372,845**	**-31,118**	**-32,417**	**-1,298**	**-122,293**	**-125,154**	**-2,861**

The expenditure position in June was £1,329k higher than budgeted levels, after underspend of £586k within reserves.

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	21,078	21,286	208	84,667	86,743	2,075	85,049	83,479	-1,570	251,339	251,339
2. Non-Pay	9,728	11,436	1,707	39,109	43,624	4,515	41,945	41,069	-827	110,931	110,931
3. Reserves	1,175	589	-586	4,298	434	-3,864	2,190	2,111	-79	14,144	14,144
Total Expenditure Position	**31,981**	**33,311**	**1,329**	**128,074**	**130,801**	**2,726**	**129,184**	**126,659**	**-2,476**	**376,414**	**376,414**

3. Conclusion

The income and pay expenditure positions have improved in July, but non pay overspends and unidentified efficiency savings have led to an in month overspend of £476k. Unidentified efficiency is causing an overspend of £1.5m in the year to date position. The remedial actions put in place in month 3, including Exec review of agency spend and a revised governance process around CIP delivery, are ongoing.

4. Recommendations

The Board is asked to note the month 4 2017/18 financial position of £10.4 million deficit, £461k adverse to plan after removal of the 16/17 STF funding.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Board of Directors Meeting

Performance - July 2017 - (Month 4)

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

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Business Intelligence Report**		
Report to:	**Board of Directors**	Date:	**29/08/2017**
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 - July 2017

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The performance report is against operational delivery in May, June and July 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.

July Performance

Trust 93.18%, Including GP attendances 93.9%, total 14535 pts attended and 992 breaches

NHSi trajectory for quarter 2 -93.1%
Medical workforce gaps remains the predominant cause of breaches though at the end of July, 2 additional consultants commenced in post with a further starting in September

Doncaster achieved **92.38**%. Total attendances 10516

801 patients failed to be treated within 4hrs, 35 less than June.
550 patients were delayed due to internal ED waits, 15 more than June. 57 were delayed due to bed waits, 47 less than June. 137 required to wait in the department due to their condition.
16.1% of patients were transferred to the urgent care centre.

Bassetlaw achieved **95.25**%. Total attendances 4019

191 patients failed to be treated within 4hrs, 44 less than in June
145 patients were delayed due to internal ED waits, 24 less than June. 6 were delayed due to bed waits, 3 less than June and 28 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 ACS footprint with each stakeholder leading on system wide improvement
System Perfect planned for the 5th of September being supported by ECIP.

Referral to Treatment

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

July 90.3%

NHSi trajectory for Quarter 2 to be at 92% by end September

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 July
The key specialities which are adversely affecting the position are general surgery, ENT and Ophthalmology, trajectories are behind plan and changes have been made to the management structure to support progress. Realistic plans for turnaround in these areas have been agreed

Diagnostic performance 98.67%

75 breaches could be tolerated in month and we had 100 breaches, key areas were in audiology though the performance improved by 50%, nerve conduction studies and CT.

Cancer Performance

June 62 day performance 85%, quarter 1 -85.1%

June 2 week wait 93.3%

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

Improved position in terms of direct access at 68.3%, 60 patients discharged with a diagnosis of stroke, 19 not transferred within 4hrs, 10 patients did not have symptoms of stroke ion admission.S

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

David Purdue Chief Operating Officer August 2017

At a Glance -July 2017 (Month 4)

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	June	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		85.1%	
		62 day wait for first treatment from consultant screening service referral	90.0%	M		96.3%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		98.9%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		90.6%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		92.5%	
6-7		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	July	93.2%	
8-9		Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	July	90.3%	
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		98.7%	
6-7	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	July	04:53	
		A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		07:29	
		A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		03:59	
		A&E: Time to treatment decision (median) HH:MM	01:00	N		00:55:00	
		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	June	659	
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes				69	
		Ambulance Handovers Breaches -Number waited over 60 Minutes				13	
10-12	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	N	May	55.0%	
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	N		68.3%	
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.0%	N		8.3%	
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N		76.9%	
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N		80.8%	
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	N	July	75.8%	
13	Theatres & Outpatients	Cancelled Operations	0.8%	N	July	1.5%	
		Cancelled Operations-28 Day Standard	0	N		2	
		Out Patients: DNA Rate		L		9.4%	
		Out Patients: Hospital Cancellation Rate		L		7.3%	
				L			
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		L	June	6.0%	

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	Jul-17	52.3%	36.7%	91.7%	
		Best Practice Criteria					
		36 hours to surgery Performance		57.1%	43.3%	91.7%	
		72 hours to geriatrician assessment Performance		75.0%	90.0%	100.0%	
		% 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		2.38%	3.60%	0.00%	

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	Jul-17	4	
		Infection Control MRSA	0	L		0	
16		HSMR (rolling 12 Months)	100	N	May-17	90.23	
		Never Events	0	L	Jul-17	0	
		VTE	95.0%	N	Jun-17	95.0%	
19		Pressure Ulcers	12 Per Month 144 full Year	L	Jul-17	3	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		0	
		Catheter UTI	Snap shot audit			0.69%	

Page		Indicator	Current Month	Month Actual	Data Quality RAG Rating
20	Complaints & Claims	Complaints received (12 Month Rolling)	Jul-17	565	
		Concerns Received (12 Month Rolling)		845	
		Complaints Performance		53.0%	
		Liabilities to Third Parties Scheme (LTPS)		1	
		Claims per 1000 occupied bed days		0.61	

Page		Indicator	Current Month	Month Actual	YTD (Cumulative)	Data Quality RAG Rating
23	Workforce	Sickness	Jun-17	3.8%	3.5%	
24		Appraisals	Jul-17		57.4%	
25		SET Training			71.0%	

Monitor Compliance Framework: Cancer - June 2017 (Month 3)

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

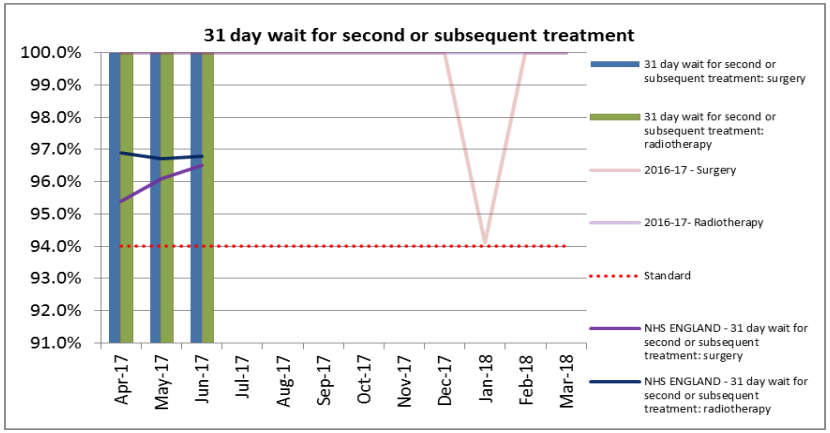
2 week wait achieved for June at 93.3%
62 day classic achieved for June at 85%, Quarter 1 achieved at 85.1%

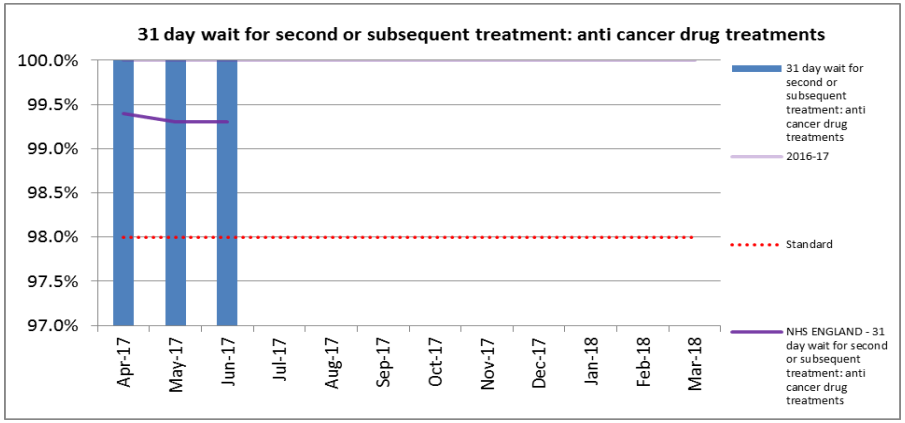
Actions being taken to address any issues

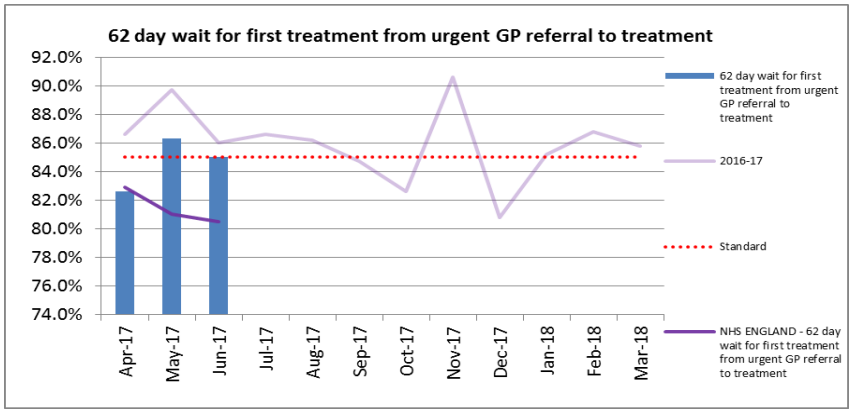
Action plan to improve 62 day performance completed
The Trust reports weekly at the PTL all 62 day target performance
External funding agreed to improve high value pathways including urology, 2 additional clinics and MRI sessions
Individual breach reports are discussed with the MDTs to ensure learning is in place
Improved access to diagnostics, KPIs set against a 7 day turnaround plan, new processes for flagging 62 day pathways launched
Changes to referral systems being reviewed in line with E referral pathways which need to be embedded by April 2018
2 week wait booking team to co-locate with Trust booking team
Cancer capacity planning with CCG
Patients being contacted when they delay their appointment outside of 14 days

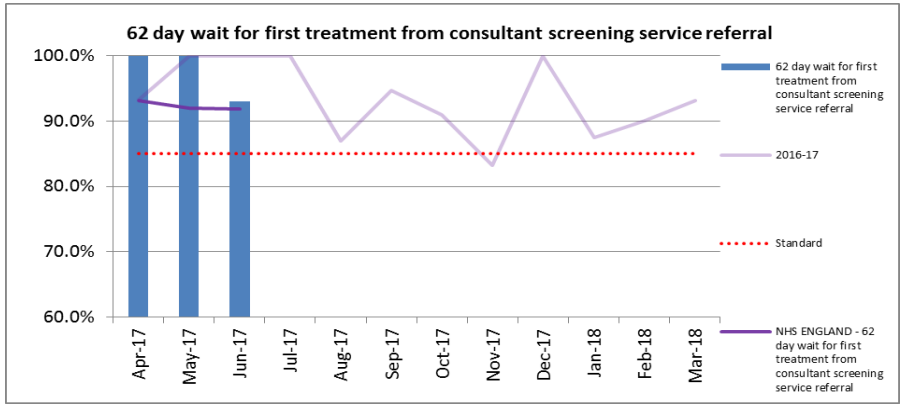
Indicator		Standard	Jun-16	QTR 1 2017-18	Apr-17	May-17	Jun-17
31 day wait for second or subsequent treatment: surgery		94.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day wait for second or subsequent treatment: anti cancer drug treatments		98.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day wait for second 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%	98.3%	100.0%	94.6%	100.0%
	Gynaecological		75.0%	93.1%	100.0%	100.0%	86.7%
	Haematological		100.0%	93.9%	100.0%	80.0%	100.0%
	Head & Neck		83.3%	62.5%	0.0%	66.7%	100.0%
	Lower Gastrointestinal		61.5%	92.0%	94.4%	85.7%	92.3%
	Lung			88.0%	100.0%	85.7%	81.8%
	Other				100.0%		
	Sarcoma		66.7%	100.0%	100.0%		100.0%
	Skin		100.0%	97.5%	90.5%	100.0%	100.0%
	Upper Gastrointestinal		100.0%	82.4%	100.0%	77.8%	71.4%
	Urological		72.7%	62.4%	52.9%	76.6%	58.8%
	All Cancers		86.0%	85.1%	82.6%	86.3%	85.0%
62 day wait for first treatment from consultant screening service referral	Tumour Type	90.0%					
	Breast		100.0%	100.0%	100.0%	100.0%	100.0%
	Gynaecological		100.0%	66.7%		100.0%	0.0%
	Haematological						
	Head & Neck						
	Lower Gastrointestinal		100.0%	66.7%	100.0%		0.0%
	Lung						
	Other						
	Sarcoma						
	Skin						
	Upper Gastrointestinal						
	Urological						
	All Cancers		100.0%	96.3%	93.1%	100.0%	93.0%
31 day wait for diagnosis to first treatment- all cancers		96.0%	98.6%	98.9%	98.6%	99.2%	98.9%
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)		93.0%	94.0%		86.7%	91.2%	93.3%
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)		93.0%	93.8%		90.1%	92.8%	94.0%

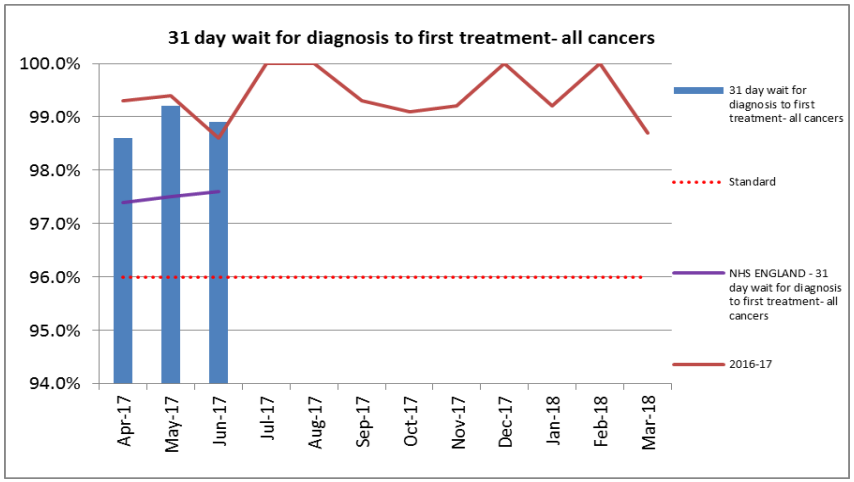
Monitor Compliance Framework: Cancer - Graphs - June 2017 (Month 3)

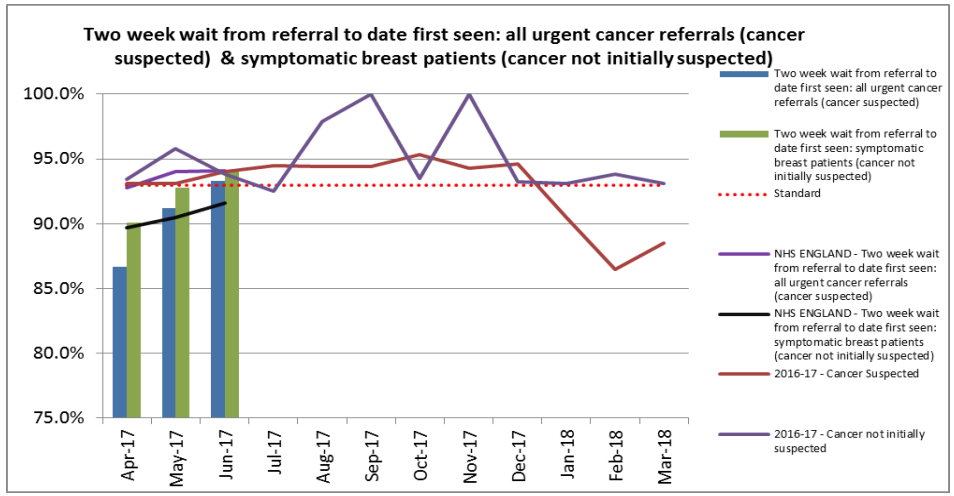












Monitor Compliance Framework: A&E - July 2017 (Month 4)

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

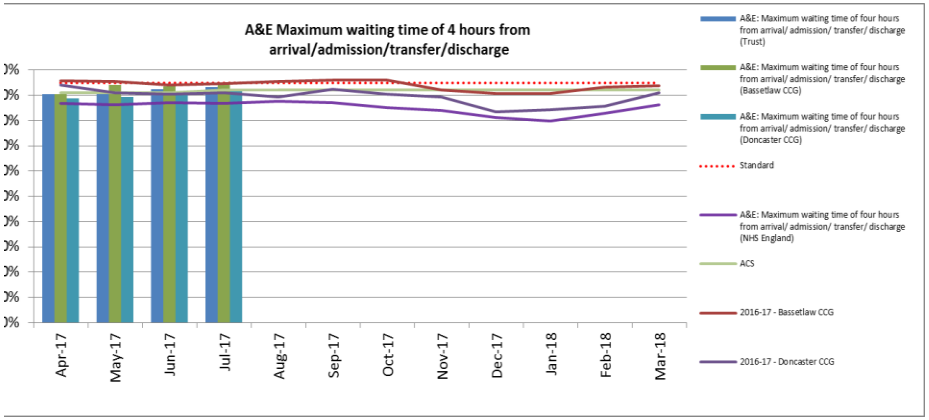
July Performance 93.18%
With GP urgent referrals 93.9%
NHSi planned trajectory for Quarter 2 93.1%
Key issues related to internal ED doctor waits in both type 1 departments
16.1% of patients streamed to UCC

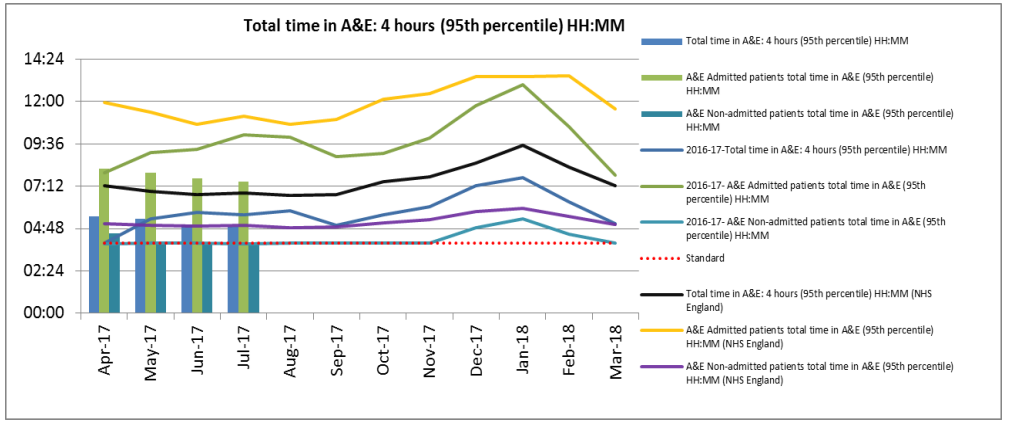
Actions being taken to address any issues

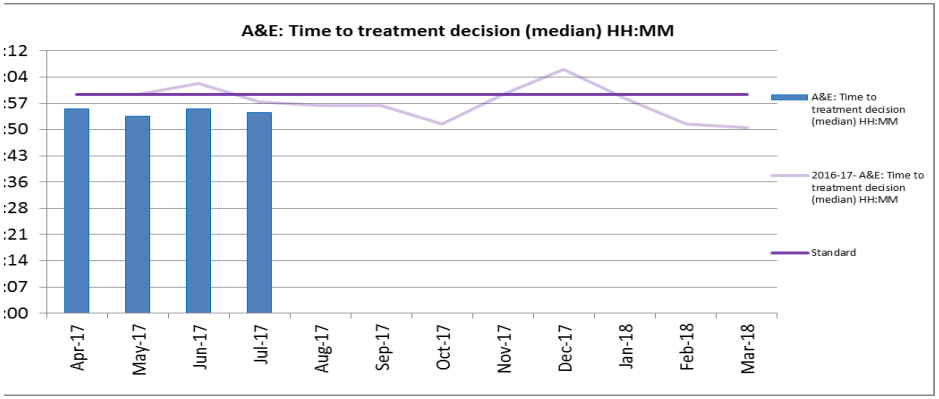
Streaming bids successful for both type 1 sites, pathways being reviewed to maintain flow out of the ED. Model agreed at BDGH jointly with BHP.
Review against high impact interventions show all Trust expectations are progressed.
Workforce reviews being undertaking to assess the potential for alternative models of specialty support into the department
DTOC level trajectory below NHSi target, work continuing to support patient flow via Red to Green initiative
TAPPs pilot being extended to rehabilitation wards at MMH.
System wide " Perfect Week" planned for the 5th of September across both health and social care systems as the launch of the winter plan.

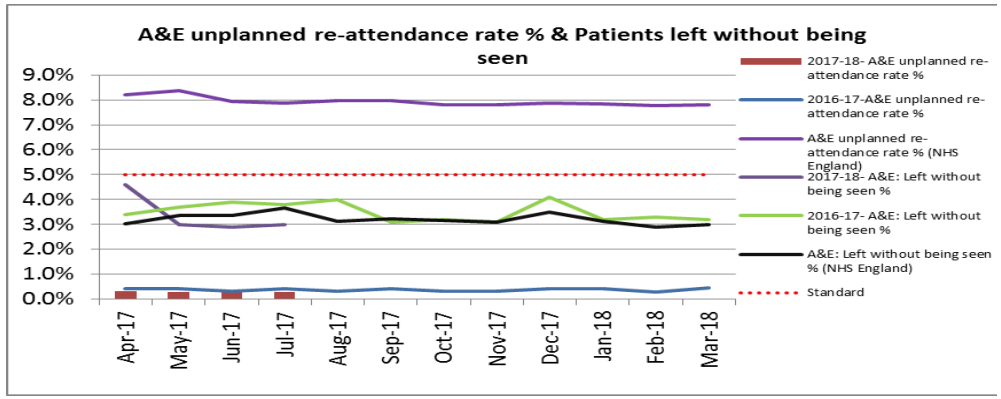
Indicator	Standard	Jul-16	Qtr 1 2017-18	May-17	Jun-17	Jul-17
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Trust)**	95.0%	92.3%	91.4%	91.4%	92.5%	93.2%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Bassetlaw CCG)**		94.0%	92.8%	94.2%	93.6%	94.7%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Doncaster CCG)**		90.6%	89.7%	89.2%	91.0%	91.6%
Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	05:42	05:19	05:20	05:01	04:53
A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	09:18	07:56	07:57	07:40	07:29
A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	0.:58	04:19	04:00	03:59	03:59
A&E: Time to treatment decision (median) MM	01:00	01:03	00:56	00:54	00:56	00:55
A&E unplanned re-attendance rate %	5.0%	0.3%	0.3%	0.3%	0.3%	0.3%
A&E: Left without being seen %	5.0%	3.9%	3.50%	3.0%	2.9%	3.0%
Indicator	**Standard**	**Jun-16**	**Qtr 4 2016-17**	**Apr-17**	**May-17**	**Jun-17**
Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		753	2062	654	648	689
Ambulance Handovers Breaches -Number waited over 30 & under 60 Minutes		76	311	69	84	69
Ambulance Handovers Breaches -Number waited over 60 Minutes		11	89	21	14	13

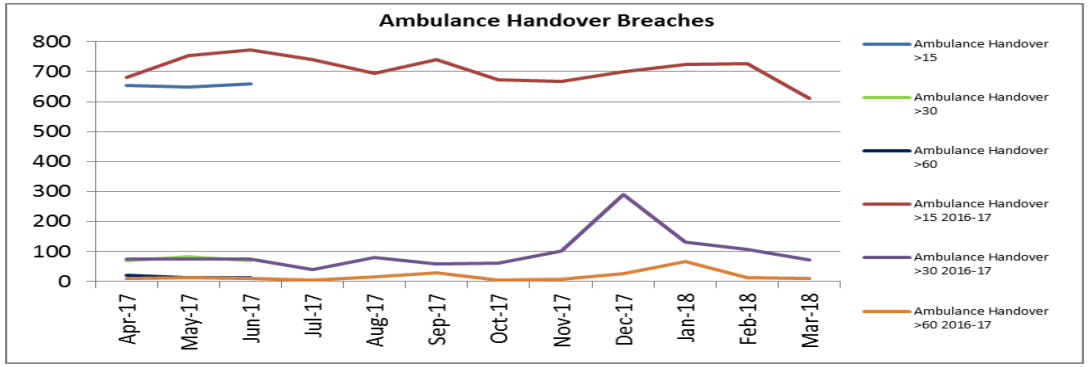
Monitor Compliance Framework: A&E - Graphs - July (Month 4)











Monitor Compliance Framework: 18 Weeks & Diagnostics -July 2017 (Month 4)

Context

The Trust has changed the way the incomplete pathways snapshot is monitored.
- Late Entered Referrals are included
- 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.

Reasons for Failure (if applicable)

Incomplete pathways for July ended at 90.3%.
There is 1 ongoing 52wk pathway. Patient chosen date for treatment is September 2017.
Specialties failed to meet 92% in July:
- General Surgery
- Urology
- ENT
- Ophthalmology
- Trauma and Orthopaedics

Diagnostic performance for July: 98.67%
Key issues: capacity issues in Audiology, Non Obstetric U/S and CT

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.
Planned Care Recovery Plans are regularly reviewed and challenged with each Care Group.
Main areas of concern; ***Ophthalmology, General Surgery, ENT and Urology***

Surgical Care Group

Advanced Monitoring for RTT performance in place on a bi-weekly basis and chaired by COO. Additional oversight provided by DCOO and weekly review sessions with General Manager, Business Manager and Service Leads.
- Outsourcing action plan agreed with care group for Ophthalmology
- Additional capacity agreed with care group for ENT resultant in 'super weekends' and planned additional clinics up to December 2017
- New Clinical Lead of ENT to be agreed with COO/CGD
- Change of Business Manager to care group specialties
- Agreed additional lists from September for General Surgery

Specialties Care Group

- Agreed RTT Recovery Plan with Urology Consultant Clinical Lead
- Weekly monitoring meeting in place with Consultant Clinical Lead and Managers
- Additional capacity agreed

Other

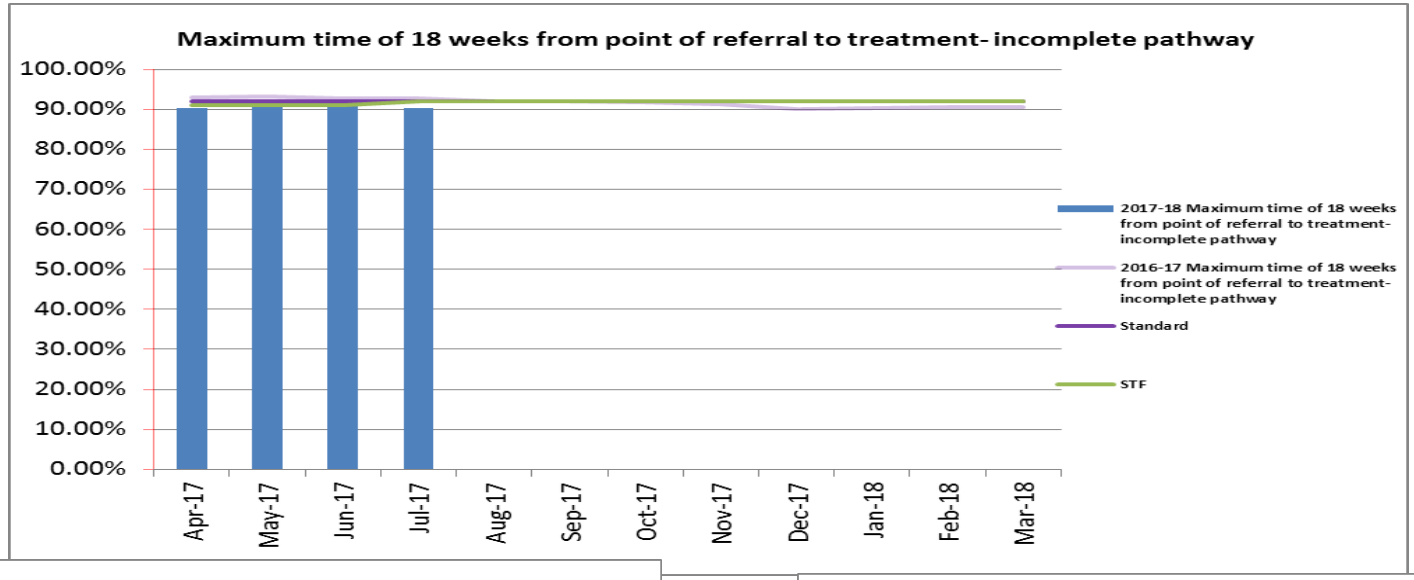
- Collaboration with CCG on referral management and support in managing demand: Planned Care Programme Board and SDIP
- Paused validating below 15 weeks to focus on patient administration quality improvement, right first time.
- Targeted training in care groups based on data quality issues and increase in 52wk breaches
- Theatre Productivity Plans led by Theatre Work stream
- New process in place to review and sign off 52wk breaches - COO and Medical Director

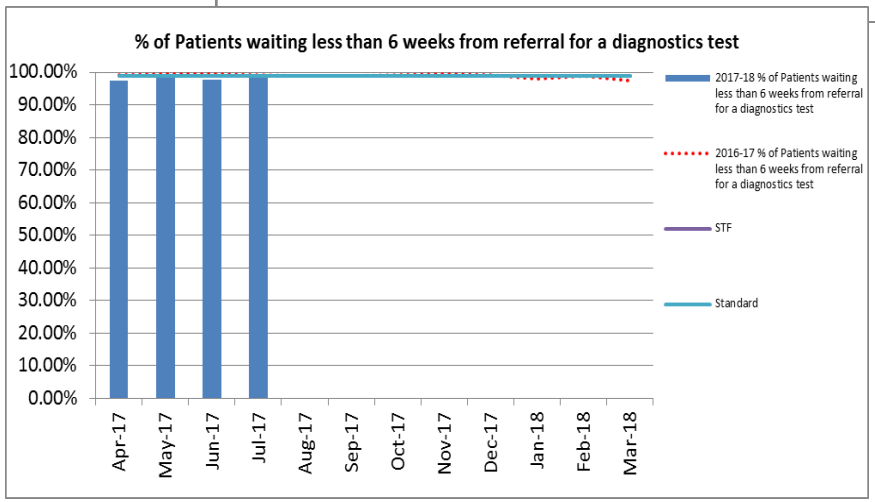
Diagnostics

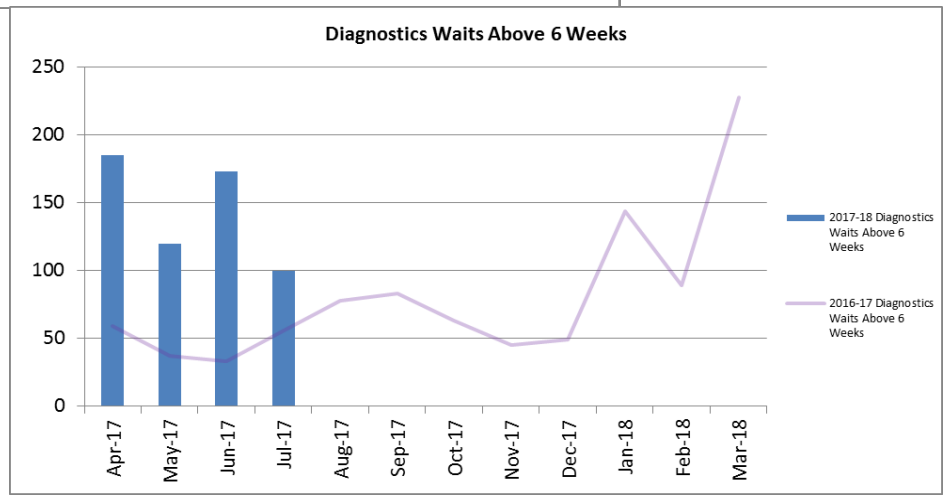
- Audiology, two locums commenced 10/04. Deep Dive into Audiology capacity - General Manager to lead.
- Endoscopy capacity secured through external supplier to mitigate patient breaches.
- Capacity reviews in non-obstetric ultrasound as a result of increases in obstetric ultrasound. Ongoing discussion with Obstetrics.

Indicator	Standard	Jul-16	Qtr. 1 2017-18	May-17	Jun-17	Jul-17	Expected date to meet standard
Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	92.60%	90.9%	90.6%	90.9%	90.3%	
Indicator	**Standard**	**Jul-16**		**May-17**	**Jun-17**	**Jul-17**	**Expected date to meet standard**
% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	99.20%		98.52%	97.76%	98.67%	
Diagnostics Waits		56		120	173	100	

Monitor Compliance Framework: 18 Weeks & Diagnostics - July (Month 4)







Stroke -May 2017 (Month 2)

Context

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

Reasons for Failure (if applicable)

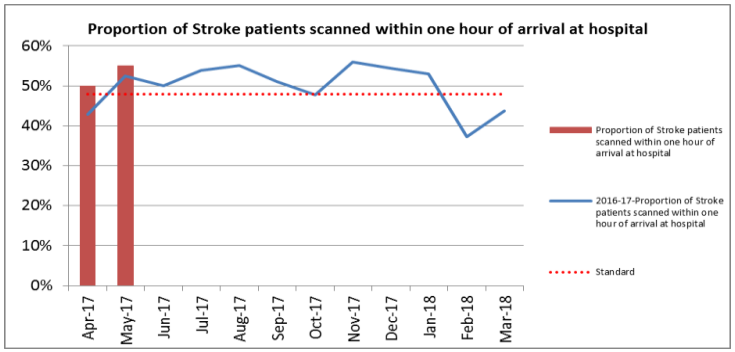
60 stroke discharges in May
Improved position in terms of direct access at 68%, 10 patients not transferred within 4 hrs, 10 patients had no stroke symptoms on arrival

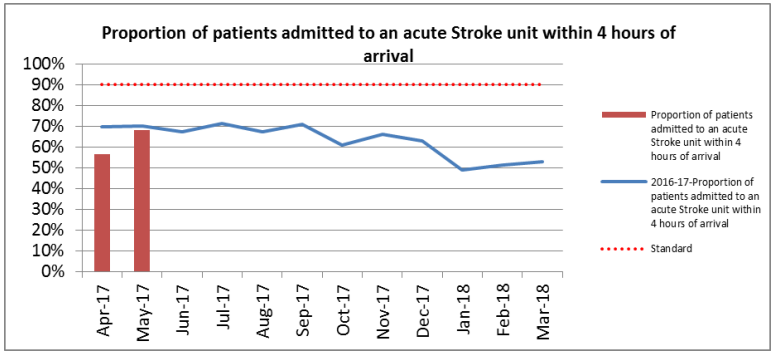
Actions being taken to address any issues

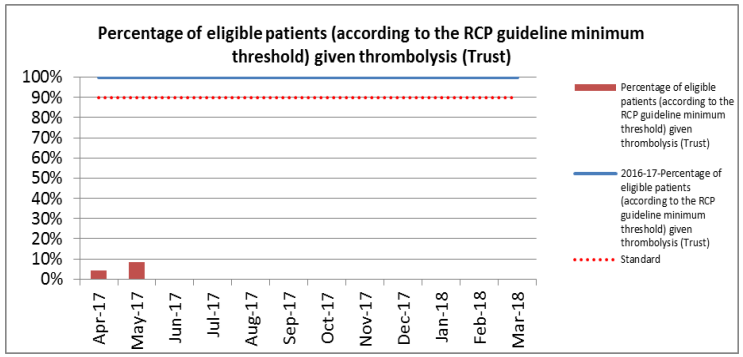
Key issues being addressed following a process mapping session on the 29th of July
Staff Education in ED
Access and Flow Demand – stroke and non-stroke
Capacity – stroke and non-stroke
Managing flow – acute site
Flow into rehabilitation services –
Early Supported Discharge
Stroke Team Assessment and Intervention

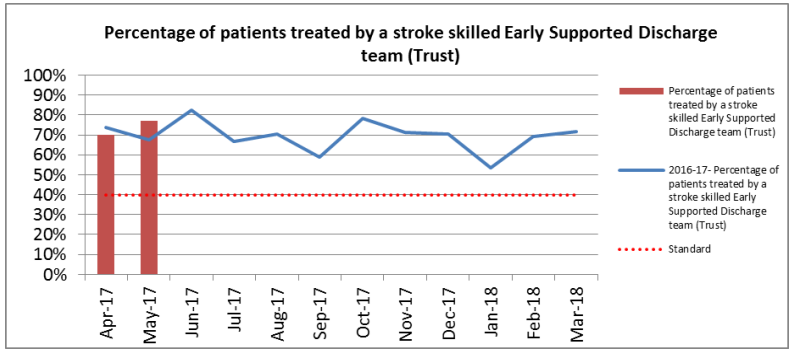
Indicator	Standard	May-16	Qtr 4 2016-17	Mar-17	Apr-17	May-17
Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	52.5%	44.9%	43.8%	50.0%	55.0%
Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	70.0%	51.3%	53.1%	56.5%	68.3%
Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.0%	N/A	N/A	N/A	4.3%	8.3%
Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N/A	65.7%	71.9%	70.0%	76.9%
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%	80.7%	85.0%	80.8%
	Standard	**Jul-16**	**Qtr 1 2017-18**	**May-17**	**Jun-17**	**Jul-17**
Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	71.8%	58.2%	57.6%	58.1%	75.8%

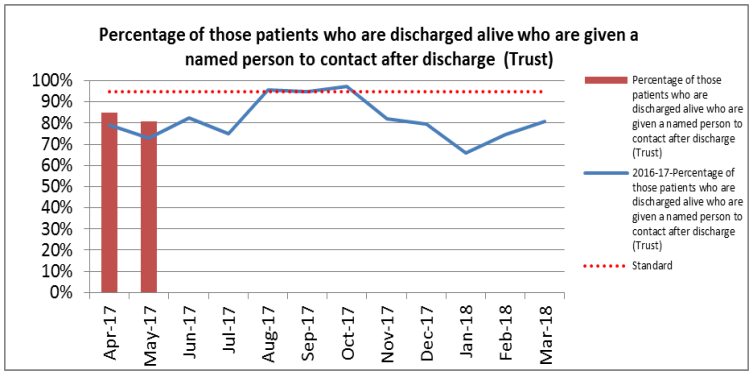
Stroke - Graphs May 2017 (Month 2)

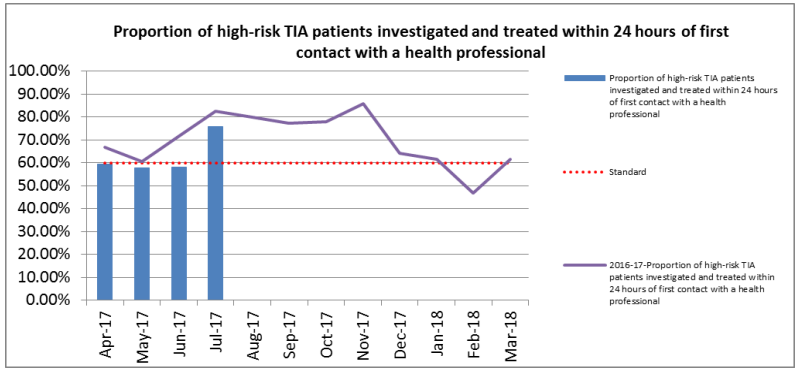




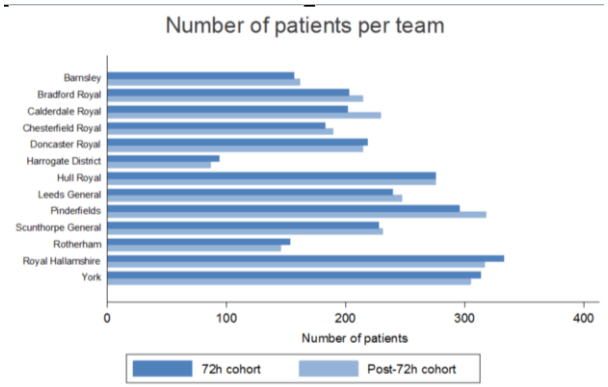




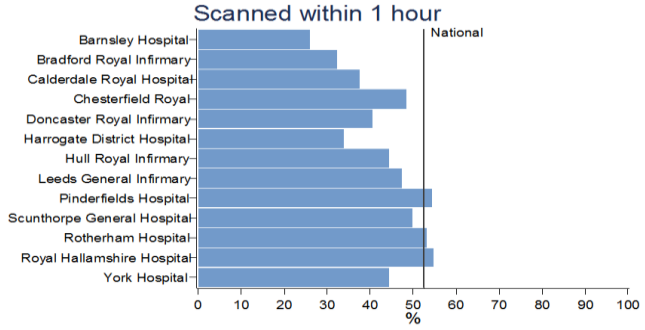




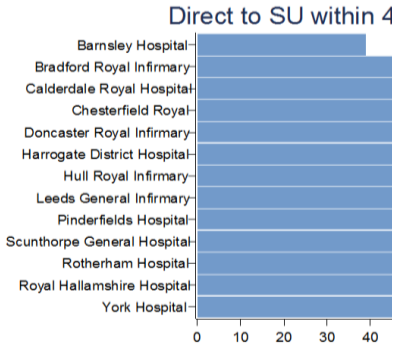
Stroke - Graphs South Yorkshire December 2016- March 2017



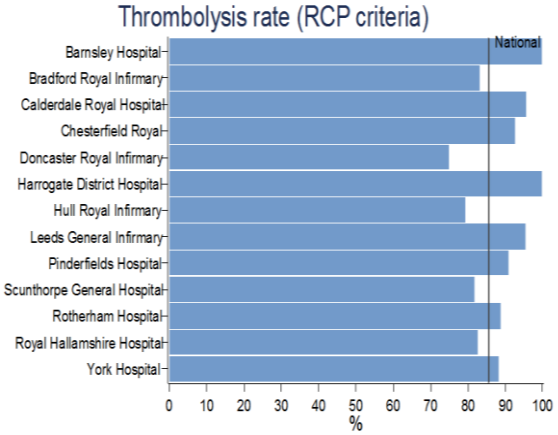
Source: SSNAP Dec 2016-Mar 2017
Number of patients in both patient-centred cohorts - D2.2 and D5.2



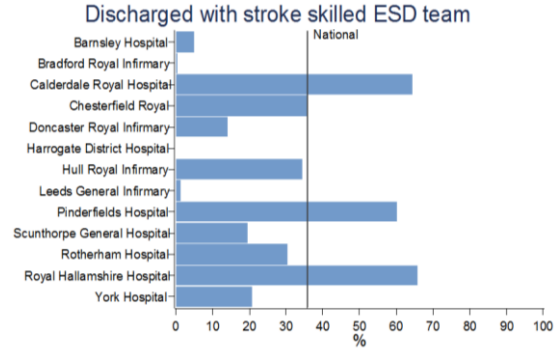
Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 1.1A



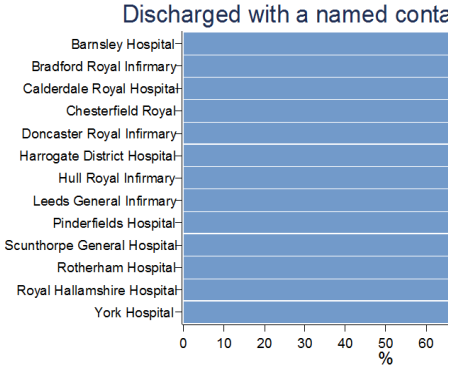
Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 2.1A



Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 3.2A



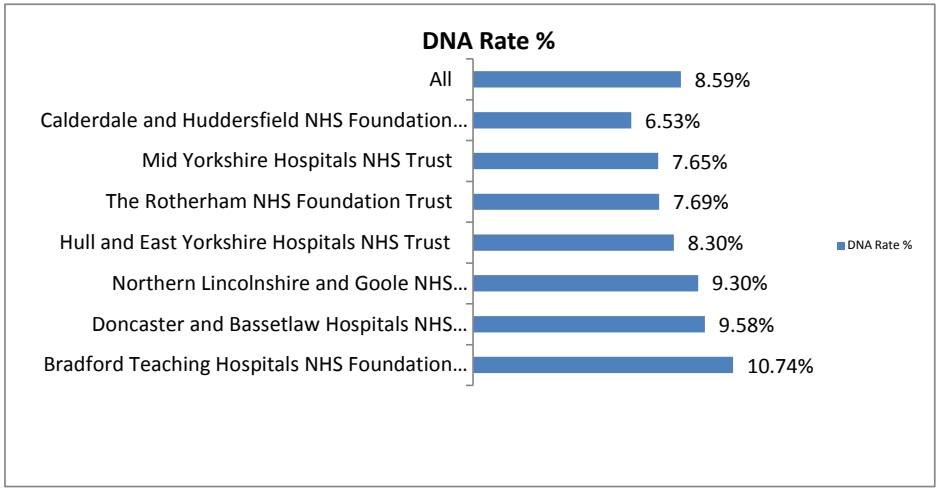
Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 10.2A



Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 10.4A

Theatre & Outpatients -July 2017 (Month 4)

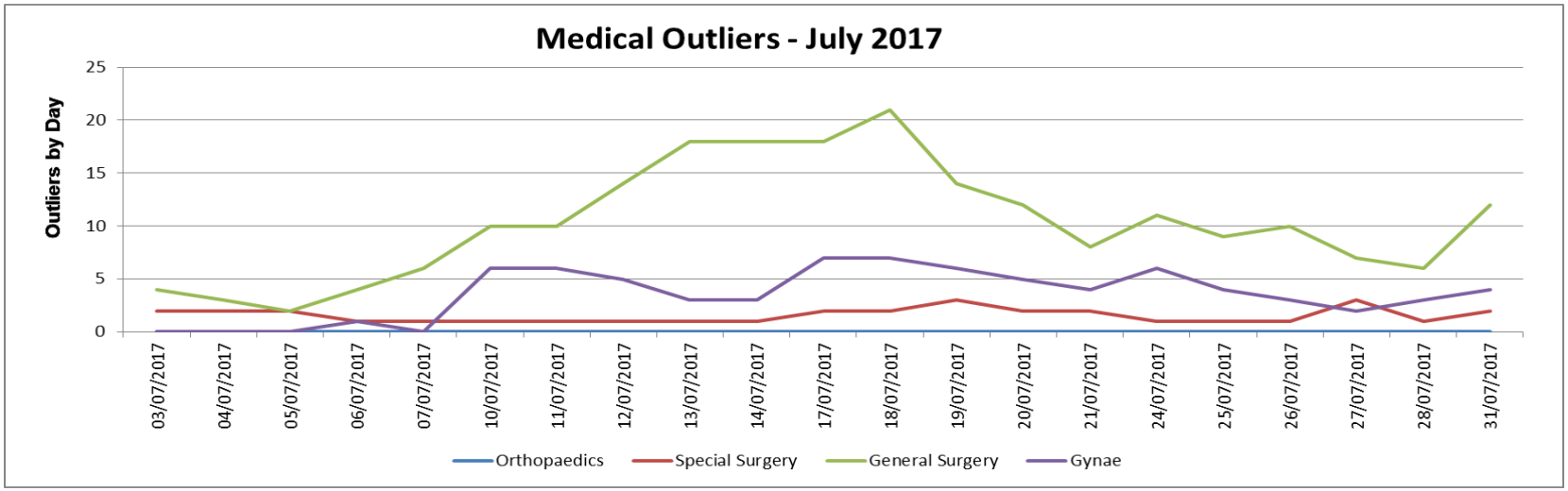
DNA Rate: Benchmarking data taken from Healthcare Evaluation Data (HED) (April 2016 to March 2017)

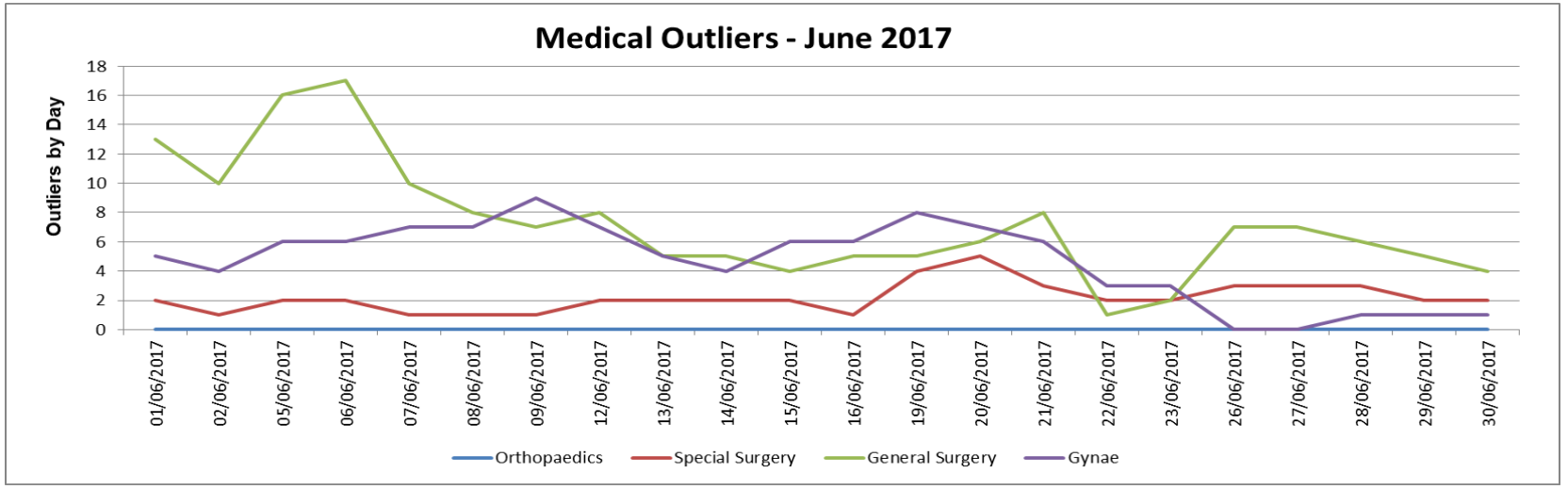


Indicator	Standard	Jul-16	Qtr 1 2017-18	May-17	Jun-17	Jul-17
Cancelled Operations (Total)	0.8%	1.2%	1.1%	1.1%	1.0%	1.5%
Cancelled Operations (Theatre)		0.9%	0.9%	0.9%	1.0%	1.0%
Cancelled Operations (Non Theatre)		0.3%	0.2%	0.2%	0.1%	0.5%
Cancelled Operations-28 Day Standard	0	1	5	4	1	2
Outpatients: DNA Rate Total (Refreshed Each Month)		9.20%	9.48%	9.66%	9.61%	9.44%
Outpatients: DNA Rate First (Refreshed Each Month)		10.08%	10.09%	10.36%	10.33%	10.04%
Outpatients: DNA Rate Follow Up (Refreshed Each Month)		10.36%	9.20%	9.34%	9.28%	9.15%
Outpatients: Hospital cancellation Rate (Refreshed Each Month)		6.77%	5.80%	5.09%	6.28%	7.33%
Outpatients: Patient cancellation Rate (Refreshed Each Month)		10.18%	10.14	10.25%	10.56%	10.76%
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 - July 2017 (Month 4)





	Daily average	Most Sleepers-out in July 2017	Least Sleepers-out in July 2017
Medicine to Ortho	0	0	0
Medicine to S12	2	3	1
Medicine to Surgery	10	21	2
Medicine to Gynae	4	7	0

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Safety & Quality - July 2017 (Month 4)

HSMR: The Trust's rolling 12 month HSMR remains better than expected at 90.23 for May 17. HSMR for April 17 was 91.89

Fractured Neck of Femur: Although DRI demonstrates a slight deterioration in achieving BPT again for July , performance at BDGH has improved. The deteriorating performance at DRI continues to impact the overall Trust position, however, work is continuing within the care group to address this. The Trust 12 month rolling relative mortality risk is at 82.21.

Serious Incidents: The number of reported SI's remains low.

Executive Lead:
Mr S Singh

C.Diff: The rate of cases is slighlty above trajectory compared to last year. Interventions on Deep Cleaning, Antibiotic stewardship and monitoring hand w ashing compliance continue.

Fall resulting in significant harm: The number of falls remains at zero and below trajectory

Hospital Acquired Pressure Ulcers: The rate of case is slighlty above trajectory this month, but this is expected to reduce when demonstrated unavoidable through investigation.

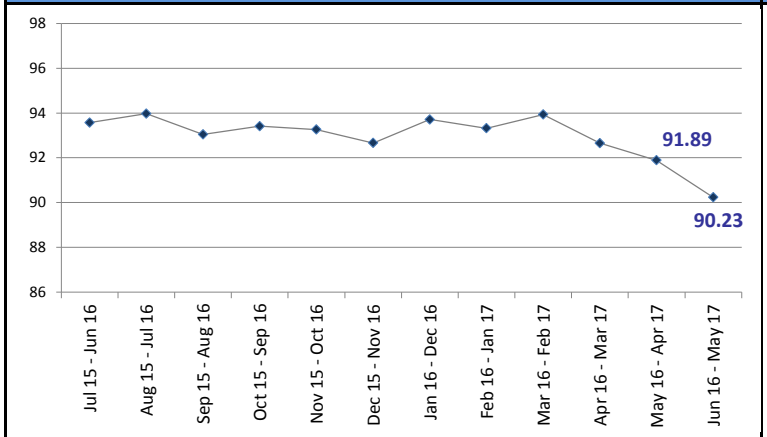
Complaints and concerns: Normal variation is seen in the rate of complaints and concerns. Performance on reply times has continued to improve.

Friends & Family Test: Slight improvement in the response rates in ED. Performance in other metrics remain better than the national average

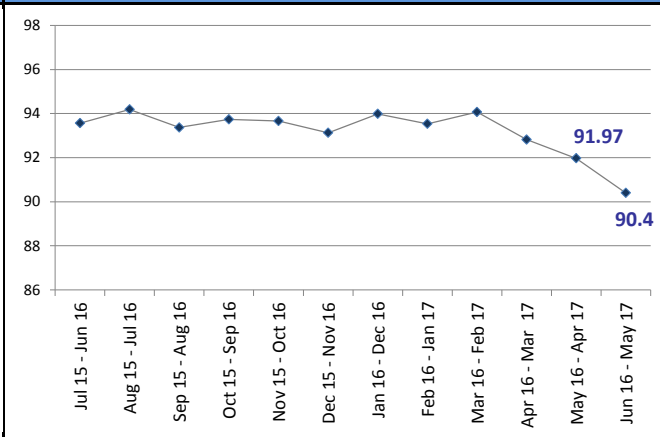
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - May 2017 (Month 2)

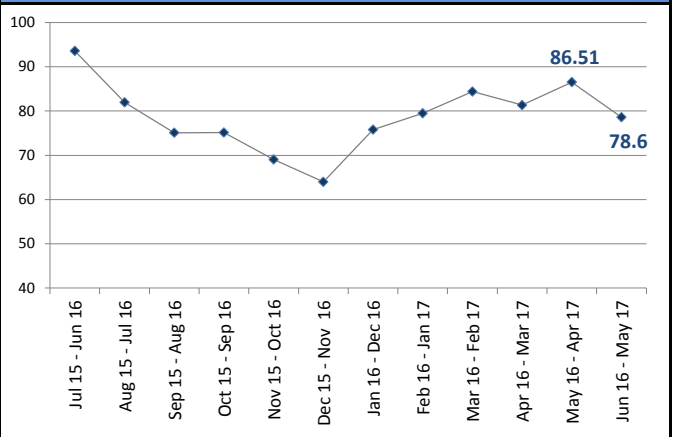
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

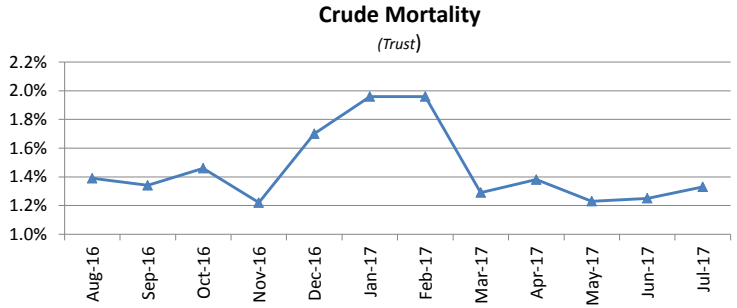


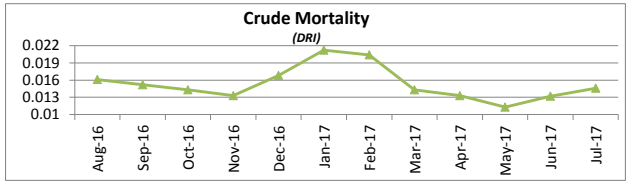
HSMR Trend (monthly)

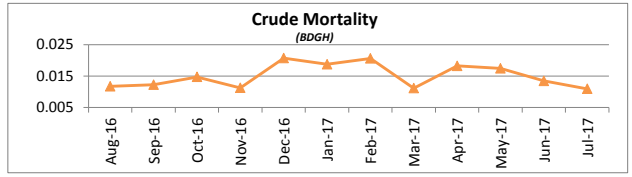
	2014	2015	2016	2017
January	115.45	116.80	99.21	94.92
February	99.11	99.94	97.73	105.53
March	102.91	90.54	97.37	82.72
April	110.49	105.91	88.50	81.96
May	90.93	101.15	96.60	77.78
June	113.74	80.27	93.67	
July	109.94	92.56	97.73	
August	120.18	100.27	87.52	
September	110.10	90.26	95.34	
October	106.58	90.29	88.67	
November	106.84	88.98	82.31	
December	115.87	82.30	93.53	

Crude Mortality (monthly) - July 2017 (Month 4)

(number of deaths/number of patient discharged)



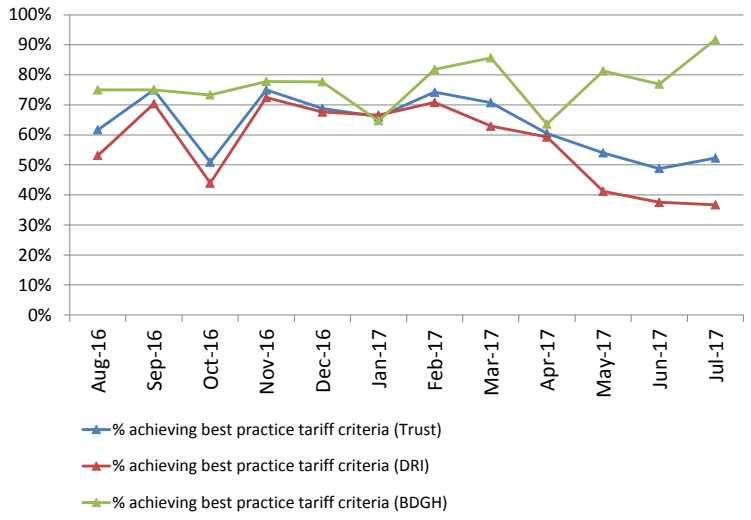




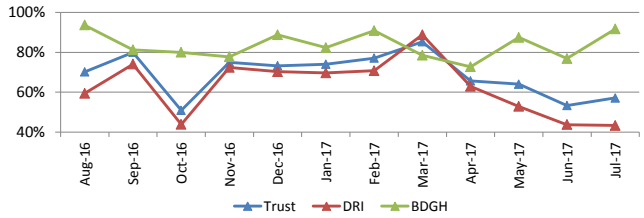
	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Trust	**1.37%**	1.34%	1.38%	1.22%	1.70%	1.96%	1.96%	1.29%	1.38%	1.22%	1.25%	1.33%
Doncaster	1.59%	1.53%	1.43%	1.33%	1.68%	2.12%	2.04%	1.43%	1.33%	1.13%	1.32%	1.46%
Bassetlaw	1.17%	1.22%	1.47%	1.12%	2.07%	1.87%	2.06%	1.11%	1.82%	1.74%	1.34%	1.09%

NHFD Best Practice Pathway Performance - July 2017 (Month 4)

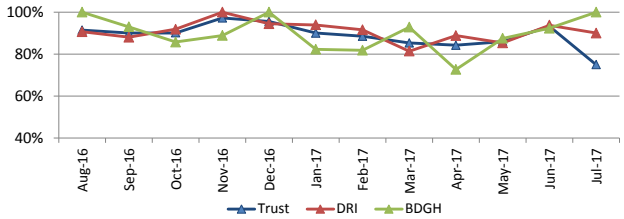
Best Practice Criteria Performance



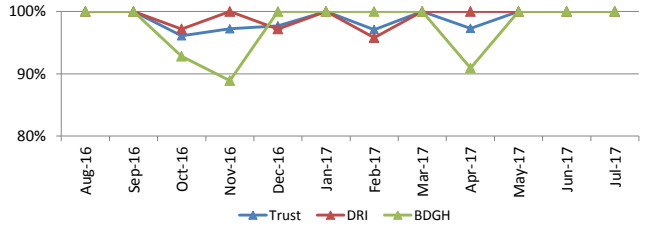
36 Hours to Surgery Performance



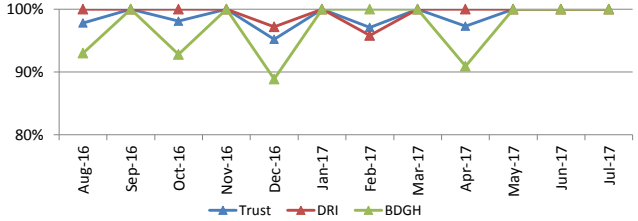
72 hours to Geriatrician Assessment Performance



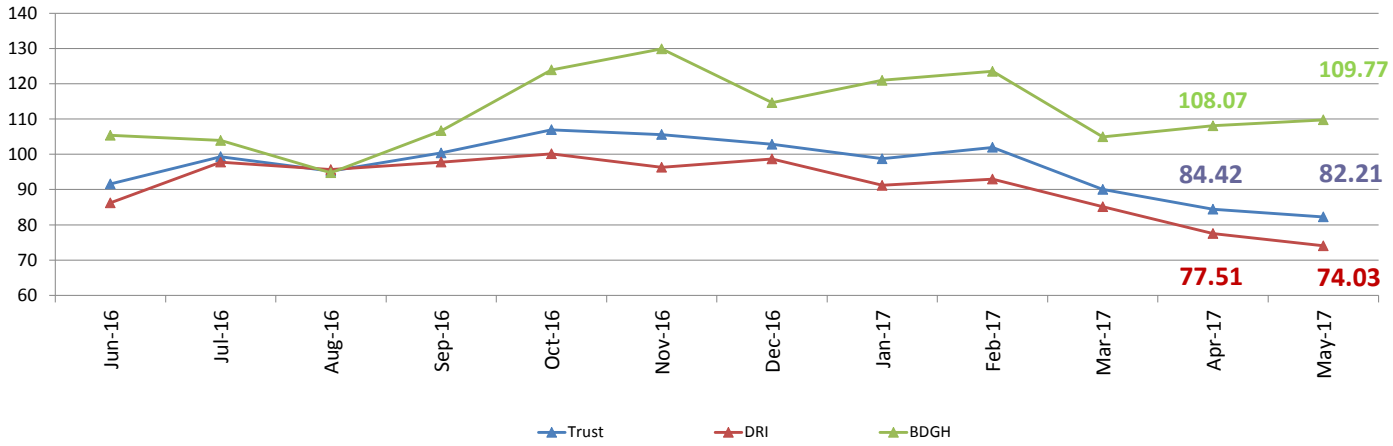
Bone Protection Medication Assessment



Falls Assessment Performance



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



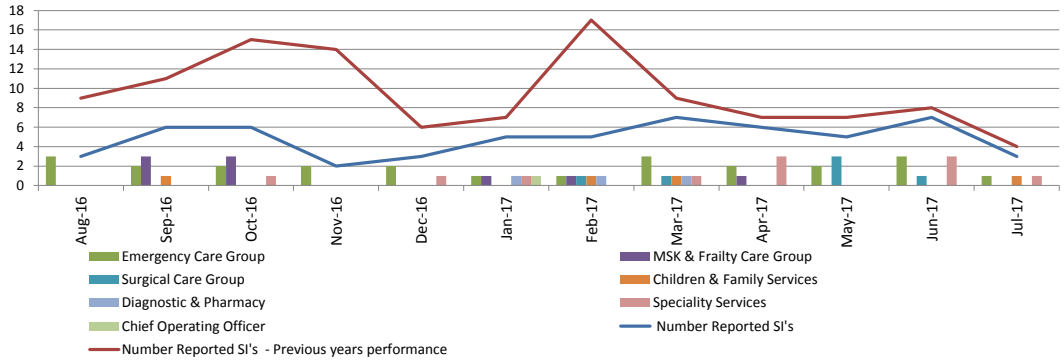
Serious Incidents - July 2017 (Month 4)

(Data accurate as at 07/08/17)

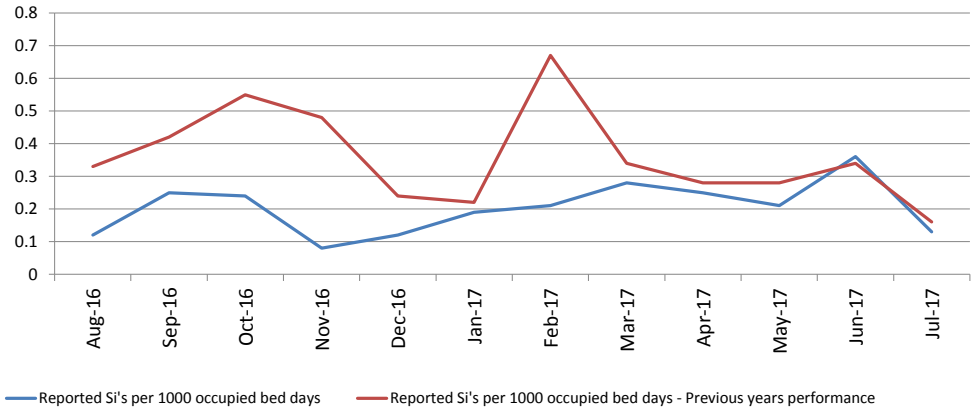
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Care Group)



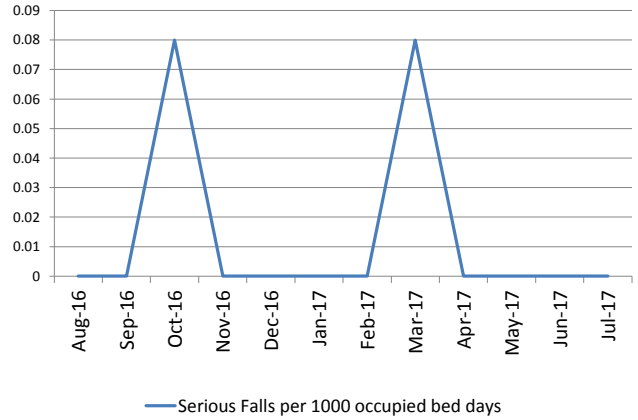
Serious Incidents per 1000 occupied bed days



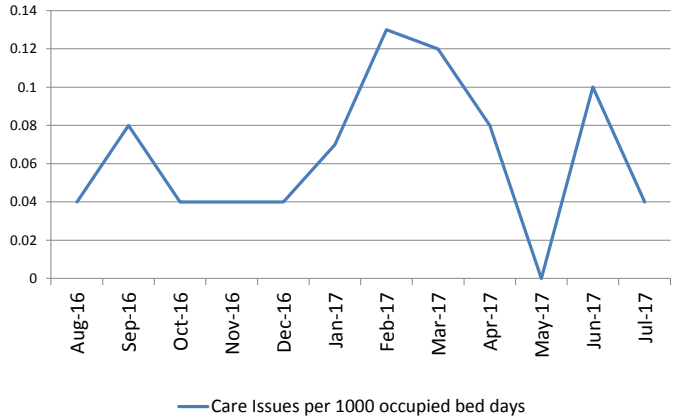
Current YTD reported SI's (Apr 17-Jul 17)	21	Number reported SI's (Apr 16-Jul 17)	26
Current YTD delogged SI's (Apr 17-Jul 17)	5	Number delogged SI's (Apr 16-Jul 17)	6

Themes

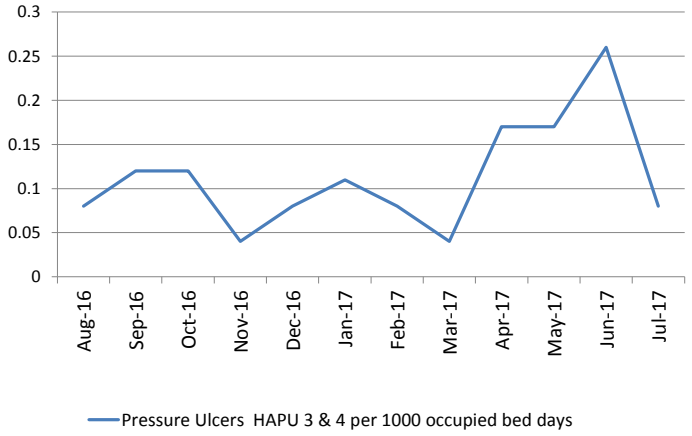
Serious Falls



Care Issues

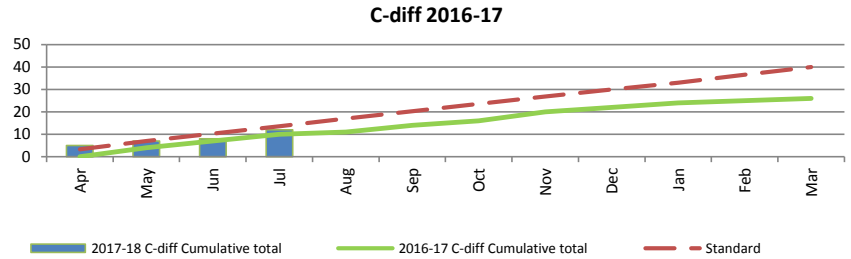


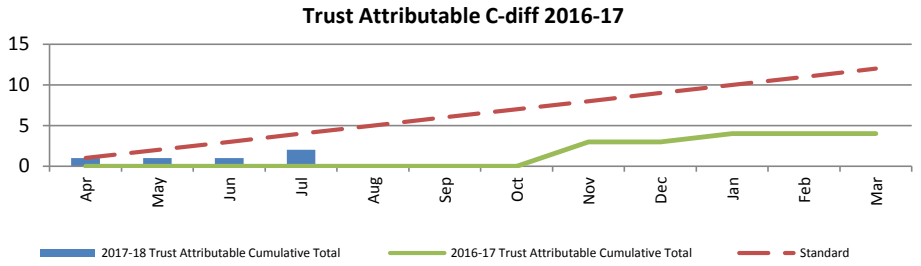
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - July 2017 (Month 4)
(Data accurate as at 14/08/2017)

	Standard	Q1	Jul	YTD
2017-18 Infection Control - C-diff	40 Full Year	8	4	12
2016-17 Infection Control - C-diff	40 Full Year	7	3	10
2017-18 Trust Attributable	12	1	1	2
2016-17 Trust Attributable	12	0	0	0

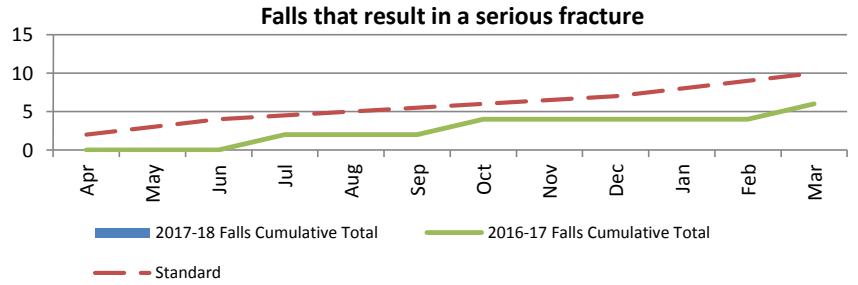




Pressure Ulcers & Falls that result in a serious fracture - July 2017 (Month 4)
(Data accurate as at 01/08/2017)

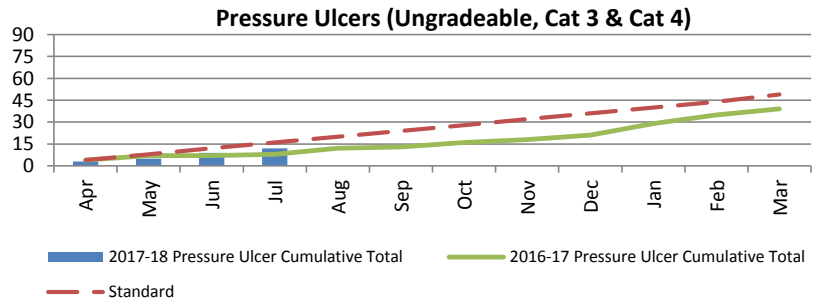
	Standard	Q1	Jul	YTD
2017-18 Serious Falls	10 Full Year	0	0	0
2016-17 Serious Falls	19 Full Year	0	2	2

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



	Standard	Q1	Jul	YTD
2017-18 Pressure Ulcers	34 Full Year	9	3	12
2016-17 Pressure Ulcers	60 Full Year	7	1	8

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

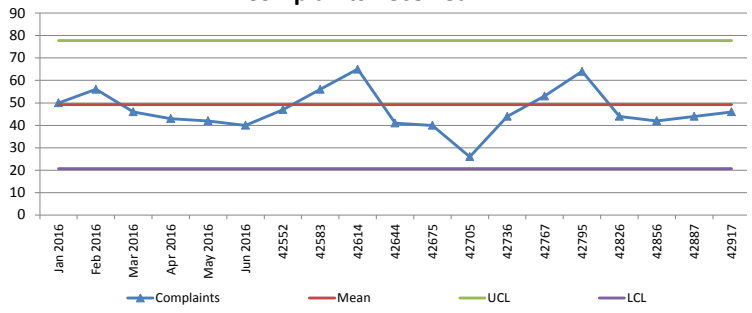


Complaints & Claims - July 2017 (Month 4)

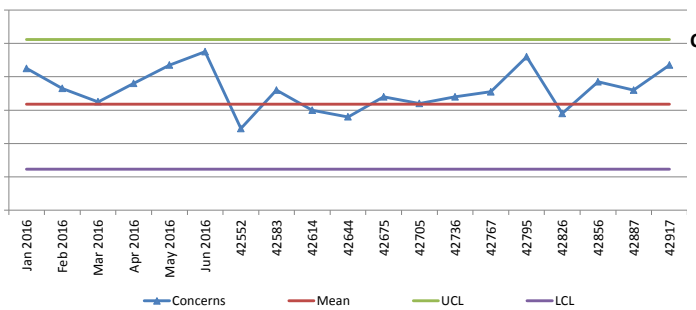
(Data accurate as at 08/08/2017)

Complaints

Complaints Received

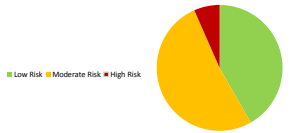


Concerns Received



July 2017 Complaints Recieved Risk Breakdown

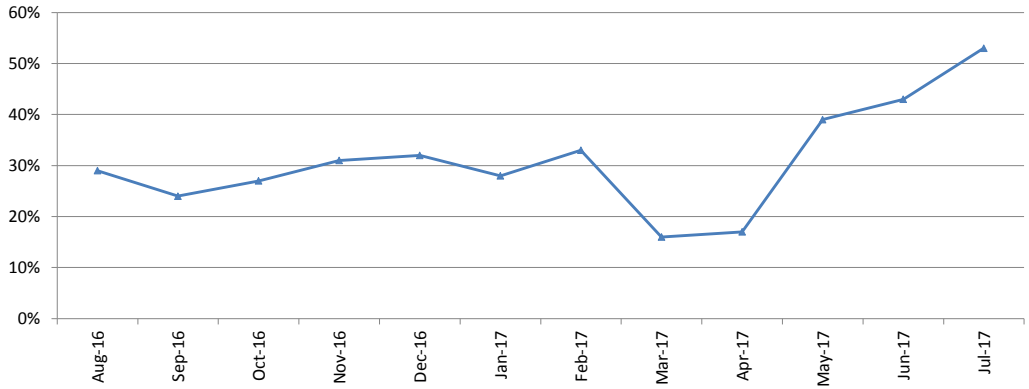
Year to Date Complaints Recieved Risk Breakdown



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
July	1	6

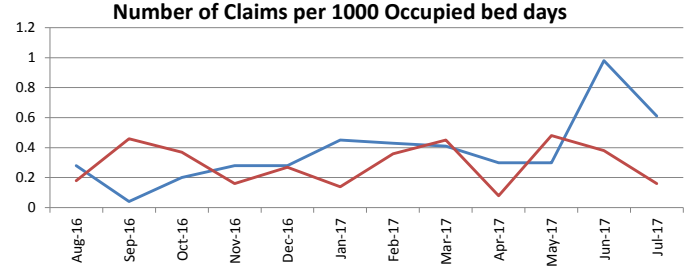
	Number referred for investigation YTD	Outcomes YTD	
2016/17	8	Fully / Partially Upheld	1
		Not Upheld	4
		No further Investigation	0
		Case Withdrawn	0
2017/18	4	Fully / Partially Upheld	0
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0

Claims

	Current Month	Month Actual	YTD
Clinical Negligence Scheme for Trusts (CNST)	Jul-16	13	40
Liabilities to Third Parties Scheme (LTPS)	Jul-16	1	7

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

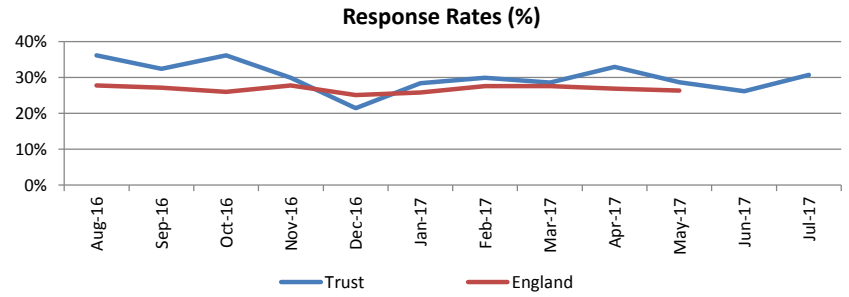


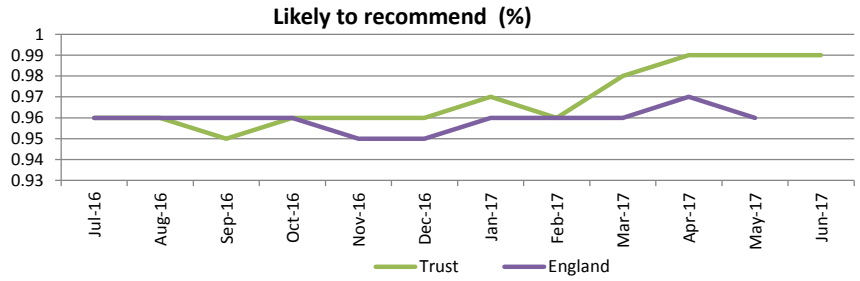
Friends & Family - July 2017 (Month 4)

(Data accurate as at 10/07/2017)

Inpatients

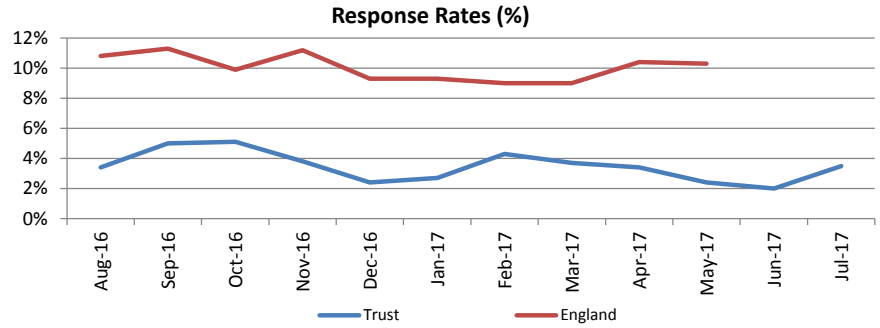
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

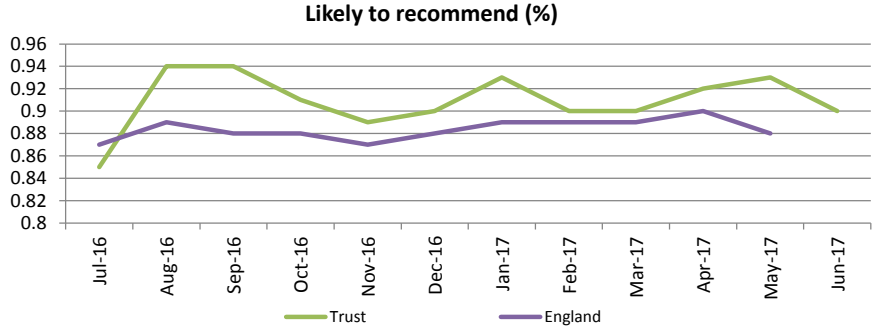




Accident & Emergency

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 - July 2017 (Month 4)

Sickness absence

Due to the timing of payroll close down month 4 data is not available but will be able to be reported verbally. As at month 3 the cumulative figure was 3.83%. 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

The Trusts appraisal completion rate continues to hover around 57-58% with a slight reduction from 58.51% to 57.38% by the end of July.

SET

We have seen an increase in compliance with Statutory and Essential Training compared to June's figures to 71% .

Staff in post

Please see attached tab covering staff in post by staff group

Workforce: Sickness Absence - June (Month 3)

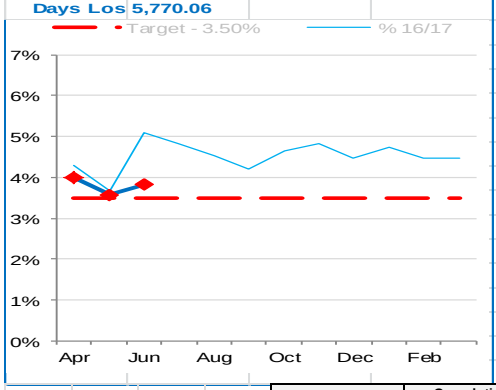
CG & Directorate Sickness Absence - June 2017 (Q1)

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

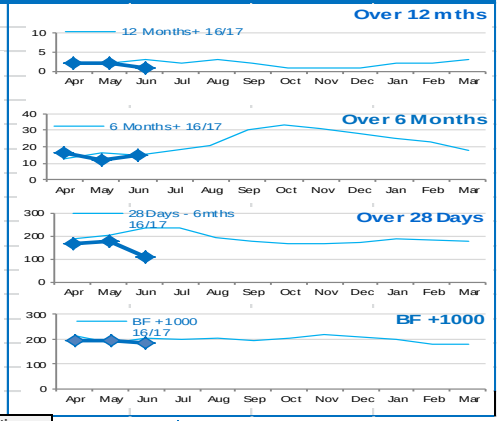
Sickness

Abs Rate = 3.50% LT Abs Rate 2.63%

Days Lost 5,770.06



Absence Occurences



	Jun-17		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospita	5770.06	3.50%	19,155.72	3.83%
Chief Executive Directorate	0.00	0.00%	21.00	0.84%
Children & Family Care Group	738.05	4.28%	2,256.01	4.29%
Diagnostic & Pharmacy Care Group	427.74	2.39%	1,942.30	3.55%
Directorate Of Strategy & Improvement	1.80	0.42%	2.80	0.21%
Emergency Care Group	628.94	2.92%	2,705.16	4.13%
Estates & Facilities Directorate	1014.74	6.00%	2,995.75	5.83%
Recharge Medics	2.00	0.13%	3.00	0.06%
Finance & Healthcare Contracting Directorat	93.41	4.35%	185.56	2.82%
IT Information & Telecoms Directorate	51.73	1.58%	233.66	2.36%
MSK & Frailty Care Group	751.38	3.06%	2,469.78	3.35%
Medical Director Directorate	0.00	0.00%	4.24	0.60%
Nursing Services Directorate	36.20	2.22%	127.53	2.62%
People & Organisational Development Direc	66.08	2.40%	168.45	2.01%
Performance Management Directorate	109.79	1.76%	407.47	2.16%
Speciality Services Care Group	693.14	3.91%	2,037.39	3.80%
Surgical Care Group	1155.05	3.87%	3,591.62	3.96%

Top 10 Absence Reasons

Absence Reason	Days Lost	%
S10 Anxiety/stress/depression/other ps	1,896.00	24.10
S12 Other musculoskeletal problems	1,003.00	12.70
S98 Other known causes - not elsewhere	722.00	9.20
S25 Gastrointestinal problems	719.00	9.10
S11 Back Problems	634.00	8.00
S28 Injury, fracture	439.00	5.60
S26 Genitourinary & gynaecological diso	378.00	4.80
S13 Cold, Cough, Flu - Influenza	269.00	3.40
S15 Chest & respiratory problems	261.00	3.30
S16 Headache / migraine	208.00	2.60

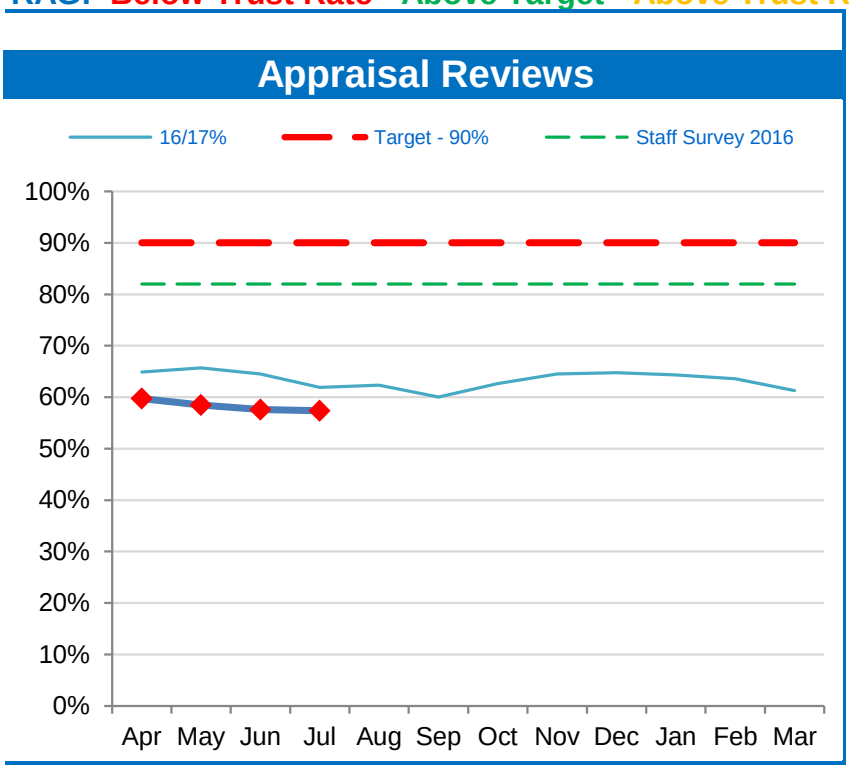
Benchmarking - Sickness Absence* April 2017

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%

CG & Directorate Appraisals - July 2017 (Q2)

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

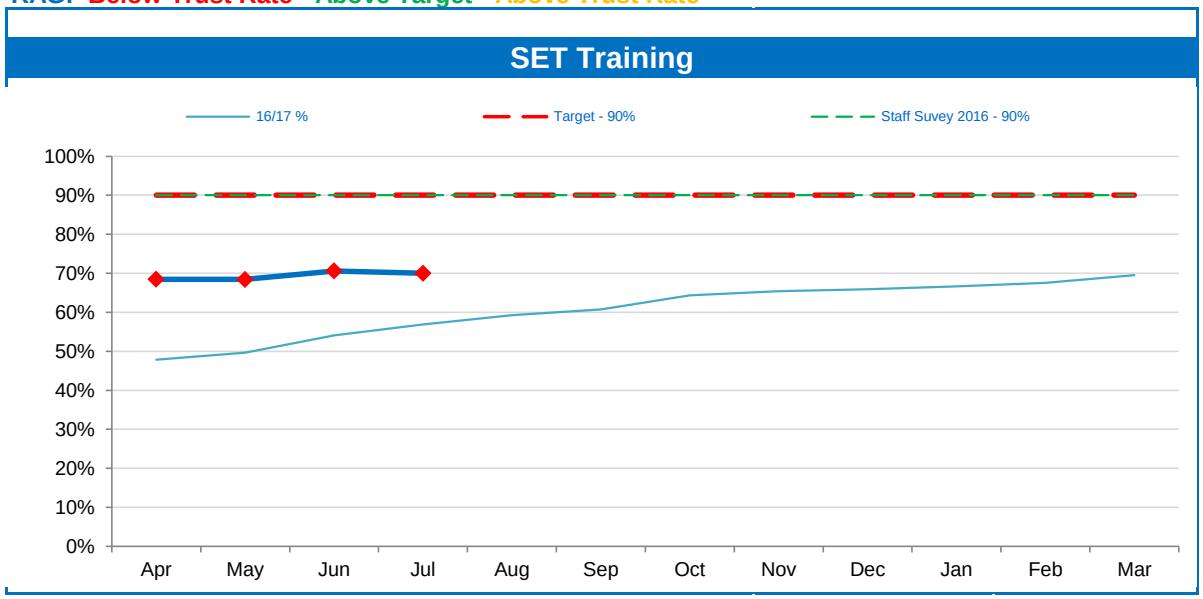


Trust Total

	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**57.38**
Chief Executive Directorate	25.00
Children & Family Care Group	67.71
Diagnostic & Pharmacy Care Group	50.53
Directorate Of Strategy & Improvement	93.33
Emergency Care Group	58.07
Estates & Facilities	15.58
Finance & Healthcare Contracting Directorate	12.50
IT Information & Telecoms Directorate	62.50
MSK & Frailty Care Group	77.54
Medical Director Directorate	75.00
Nursing Services Directorate	60.94
People & Organisational Directorate	88.66
Performance Directorate	81.47
Speciality Services Care Group	53.81
Surgical Care Group	63.25
Trust Funds	0.00

CG & Directorate SET Training - July 2017 (Q2)

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



	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**71.00%**
Chief Executive Directorate	**70.00%**
Children & Family Care Group	**74.97%**
Diagnostic & Pharmacy Care Group	**78.00%**
Directorate Of Strategy & Improvement	**96.93%**
Emergency Care Group	**63.11%**
Estates & Facilities	**46.88%**
Finance & Healthcare Contracting Directorate	**81.42%**
IT Information & Telecoms Directorate	**86.72%**
MSK & Frailty Care Group	**80.98%**
Medical Director Directorate	**86.52%**
Nursing Services Directorate	**78.23%**
People & Organisational Directorate	**89.45%**
Performance Directorate	**70.54%**
Speciality Services Care Group	**69.23%**
Surgical Care Group	**73.39%**
Trust Funds	**72.73%**

Workforce: Staff in post - July (Month 3)

Staff in Post

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Apr-17**		**May-17**		**Jun-17**		**Jul-17**	
Add Prof Scientific and Technic	173.34	189.00	173.68	189.00	174.74	191.00	172.45	188.00
Additional Clinical Services	1,116.66	1,356.00	1,124.68	1,365.00	1,134.49	1,376.00	1,136.40	1,378.00
Administrative and Clerical	1,089.28	1,338.00	1,097.51	1,344.00	1,091.66	1,339.00	1,090.42	1,338.00
Allied Health Professionals	317.79	369.00	316.78	367.00	320.54	372.00	325.55	378.00
Estates and Ancillary	572.83	825.00	571.80	827.00	571.28	826.00	572.38	828.00
Healthcare Scientists	129.53	143.00	129.10	142.00	127.60	141.00	127.07	140.00
Medical and Dental	498.11	523.00	497.26	522.00	501.41	616.00	500.76	617.00
Nursing and Midwifery Registered	1,593.42	1,850.00	1,593.67	1,850.00	1,585.23	1,838.00	1,584.72	1,838.00
Students	3.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total	**5,493.97**	**6,596.00**	**5,504.48**	**6,606.00**	**5,506.95**	**6,699.00**	**5,509.75**	**6,705.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Nursing Workforce Information**		
Report to	**Board of Directors**	**Date**	**29 August 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 UNIFY return for July 2017 planned and actual hours: • The workforce data submitted to UNIFY demonstrates the overall planned versus actual hours worked to be 99% for July 2017. • Care Hours Per Patient Day (CHPPD) for July 2017 shows a slight increase from recent months to 7.8, with a slight increase for registered staff and a slight reduction for non-registered staff. • Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), relating to Hard Truths demonstrates that no wards were Red for Quality.
Key questions posed by the report
• 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 99% in July. 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.

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 DBTH Strategy and Improvement programme
- Exploring recruitment opportunities for nursing and midwifery
- Analyse the AUKUH data collection from July, ward nurse staffing requirements will be available to the Quality Effectiveness Committee in October 2017.
- Consider the NQB consultation on Midwifery Staffing levels.

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 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.

2. WORKFORCE INFORMATION

The workforce data submitted to UNIFY provides the actual hours worked in July 2017 by registered nurses and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 99% in July 2017, dropping from 100% in April to June.

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

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

- within 5% for 21 Wards (51%), four less than June
- between 5% – 10% for 12 Wards (29%) five more than June
- surpluses over 10% for 6 Wards (15%) two more than June
- deficits over 10% for 2 Wards (5%) three less than June

The wards where there were surpluses in excess of 10% of the planned hours are Mallard, Ward 18, CCU/C2, A5, C1 and Ward 25; 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 Rehab 2 and Labour Ward at Bassetlaw Hospital. The lower than planned staffing levels were due to:

- 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.
- Rehab 2 is due to a reduced bed capacity and adjustment of planned and actual staffing as a consequence.

3b. Care Hours Per Patient Day (CHPPD)

Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for July 2017 are shown below, with a slight increase in the overall and registered midwives and nurses:

Care Hours Per Patient Day (CHPPD) – July 2017			
Site Name	**Registered midwives/ nurses**	**Care Staff**	**Overall**
BASSETLAW HOSPITAL	5.5	3.7	9.2
DONCASTER ROYAL INFIRMARY	4.5	3.2	7.7
MONTAGU HOSPITAL	2.5	2.3	4.8
TRUST	**4.5**	**3.3**	**7.8**

The CHPPD care hours data from May 2016 –July 2017 remain consistent, with a slight increase overall from March 2017.

3e. Quality and Safety Profile

The Quality Metrics (appendix 1) for adult wards include 19 indicators that cover each of the five CQC Key Assessment Criteria (safe, effective, caring and responsive, with the overall score illustrating well led). There are no wards flagging as high risk for July 2017.

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 continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme
- Analyse the Safer staffing, AUKUH data collection from July, ward nurse staffing requirements will be available to the Quality Effectiveness Committee in October 2017.
- -Consider the NQB consultation on Midwifery Staffing levels.
- Provide further detailed comparison CHPPD data as this becomes available nationally
- Continue to explore recruitment opportunities for nursing and midwifery

5.RECOMMENDATION

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

APPENDIX 1: HARD TRUTHS August 2017 Paper

ce /Quality/Safety Profiles July 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	94%	1.0	2.0	0.0	1.5	4.5				
	NS	20	27	99%	1.0	1.0	1.0	1.0	4.0				
	NS	21	27	96%	1.0	1.0	0.0	1.0	3.0				
	LM	S12	20	100%	2.0	1.0	1.5	3.0	7.5				
	RF	SAW	21	92%	1.0	0.0	1.5	1.5	4.0				
	LC	ITU DRI	20	96%	0.0	1.0	0.0	2.0	3.0				
	LC	ITU BDGH	6	92%	0.5	0.0	0.0	1.0	1.5				
				96%									
MSK and Frailty	SS	A4	24	99%	0.0	0.5	0.0	2.0	2.5				
	SS	B5	30.7	92%	0.0	1.0	0.0	1.0	2.0				
	AH	St Leger	35	101%	1.0	1.0	2.0	1.0	5.0				
	AH	1&3	23	103%	1.0	0.5	0.5	1.5	3.5				
	SS	Mallard	16	117%	1.0	1.0	0.5	1.0	3.5				
	SS	Gresley	32	104%	1.0	1.0	3.0	1.0	6.0				
	SS	Stirling	16	107%	0.0	1.0	0.0	1.5	2.5				
	KM	Rehab 2	19	89%	0.0	0.0	0.0	1.0	1.0				
	KM	Rehab 1	29	102%	1.5	0.0	0.0	1.5	3.0				
				101%									
Specialty Service	JP	18	12	113%	0.5	0.5	0.5	1.0	2.5				
	JP	18 CCU	12	98%	0.5	0.0	1.0	1.0	2.5				
	AW	32	18	95%	1.5	1.0	1.5	1.5	5.5				
	AW	16	24	102%	1.5	1.0	0.0	1.5	4.0				
	RM	17	24	97%	1.5	1.0	2.0	2.5	7.0				
	JP	CCU/C2	18	111%	0.5	0.0	0.0	3.0	3.5				
	RM	S10	20	94%	0.5	0.0	0.0	1.5	2.0				
	RM	S11	19	103%	1.5	0.0	0.0	1.5	3.0				
				101%									
Emergency	MH	ATC	21	92%	0.5	0.5	2.0	1.5	4.5				
	SS	AMU	40	104%	3.0	1.0	1.0	2.5	7.5				
	MH	A5	16	116%	1.0	2.0	0.5	3.5	7.0				
	MH	C1	16	113%	0.5	2.0	1.0	1.0	4.5				
	SC	24	24	102%	2.0	1.0	1.0	1.5	5.5				
	SC	25	16	114%	2.0	3.0	0.0	1.0	6.0				
	SC	Respiratory unit	56	95%	2.5	1.0	2.0	2.0	7.5				
				102%									
Children and Families	AB	SCBU	8	100%	0.0	0.0	0.0	0.5	0.5				
	AB	NNU	18	91%	0.5	0.0	0.0	1.0	1.5				
	AB	CHW	18	98%	0.5	0.0	0.0	1.0	1.5				
	AB	COU/CSU	21	98%	0.5	0.0	0.5	1.0	2.0				
	SS	G5	24	100%	1.0	2.0	1.5	2.0	6.5				
	SS	M1	26	92%	0.0	2.0	0.0	1.5	3.5				
	SS	M2	18	91%	1.0	2.0	0.5	1.5	5.0				
	SS	CDS	14	95%	0.0	0.0	1.0	1.5	2.5				
	SS	A2	18	92%	0.0	2.0	0.0	2.0	4.0				
	SS	A2L	6	83%	0.0	0.0	0.5	2.0	2.5				
				93%									
		Trust Position		**99%**									

Footnote: Paediatrics undertake a patient experience survey but will move to utilising FFT

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 than 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 86%	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 assessment
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	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**29 August 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' work in August 2017 and includes updates on a number of activities: • Flu fighters • DBTH Stars • Governors update • Risky Business • This month's meetings • Next month's Board of Directors
Key questions posed by the report
N/A
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
N/A
Recommendation(s) and next steps
That the report be noted.

Chair's Report – August 2017

Fighting flu on every front

Flu season is right around the corner and I understand that we are pulling together final preparations ahead of vaccinating Team DBTH against the virus.

As a Trust it is important our staff get the jab in order to protect themselves, their family and our more vulnerable patients from the flu virus. The vaccine helps the body create antibodies which in turn help in the fight against infection, putting down any tricky bugs before they can spread.

The flu vaccine protects against a number of flu strains which research indicates will be the most common during the next few months.

As you will know, last year we were the first trust in the country to achieve 75% of frontline staff vaccinated against flu. I would like to see how we, as the Board, can play our part in promoting the campaign this year.

DBTH Stars

The DBTH Stars event is on the evening of 7 September at the Keepmoat Stadium and I believe we are on for a sell-out. The evening provides opportunities to showcase excellence at DBTH and will feature awards in 11 categories as well as my Chair's award.

Governors update

As reported in other fora, I have been working with Helen Stevens of the SYB ACS, Emma and Matthew in organising a governors' conference on the Accountable Care System that will take place on the morning of 27 October at Rotherham's New York Stadium. Plans are still being finalised but we have some big name speakers and an exciting programme to attract governors. A separate conference for NEDs is planned for January.

I was sad to hear Dev Das resign as Doncaster public governor after four years. I know Dev was a committed and well-respected governor but I understand personal circumstances were making it harder for him to attend. Dev is replaced by David Northwood, a former consultant at the Trust who is also recommended for Emeritus status on today's agenda.

In addition to last month's Board of Governors meeting, we held a successful evening briefing for governors on 26 August where Richard ran an induction session and Adam Tingle, Communications Manager, set out some of the positives and pitfalls of how governors can use social media to support the Trust.

September is another busy month for governors. They are meeting for an externally facilitated session on their effectiveness review on 12 September followed by a meeting with NHSI on 15 September in addition to the scheduled timeout and governor briefing.

Finally, I have sent my congratulations on behalf of the Board to Doncaster public governor Nicola Hogarth and family who on Friday 28 July welcomed into the world baby Theodore George, weighing 7lb14. He was delivered at DRI and I was pleased to hear Nicky and baby were made as comfortable as possible by our team of nurses and midwives. I hope to see mother and baby soon.

Risky Business

Richard and I have discussed having a regular newsletter highlighting the lessons learned from patient safety incidents, complaints, claims and inquests. So I was pleased to see the first issue of Risky Business drop into my inbox last month.

Well done to the Patient Safety, Experience and Legal Team for getting it off the ground. I look forward to seeing the next issue.

This month's meetings

In addition to the usual round of meetings, I met with Louise Haigh MP, visited the Allied Health Practitioners in Emergency Medicine and was brought up to date by Helen Houghton on the work being undertaken on the staff well-being agenda.

I was 'chief guest' at Mr Quraishi's family celebration meal to mark his OBE and I am very pleased that he is able to join us today to talk more about his very important work as part of the world renowned ENT Masterclass.

I also attended another round of Working Together Partnership meetings and met with Sir Andrew Cash and Tony Pedder on the importance of furthering joint working in relation to vascular services across South Yorkshire and Bassetlaw. I am meeting Tony separately in his capacity as Chair and Pro-Chancellor of Sheffield University.

Next month's Board of Directors

It is really important that our new cohort of junior doctors feel valued and see how the Board of Directors works for them. So, for the next meeting on 26 September, I have agreed that we will meet in the Lecture Theatre from 2.30pm and be joined by junior doctors for the first hour. As part of that, there will be a special presentation about how we take forward our future as a teaching hospital. I look forward to it.

In the morning of that day I understand there will be a meeting of the Quality and Effectiveness Committee to consider the enabling strategies that come under the quality, leadership and improvement remit. This will enable all the strategies to be approved by Board in October.

NED updates

Linn Phipps

Linn attended the Friday Lunchtime Lecture on 18 August on Caring for Patients Who are Jehovah's Witnesses, given by Richard Colley, Chairman for the Sheffield Liaison Committee for Jehovah's Witnesses. This was a very interesting and interactive lecture, raising many issues of technologies, consent and ethics. The speaker covered:

- The expectation that medical staff will focus on the whole person and respect their values and beliefs
- The religious basis of why Jehovah's witnesses refuse lifesaving treatments such as transfusion
- What blood products are typically refused
- The legal documentation (Advance Decision Document) they carry once >18, effectively an EPA and how to get a copy
- JW children (and parents on their behalf) not expected to refuse blood
- There is an extensive list of local Drs who agree to treat JW patients without blood
- Interesting discussions eg the extent to which staff should seek to make an effort to change the patient's view.

Linn attended the Friday Lunchtime Lecture on 23 June on the Friday Ward Round Project, given by Dr Rekha Ramanath Consultant Physician and Sara Crowcroft, Matron Emergency Care Group. A good example of learning by working with patients. Junior doctors had suggested an opportunity to improve patient experience, safety and overall communication between parent teams and out of hours teams, through the management plans for patients under their care. The revised pro-forms also helps effective decision-making around weekend discharges.

Alan Armstrong

Alan undertook two visits on 22 August.

Maternity: Areas covered included clinical governance, new leadership structure, tour of areas and update on manager of the day approach, standardised equipment checks within diary format, and "batphone" emergency procedure.

Ward 20: Tour of area covered visual management; nutrition board, infection control board, tissue viability board.

Both visits highlighted importance of estates support on maintenance tasks to resolve safety issues and ward clerks' role in efficient running of wards.

Chief Executive's Report
29 August 2017

We are going System Perfect!

From 5 to 12 September, health and social care in Doncaster and Bassetlaw will go System Perfect. This means that all those involved in public sector care in Doncaster and Bassetlaw will work to ensure that patient flow is as efficient and safe as possible – in short the ambition is to try and ensure that everything that should happen will happen during the seven days of the scheme.

Being System Perfect means that we will work together not just as individual organisations but as a care community ensuring that we deliver the best quality care for the people of Doncaster, Bassetlaw and beyond. Throughout the week, from Board to ward, all members of staff will be involved to ensure that things are running as perfectly as possible.

This will mean that we make sure the right people are available, at the right time, to make the right decisions to help patient flow, both within our hospitals and communities. It means that we have all hands on deck and ensure the best possible experience for our patients.

The week will be the perfect opportunity to 'recalibrate' our system, investigating where things can improve and implementing the things that work well and which can be sustained 52 weeks a year.

IRMER CQC Inspection

Earlier this month, the Trust underwent a CQC inspection in respect of a reported IRMER (Ionising Radiation Medical Exposure Regulations) incident.

These types of inspections are undertaken from a health and safety perspective and not as part of the hospital ratings system. A number of issues were raised. Following investigation, these were not as significant as first thought and an action plan is now being developed.

Sight saving op first at Montagu Hospital

The first corneal transplant in Doncaster has been performed at Montagu Hospital. The gentleman travelled from Lincolnshire to undergo the operation which took 90 minutes. He has recovered with restored eyesight.

A corneal graft is a transplant operation during which the central part of the cornea (the clear front window of the eye) is removed and replaced with a cornea from a donor. The gentleman underwent a partial transplant which means only a thin inner layer of his cornea was replaced. Although this operation is much more technical than a traditional corneal transplant, it does not require the use of stitches which meant that his recovery was quicker, with less chance of infection or permanently weakening his eye.

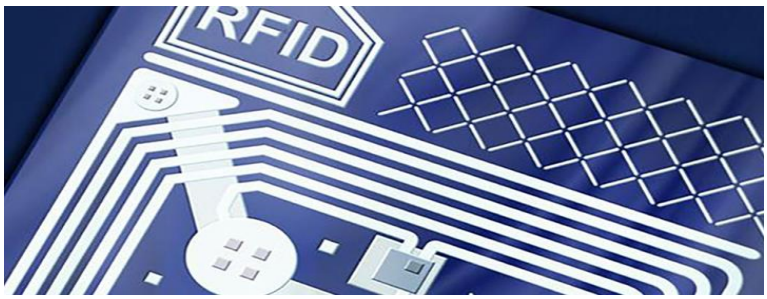
Medical records update

Board members saw for themselves at last month's pre-Board briefing some of the issues we have encountered in Medical Records and what we are doing about it to ensure a more efficient and effective service. We will shortly be introducing our case note tracking and locating system called Radio Frequency Identification (RFID).

The new service uses sensors, barcodes and software to tag, track and file case notes, meaning that they will be easier to find, making this process much more efficient and effective.

Known as iFIT, this system will replace our current CaMIS tracking module, with go live planned for September. Currently IDOX (the company responsible for our adoption of RFID) and IT are working together on the data migration to ensure a smooth launch.

Implementation of this new system will introduce many benefits for our Medical Records teams and other staff requiring access to patient records, such as tracking and advanced searching facilities.



The system does not replace the need for tracking case notes. A training plan is being discussed and developed to commence in August in line with completion of data migration.

Qii

Qii means identifying areas where care could be improved, where patient pathways could be made more effective, where things are not working as well as they could be, or where there are different and better ways possible.

A quality improvement project enables changes using a simple structured framework, which results in visible and effective improvement. Board saw some of the work going on in this area at their pre-Board briefing last month. Governors are receiving a briefing on 7 September.

The Trust's new Qii intranet page is now live: intranet/new_developments/qii.aspx

Use the new page for everything Qii at DBTH, including practical and useful tools, details of Qii team members and how they can support you, training and much more.

Devo update

Today's Board meeting is taking place at the later time of 10.30am due to a meeting I am attending in Warmsworth organised by the Chamber of Commerce about the future of devolution in Doncaster.

A number of local authorities in Yorkshire (including Doncaster, Leeds, Hull and Bradford) have recently stated their interest in exploring a Yorkshire-wide devolution deal. Contrastingly, a number of partners have expressed concern at this development as they believe that the primary focus should, instead, be on finalising a Sheffield City Region devolution deal.

The Sheffield City Region Combined Authority has agreed to postpone making a decision about what the SCR deal should look like until September 2017 whilst different options are explored. The Chamber is using this hiatus to engage with Doncaster firms and explore their views on devolution.

Lee Tillman, Assistant Director Strategy and Performance at Doncaster MBC is presenting on what a Yorkshire Devolution Deal would look like and details about a Sheffield City Region deal will also be shared. A discussion will follow. I will of course keep Board updated.

ACP Agreement

Next month we will be bringing to Board the Accountable Care Partnership Agreement that sets out the basis upon which the Providers have agreed to work together to provide the services as an Accountable Care Partnership. The Accountable Care Partnership will be governed by an ACP Executive Group, comprising senior representatives of each Provider.

This ACP Agreement also governs how the Providers will allocate the risks of participating in the Accountable Care Partnership between them, and how the Providers will allocate payments made by the Commissioners for the services delivered by the Accountable Care Partnership.

Delayed transfers of care – local system expectations

The Departments of Health and Communities and Local Government have written to providers to spell out their expectations for the £1bn of additional adult social care funding provided in 2017-18.

The Government wishes to reduce the transfers of care rate to 3.5% by September 2017 which means reducing the number of people delayed in a hospital bed on an average day to no more than 9.4 per 100,000 of population from the current position of 13.2 per 100,000. Delivering 9.4 per 100,000 will release around 2,500 beds.

The numbers people delayed in a hospital bed on an average day in Doncaster and Notts are currently 10 and 4. Government has set Doncaster's target at 7.1 and Notts' at 6.8 respectively.

Get involved in research

The Trust's Research and Development team are available to talk in the Research & Development Department on Ext. 644069 or just drop-in to have a chat with them.

They can help with developing research skills through training; undertaking additional qualifications; running your own research study; or developing a career in research.

They are also running a Friday Lunchtime Lecture, 1 September, 1.00 to 1.30pm, on current research opportunities at DBTH. This is aimed at a multi-professional audience, including Doctors, Nurses, Midwives and AHPs. Board members are of course welcome.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Proposed Annual Members' Meeting (AMM) arrangements**		
Report to	**Board of Directors**	**Date**	**29 August 2017**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues
The report sets out the arrangements for the 2017 AMM.
Key questions posed by the report
• Is Board supportive of the arrangements for the 2017 AMM?
How this report contributes to the delivery of the strategic objectives
The AMM is statutorily and constitutionally required.
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That Board supports the arrangements attached for the 2017 AMM.

Proposed AMM Arrangements

The Trust is required to publicise and hold an annual meeting of its members ('Annual Members' Meeting') prior to 30 September each year to present the following documents:

- the annual accounts;
- any report of the auditor on them; and
- the annual report.

This year the AMM will take place at the Trust's own Fred and Ann Green Rehab Centre on Wednesday 20 September 2017. There will be no Board of Governors meeting following the AMM.

The format will be as previous years. The first hour is an opportunity for members and the public to find out more about the Trust and its work in 2016/17 by visiting one of 15 display stalls. This year the following displays will be presented:

- Diagnostics & Pharmacy, focusing on Infection Prevention
- Healthwatch Doncaster
- Fred and Ann Green Legacy focussing on Film Array project
- Knowledge, Library & Information Services
- Health and Wellbeing including smoking cessation, healthy lifetsyles and flu fighters
- Membership & Be a Governor
- MSK & Frailty Care Group with a focus on person-centred Care
- Communications & Engagement including the new website launch
- PALS / Patient Experience
- Place Plans (Bassetlaw CCG/Doncaster CCG)
- Play & Activity Team
- Procurement
- Specialty Services Care Group including End of Life Care and Echocardiography
- Strategic Direction
- Teaching Hospital

The formal meeting will commence at 5pm and a draft agenda is attached over-page.

The meeting is open to the public. A quorum of 20 members is required. A press release was issued on 21 August and members will receive their invite with Foundations for Health within the next few days.

Copies of the 2016/17 annual report are available from the Trust Board Secretary. A limited number of hard copies have been produced as well.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Annual Members Meeting

To be held on Wednesday 20 September 2017 at 4pm

at The Fred and Ann Green Rehabilitation Centre, Montagu Hospital, Adwick Rd, Doncaster S64 OAZ

AGENDA

INFORMAL SESSION		
1.	Displays regarding health topics and the Trust's activities and achievements over the past year, and opportunity to meet the Directors and Governors of the Trust.	4:00 pm
FORMAL SESSION		
2.	**Welcome and apologies** Suzy Brain England, Chair of the Board	5:00 pm
3.	**To receive:** Minutes of the Annual Members' Meeting held on 21 September 2016	5:05 pm
4.	**To note:** Annual Report and Accounts 2016/17 Suzy Brain England, Chair of the Board *Copies available via the Trust website. Hard copies available on request.*	5:10 pm
5.	**Presentation: Chief Executive's Review of 2016/17** Richard Parker, Chief Executive	5:15 pm
6.	**Presentation: Finance Director's Report** Jon Sargeant Director of Finance	6:00 pm
7.	**Question & answer session on matters relating to the business of the meeting**	6:30 pm
8.	**Closing remarks** Suzy Brain England, Chair of the Board	6:45 pm
9.	**Date and time of next meeting:** To be confirmed	

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:15am on Thursday 20 July 2017
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-executive Director (Chair) Martin McAreavey, Non-executive Director Philippe Serna, Non-executive Director Jon Sargeant, Director of Finance Karen Barnard, Director of People & OD David Purdue, Chief Operating Officer
ALSO IN ATTENDANCE:		Angie Lawson, Head of Transformation Kate Atherton, Head of Transformation Ellen Rockley, Costing & SLR Manager Matthew Munday, Information Analyst Matthew Kane, Trust Board Secretary Angela O'Mara, Exec Team PA
WORKSTREAMS	:	Pauline Antcliff, Project Manager
OBSERVER	:	Suzy Brain England, Chair of the Board Bev Marshall, Governor Observer

Action

Apologies for Absence

17/7/1 Apologies were noted from Marie Purdue.

Introductions

17/7/2 Colleagues were welcomed to the meeting and introductions made around the table.

Action Notes from Previous Meeting

17/7/3 The action log was reviewed and updated.

Pre-Meeting Discussion

17/7/4 The Chair clarified his requirements with regards to despatch of committee papers. It was agreed papers, including presentations, should be circulated at least two clear working days ahead of the meeting, without exception. Member's views were sought and it was accepted that following circulation subsequent updates may be made to presentations or verbal updates provided at the meeting. The Chair agreed to brief the Chief Executive of the discussions and agreed actions. **NR**

Any other business

17/7/5 No additional business was declared.

FINANCE

Clinical Admin & Outpatients Workstream

17/7/6 David Purdue, SRO and Pauline Antcliff, Workstream Lead presented to the Committee an overview of the Clinical Admin and Outpatients workstream.

17/7/7 The Committee were informed of the aims and objective, work to date, anticipated savings and associated risk linked to the project. The ultimate aim being to develop a professional clinical admin service which was efficient, cost effective and patient focused.

17/7/8 A summary of actions to deliver service improvements was provided and the Chair suggested it would be helpful for the Project Initiation Document (PID) to accompany future work stream presentations. David Purdue assured the Committee that a reduction in staffing costs could be achieved without impacting upon the quality of patient care. **PMO**

17/7/9 Planned delivery of savings for the clinical admin re-design element of the workstream was reported at 690k in 2017/18. A high level of confidence was noted and although slippage had been seen in the first three months, the value was minimal due to the phased savings profile. If posts had not been removed by the end of July the Chief Operating Officer advised a vacancy freeze would be put in place.

17/7/10 In answer to a question from Martin McAreavey, the Committee were advised of plans for service provision to be externally benchmarked with trusts operating comparable patient administration systems. Learning opportunities would be explored via regional meetings, as part of the Right First Time working group and through the sharing of existing internal good practice. The aim would be to professionalise the clinical admin function ensuring an appropriate skilled and trained workforce, including the use of apprenticeship opportunities.

17/7/11 Staff engagement was recognised as a key factor in the success of this project. In addition to IT and procedural changes a need to address cultural issues was acknowledged. The Chair of the Board enquired if opportunities to promote "self-help" were being considered in order that clinicians maximise the use of technology available to them at the first point of contact, minimising the need for requests to be passed to others. Such activities had been considered and were included within the project plan.

17/7/12 Finally, in terms of support from the committee, members were asked to appreciate the complexity and scale of the project and have an awareness of the indirect benefits linked to the changes from both a patient and workforce perspective.

The Clinical Admin & Outpatients Workstream update was NOTED.

Finance Report – Month 3 2017/18

17/7/13 The Director of Finance presented to the Committee a paper summarising performance in Month 3. The position was reported as a deficit of 8m, 15k ahead of the year to date plan.

17/7/14 Income had over performed against plan in June, but high agency expenditure had continued due to a number of vacancies at consultant and middle grades. Significantly fewer junior doctors were included on the last rotation and this had impacted upon rota gaps; a stronger position was anticipated for August's rotation. A series of weekly challenge meetings to focus on agency spend had been introduced between the Medical Director and the Director of People & OD, supported by the Chief Operating Officer and the Director of Finance. These meetings would consider factors contributing to usage, such as sickness absence, rota management and short notice leave.

17/7/15 As part of the month end process meetings were held with three care groups to review medical agency expenditure. A variable approach to rota management and scrutiny was observed and moving forward options to centralise or standardise practice would be considered, including the potential to use a module within e-Roster.

17/7/16 At month 3 delivery of the Efficiency and Effectiveness Programme was 709k, against a plan of 1.7m. The main reasons for non-delivery related to the impact of IR35 within the procurement workstream and the run rate efficiencies and unidentified CIP balance in grip and control. The year-end forecast was currently 7.9m against a 14.5m target, leaving a gap of 6.5m to be identified. 5.3m of potential pipeline opportunities were being scoped.

17/7/17 In response to a question from the Chair, the Director of Finance agreed to report at the next committee meeting the estimated impact of IR35 for the current financial year. **JS**

17/7/18 A month end cash balance of 2.2m was noted against the plan of 1.9m. The backlog of invoices was now almost clear and balances outstanding with neighbouring trusts were being cleared as a priority when authorised invoices were received. The Director of Finance confirmed this related purely to technical problems where order numbers had not been generated and was not cash related.

17/7/19 Capital expenditure year to date was 0.54m against a year to date plan of 0.77m.

17/7/20 In order to meet the quarter end target the Trust had utilised cross year balance sheet flexibility and budget reserves. These were one–off actions to allow the deficit to be managed within plan and to ensure receipt of Sustainability and Transformation funding, details of which would be shared with NHSI.

The Finance Report was NOTED.

Annual Costing Submissions

17/7/21 The Committee received the first of a series of reports which provided an overview of the patient-level information and costing systems (PLICS), upcoming submissions and associated deadlines.

17/7/22 A need for improved cost information was recognised and the Costing Transformation Programme supported a move away from reference costs towards a submission at patient level. The Trust joined a cohort of approximately 80 acute trusts as a volunteer "early implementer" in 2016/17 but submission was expected to be mandated by 2018/19.

17/7/23 The Committee would receive a report in August detailing the processes and reconciliations, followed by a post submission review in September 2017.

17/7/24 The Director of Finance highlighted the benefits of patient level costings and welcomed the meaningful data to aid planning and inform EEPs.

The Annual Costing Submissions report was NOTED.

Finance Strategy

17/7/25 An initial draft of the five year financial strategy was received by the Committee.

17/7/26 A baseline position from 2017/18 and 2018/19 had been utilised and once the various strategies were finalised outputs would be incorporated to determine EEPs, capital and cash requirements.

17/7/27 In response to a question from the Chair, Jon Sargeant advised the format had been taken from a Monitor long term financial model template with some minor adjustments. Assumptions from the STP were included within the strategy. Where identified suggested amendments should be shared with the Director of Finance.

The Finance Strategy was NOTED.

New PMO Arrangements

17/7/28 Jon Sargent presented to the Committee an update on the Efficiency & Effectiveness Programme, responsibility for which had been transferred to his portfolio. The Quality, Improvement and Innovation (Qii) and strategic planning elements remained the responsibility of the Acting Director of Strategy & Improvement.

17/7/29 An overview of the proposed changes to the management and governance of EEPs was provided, which incorporated an escalation process involving the Director of Finance and Chief Executive. A need to improve ownership within care groups was noted to ensure colleagues responsible for budget savings became the delivery mechanism, supported by the workstream and PMO personnel.

17/7/30 In response to a question from Martin McAreavey, the Director of Finance confirmed the process refresh would revitalise the approach to be forward thinking and drive appropriate ownership and colleague engagement.

17/7/31 The importance of pipeline opportunities was recognised and improved tracking of these, including RAG rating, would be introduced. This would provide a continuous improvement picture prior to plans being firmed up.

17/7/32 Positive initial discussions had taken place with Directors around opportunities to close the unidentified gap. Changes to bed capacity had been identified by the Chief Operating Officer and were currently being progressed. A number of areas within Estates and Facilities around energy, site usage and recovery of the slippage associated with the catering bid were also being pursued. The Chair highlighted that whilst the catering bid was expected to be brought to August's meeting the Committee would welcome the opportunity to scrutinise this prior to the decision being submitted to the Board of Directors.

17/7/33 A number of potential opportunities had been identified for scoping; Bev Marshall requested appropriate governor consultation prior to decisions being made.

17/7/34 At the request of Philippe Serna, the Director of Finance provided a view of the RAG rating of individual workstreams. The Chair requested that the format of future reports be standardised and include suitable commentary in support of the data. Finally, in response to a request from last month an indication of 2018/19 opportunities were provided.

The PMO update was NOTED.

Escalation Items for Workstreams

17/7/35 No items were noted for escalation.

Strategy & Improvement Update

17/7/36 In the absence of Marie Purdue the paper was received for information. Updates included previously discussed changes to the management of EEPs and progress updates related to the strategic planning process and quality, improvement and innovation.

The Strategy & Improvement Report was NOTED.

PERFORMANCE

Draft Balanced Scorecard

17/7/37 Matthew Munday presented to the committee an initial view of the balanced scorecard, the intention being for the overarching summary to be provided at the next meeting of the Committee.

17/7/38 A range of key performance indicators would be shown rather than receiving alerts by exception. Measures would include 4 hour access, RTT, cancer,

sickness absence and HSMR. Performance would be RAG rated and future enhancements would provide the opportunity to drill down for further detail. Where performance was above a regulatory target but below a national target it was noted that these would be colour coded white. Future development would allow performance to be ranked across the care groups.

17/7/39 A discussion took place with regards to data comparisons with peers and nationally, it was recognised there would be different requirements from an operational and committee perspective to ensure a fully informed picture was available. The Chair reiterated his requirements for the report to the Committee to include explanatory commentary and analysis, in support of the data. **DP/KB**

17/7/40 In terms of availability of real time data David Purdue briefed the Committee on the range of local meetings to review performance. In addition a live dashboard for 4 hour access was available online and this was shared with the group. Plans to develop this into an app were currently being progressed.

The Draft Balanced Scorecard update was NOTED.

Locum Deep Dive

17/7/41 Karen Barnard presented to the committee a summary of agency spend, highlighting the vacancy and recruitment challenges and planned actions to reduce spend across care groups.

17/7/42 Whilst areas such as finance and clinical admin were expected to see a reduction in agency usage due to procedural changes others would require specific actions to redress the balance. Colleagues were briefed on initiatives to ensure the most cost effective means of staffing and recent medical recruitment appointments were shared. Opportunities to promote the Trust as an employer were also being explored through web site development, international recruitment and through the Trust's teaching hospital plans.

17/7/43 An expected reduction in rates though HOLT had not been seen and a need to understand the Trust's performance, as compared to others across the patch, was noted.

The Locum Deep Dive presentation was NOTED.

Business Intelligence Report

17/7/44 The content of the report was not reviewed within the meeting and the Chair agreed to consider this outside of the meeting with the relevant colleagues. **NR/DP**

RISK

Risk Mapping

17/7/45 The content of the report was not reviewed within the meeting and the Chair agreed to consider this outside of the meeting with the Trust Board Secretary. **NR/MK**

Items for escalation to the Board of Directors

17/7/46 No items were noted for escalation

Time and date of next meeting:

Date: 22 Auguust 2017
Time: 9:15am
Venue: Boardroom, DRI

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

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Quality & Effectiveness Committee
held at 2pm on Friday 23 June 2017
in the Boardroom, DRI

PRESENT	:	Linn Phipps, Non-executive Director (Chair) Alan Armstrong, Non-executive Director Martin McAreavey, Non-executive Director Sewa Singh, Medical Director Karen Barnard, Director of People & OD Moira Hardy, Acting Director of Nursing, Midwifery & Quality
IN ATTENDANCE	:	Andrew Beardsall, Doncaster and Bassetlaw CCGs Matthew Kane, Trust Board Secretary Angela O'Mara, Exec Team PA

Action

Agenda Review

17/6/1 The Chair welcomed colleagues to the meeting and thanked everyone for their efforts to date. A number of good practices for effective meetings were discussed:

- Executive reports, supported with a front sheet, to include assurance question(s), to help steer the debate and enable pre-meeting reflection. While the discussion would start with these question(s), other key issues could then be raised by participants
- Expectation that all participants have read the papers so no presentation required, maximising time for discussion
- Agendas would be timed to optimise use of time
- Agenda review: opportunity for all participants to agree/ propose to amend session timings **All**
- Inclusion of a strategic discussion item at the start of the agenda.
- An agenda setting and debrief meeting would be scheduled for all future meetings.

On this occasion adjustments to the timing of the agenda were made to devote an extended period for discussion of the CQC action plan. The Chair asked members to reflect on the meeting and offer feedback and suggestions for improvement to herself and the Trust Board Secretary.

Introductions

17/6/2 Introductions were made around the table.

Apologies for Absence

17/6/3 None reported.

Action Log

17/6/4 The action log from the last meeting of the Clinical Governance Oversight Committee was reviewed and updated.

17/6/5 17/111 - Moira Hardy clarified the update would be provided in the Clinical Effectiveness Annual Report, which would be received by this committee in August 2017. **MH**

17/6/6 Action 17/5/42 had been remitted from the Finance & Performance Committee, as this related to educational provision. It was confirmed this would fall under the responsibility of the Workforce and Education Committee which would provide assurance or escalation to this committee.

17/6/7 Thought was given to research governance, arising from the Trust's teaching hospital status and it was agreed that Sewa Singh, in his capacity as research executive lead, would consider and propose the most appropriate committee to review this. **SS**

17/6/8 The Chair requested that the committee's terms of reference be included as a standing agenda item. A simplified summary of key areas of responsibility for each Committee, prepared by the Trust Board Secretary, would also be shared with members for information. **MK**

Strategic Discussion Item – DBTH Care Quality 2012-2020

17/6/9 Sewa Singh presented to the committee an overview of patient safety and care quality since his appointment as Medical Director in 2012. The presentation highlighted trends in key performance measures, including resultant claims history and associated NHSLA premiums. In order to address areas of concern a number of pathway and service redesigns had been implemented, the nurse and midwife establishment had been increased and a revised clinical governance structure put in place. Considerable improvement was noted and future developments would aim to sustain quality improvements with a focus on improving the overall patient experience. A need to transform services was recognised and development as a teaching hospital would assist with recruitment and retention of appropriately skilled colleagues. A number of challenges were identified including workforce gaps, finances, the impact on changes in service delivery and patient and staff engagement.

17/6/10 From the assurance questions identified it was agreed to carry forward question one ***"How do we collect representative information of patient experience, especially soft intelligence?"*** as part of the proposed thematic/deep dive topic at the next meeting. **MH**

17/6/11 A discussion took place around question three ***"How do we continue to develop a patient safety and care quality culture?"*** The Medical Director's view was that care quality was now colleagues' number one priority, however,

a need to embed service and quality improvement was recognised. The ward quality assurance tool currently tracked and drove improvement. The recent appointment of Petra Bryan, Head of Quality Improvement & Innovation would see a dedicated lead to focus and spread those pockets of improvement already identified through the sharing of good practice, celebrating success, and learning from others in a bottom up approach. A need to be ambitious in the approach to quality and to incorporate learning into educational training was noted. From a CCG perspective the Trust's approach over the last five years was noted as open, honest and collaborative, however, as a committee QEC needed to seek assurance that any reductions in areas such as near misses or complaints represent genuine improvement and not a fear of reporting. A need to be assured that we have a plan and was delivering against this on soft and hard metrics was acknowledged.

17/6/12 In respect of question two ***"How do we overcome workforce gaps that risk care quality?",*** Karen Barnard confirmed the need to take a triangulated view of the service model, workforce and infrastructure. Although development of new roles was under way a time lag should be expected. Service design was recognised as the key driver, and had recently been explored as a single item agenda at Management Board. The Medical Director suggested that the preferred approach would be to determine emergency services initially, with elective services falling into place around this, and that the service model needed to be determined ahead of the workforce plan. In terms of a timeline, it was suggested the Chief Operating Officer would be best placed to present further on this. A discussion took place around the definition of workforce gaps and the Medical Director and Director of People & OD offered their explanations around rota requirements and variances in staff in post versus plan, including educational gaps. Consideration would be given to include this as a future strategic/thematic topic to seek assurance on the plan and trajectory for service redesign linked to the workforce plan. **MK**

17/6/13 With regards to question four ***"How will we provide assurance to the Board on delivery and improvement on care quality and responsiveness to patient experience?"*** the Chair identified a need for the committee to receive assurance on the quality metrics section of the business intelligence report and consider any gaps in data requirements. Quality metrics were currently extracted from CQC Insights and the Medical Director identified this data would be refined for submission to Board along with the addition of patient experience feedback from the care groups. Support for collation and theming of patient feedback was being discussed with Healthwatch, along with input from the Patient Experience and Engagement Committee. Andrew Beardsall confirmed CCG patient engagement was completed via GP patient participation groups. As a future deep dive topic, following up outcomes of SUis was suggested.

The DBTH Care Quality 2012-2020 presentation was NOTED.

Added Value Committee

17/6/14 The Chair asked members to consider what an added value committee would look like. The following thoughts were shared:

- To ensure a clear strategy was in place with appropriate controls and accountability, demonstrating a good example.

- To ensure the committee was efficient and effective, running to time and focused on key areas to make a difference.

- Challenging ourselves to be the best; to be innovative, creative and learn from others.

- To ensure that the Board is fully informed on all aspects of quality and safety, a "no surprises" culture.

- To welcome opportunities to explore difficult issues with colleagues, to consider the risk and present an informed view to the Board.

- To consider the importance of outcomes, to ensure scrutiny and challenge is undertaken on behalf of the Board.

17/6/15 A self-review of the committee's effectiveness would be included within the work plan, scheduled to take place in twelve months.

17/6/16 The Committee identified an initial 5 elements for an Assurance Report, detailed on page 4 of the action log. The Chair requested that members share any further ideas on the format and content of an assurance report, including good practice examples. **All**

QUALITY

Assurance Report from CGC

17/6/17 The Medical Director presented the CGC assurance report which was in the process of being reformatted.

17/6/18 The committee's attention was drawn to the following:

- Since the start of April 2017 7 cases of C.Diff and 1 MRSA bacteraemia, had been reported. As a result the proactive deep clean programme had been reintroduced. Communications regarding hand hygiene and appropriate antibiotic stewardship had also been reinforced.

- The number of temporary patient notes remained a concern in some care groups, however, the overall position in medical records was noted to be improving. The implementation of RFID (radio frequency identification) was expected shortly.

- Phase 1 of the Bloodhound project had now been implemented. This involved the bar coding of bloods to ensure accurate usage. Phase 3 of the project was currently on hold awaiting the necessary funding for the hand held devices.

17/6/19 In response to a question from Martin McAreavey, the Medical Director confirmed that the relative mortality for fractured neck of femur was 95 for both sites. A review of resultant deaths was continuing and CGC expected an update from the trauma and orthopaedics clinical governance team in September 2017. No concerns were noted by the Medical Director.

17/6/20 In response to a question from Alan Armstrong regarding the Getting It Right First Time (GIRFT) Programme the Medical Director confirmed participation in the national programme was now taking place across specialties. No care quality issues had been flagged and appropriate action plans were in place for performance improvements.

17/6/21 Following discussion between the Chair, Moira Hardy and Sewa Singh it was agreed that the Patient Experience and Engagement Committee would continue to report to the Clinical Governance Committee, to ensure that patient experience feedback is given a strong weight alongside clinical quality in the presentations by and discussions with the Care Group Directors; and with input to this committee via a six monthly assurance report. **MH**

17/6/22 The revised terms of reference for the Clinical Governance Committee were APPROVED subject to clarification that 5.1 (i) should read "The Single Oversight Framework". The updated terms of reference would be reissued to members. **MK**

17/6/23 The committee noted the presented Health Evaluation Data. Future reports would be supported by narrative to indicate what the data was telling the committee, the areas of concern and root causes. **SS**

The assurance report from CGQC was NOTED.

CQC Action Plan

17/6/24 The Committee received a report and supporting appendices detailing progress against the Nottinghamshire Children and Looked After Safeguarding action plan, the Internal Audit CQC action plan and an update on CQC's response regarding its next phase of regulation consultations.

17/6/25 Recommendations included ongoing monitoring of the action plans, involvement in the CQC engagement meetings, development of improvement plans following the joint review by the Royal College of Obstetrics and Gynaecology and the Royal College of Midwifery and fulfilment of internal mock inspection/self-assessment.

17/6/26 Moira Hardy confirmed the Internal Audit Action Plan provided a high level view of those care groups identified as requiring improvement at the comprehensive inspection of 2015. Work to address these areas was ongoing, with observations from the Heads of Nursing being peer assessed by the Acting Deputy Director of Nursing, Midwifery & Quality, Rick Dickinson. In answer to a question from Andrew Beardsall, this process offered assurance independent from the clinical governance lead, and often included a view external to the care group, e.g. the Deputy Chief Pharmacist. It was anticipated that the next

inspection would include a cross section of areas ranging from those requiring improvement to those judged to be outstanding.

17/6/27 The Chair requested the headings of the Internal Audit plan be clarified and for each action and evidence of its completion be recorded separately. **MH**

17/6/28 Assurance was provided to the committee in respect of clinical governance arrangements arising from the RCOG visit and it was confirmed that Dr Noble was now working with O&G and Paediatrics to ensure robust processes were in place. This would be further strengthened by a recent consultant appointment with experience in both clinical governance and service reconfiguration. It was agreed that micromanagement of these plans was not the focus of the Committee's responsibilities but would be addressed by the care group's clinical governance team, assessed by the Acting Deputy Director of Nursing, Midwifery and Quality and reported on a "by exception" basis to this committee by CGC.

17/6/29 Steps to improve multi-disciplinary teamwork continued, with the ultimate aim of a one team approach linked to service redesign. Colleague's opinions were currently being responded to as part of the College report and a means to measure changes in colleague's perceptions was proposed via focused staff survey/FFT questions.

17/6/30 In view of the anticipated CQC visit it was suggested that a future agenda item be tabled on this to offer assurance on readiness and action planning. **MH**

The CQC Action Plan report was NOTED

Nursing Workforce & Ward Quality Metrics

17/6/31 The Acting Director of Nursing, Midwifery & Quality presented to the committee a report which detailed planned versus actual staffing hours, care hours per patient day, the Trust's position regarding safe nurse staffing and efficiency and quality and safety metrics.

17/6/32 From the identified assurance questions it was agreed that the discussion would be focused on ***"Does the triangulation of staffing and quality data provide assurance on the adequacy of resources balanced with quality improvement potential?"***

17/6/33 The quality metrics contained in appendix 1 were considered against planned vs actual staffing, to provide a view of the impact on care quality. It was noted that the staffing picture does not include a breakdown by staff type e.g. permanent or agency.

17/6/34 In response to a question from the Chair regarding the extent to which triangulation was deployed in practice, Moira Hardy confirmed this was perhaps more prevalent in areas of concern which were scrutinised to establish the detail behind the issue. The Director of People & OD highlighted the overall level of achievement of quality metrics and asked how these standards could be replicated across appraisal and SET performance.

17/6/35 As quality metrics were standardised, it was acknowledged that these did not always correspond with care group activities and as such the data should not be viewed in isolation. This was particularly noticeable in O&G where patients would be unlikely to experience falls or pressure ulcers; in this instance it may be more appropriate to have service specific measures as long as these were under the influence or control of the ward manager. In view of this the Chair acknowledged the need to consider more subtle metrics alongside the quality rating. A question to consider in future would be ***"What is the future trajectory and is this an improved or deteriorating position?"***

The Nursing Workforce and Ward Quality Metrics report was NOTED.

EFFECTIVENESS

Progress against Staff Survey Action Plan

17/6/36 The report presented to the Committee detailed progress against the 2016 corporate staff survey action plan. From the identified assurance questions it was agreed that the discussion would be focused on ***"Are we addressing the issues in the right way to ensure we improve our survey results".***

17/6/37 In response to a question from Alan Armstrong regarding care groups' data analysis and action plans, Karen Barnard highlighted the work undertaken by the HR Business Partners to review locality reports to identify key areas of focus within the care groups. However, rather than devoting time to interrogating the data the main aim had been to actively engage with staff, and various approaches had been taken across the care groups and directorates to facilitate this.

17/6/38 The Director of People & OD clarified the purpose of the amendments to the appraisal paperwork as to demonstrate the importance of conversation, to improve discussions and build relationships through the inclusion of conversational prompts, such as health and well-being related questions. The drive on appraisal completion rates would be via accountability meetings.

17/6/39 In response to a question from Martin McAreavey regarding how the DBTH management passport would ensure staff felt empowered, Karen Barnard outlined the programme modules, which focused on ensuring managers had the necessary line management skills. Line managers would also be encouraged to examine and understand their own style and consider individual reactions and responses to build effective relationships with their staff.

17/6/40 In response to a question from the Chair as to how interim data between the national staff surveys was collated, Karen Barnard explained the principles around the quarterly FFT survey. The committee were briefed on the standard questions and the three health and wellbeing related questions which would be used to determine achievement of the CQUIN target this year. Discussions were already underway to agree the next FFT questions around staff motivation and involvement, along with further staff listening events and the launch of the staff experience group in July.

17/6/41 Martin McAreavey sought a view of the level of staff engagement within the medical and nursing workforce. An improving but variable position was noted across the care groups.

The progress against staff survey action plan was NOTED.

Minutes of sub-committees

17/6/42 The minutes of the following committees were NOTED:

- Clinical Governance & Quality Committee held on 21 April & 19 May 2017.
- Patient Engagement and Experience Committee held on 31 March & 28 April 2017.
- Workforce & Education Committee held on 20 March 2017.

17/6/43 A request was made by the Chair to receive an assurance report from the Workforce & Education Committee at future meetings. **KB**

17/6/44 Martin McAreavey enquired how the Workforce & Education Committee was aligned to the Trust's strategic aims. It was recognised that the newly formed committee was still evolving and following agreement of reporting structure there would be a need to amend its terms of reference for approval by this Committee. A refresh of the People & OD strategy was also underway.

17/6/45 In relation to research activity and development of phase 2 of the teaching hospital status it was noted that a revised strategy would be drafted and reporting of progress clarified as per 17/6/7.

GOVERNANCE AND RISK

Mapping the Risks for Quality & Effectiveness

17/6/46 The Trust Board Secretary presented to the committee the corporate risk register and BAF which was noted to be work in progress. To date a number of actions had been taken to refresh and renew, risks had been merged and a number of new risks added. Each sub-committee of board would now own a portion of the register which would be considered at future meetings.

17/6/47 The BAF had been updated to reflect the risks to strategic aims and the format was now more aligned to other NHS frameworks. Further development was required, especially around the 4th strategic aim and colleagues were encouraged to provide input to its development. In response to the Chair's prior request, the Trust Board Secretary provided a working definition of "control" and "assurance" from Building the Assurance Framework NHS guidance document and these would be incorporated within the framework for reference purposes. **MK**

17/6/48 Where joint risks were identified it was agreed that a discussion between Linn Phipps and Neil Rhodes would take place to agree how these were managed. **LP/MK**

17/6/49 The Committee were encouraged to consider the questions posed by the report **MK**

and a discussion took place around the risks identified for QEC. The following suggestions were proposed for inclusion in the register:

- Failure to engage with patients around the quality of care & proposed service changes.
- Impact on staff morale
- Failure to engage in STP and place plan work

17/6/50 The process of identifying risks was recognised as an ongoing matter and an agenda item would be added for identification of new risks at future meetings. **MK**

17/6/51 The option to undertake a deep dive on a specific risk as part of the thematic/strategic question was proposed and the Chair agreed to share with the committee good practice questions used to interrogate risk. **LP**

The update for Mapping the Risks for Quality and Effectiveness was NOTED**.**

Items for Escalation to the Board of Directors

17/6/52 None.

Minutes of the Clinical Governance Oversight Committee meeting held on 18 April 2017

17/6/53 The minutes were received for information only and would be approved by the Board. The CGOC Annual Report would also be presented to the June Board of Directors.

Any other business

17/6/54 None.

Governor questions regarding the business of the meeting

17/6/55 No governor representatives were in attendance at this meeting. Those recently appointed colleagues had been provided with a schedule of meetings and activities in which they could be involved and responses are awaited. The Chair highlighted that governors questions would now be taken at the end of the meeting and once governor observers were identified they would be briefed with regards to the meeting format and their role.

Meeting Round-up

17/6/56 The Chair thanked members for their contribution, it was acknowledged that the committee would evolve over time as practice was reviewed and refined. Consideration should be given to future strategic discussion topics. A suggestion was made by Martin McAreavey that after considering items it would be helpful to ascertain the level of assurance that Committee members felt they had gained. **All**

Time and date of next meeting:

Date: 22 August 2017
Time: 2pm
Venue: Boardroom, DRI

Signed:…….. **…….**
Linn Phipps **Date**

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
SEPTEMBER 2017			
CE Report		Fred & Ann Green Legacy minutes	Catering Report
Business Intelligence Report			Teaching Hospital
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
OCTOBER 2017			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives		
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
NOVEMBER 2017			
CE Report	QEC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Business Intelligence Report	Board Assurance Framework & corporate risk register Q2		
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

As at 19 July 2017

DECEMBER 2017			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Business Intelligence Report			
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
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)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
FEBRUARY 2018			
CE Report	QEC 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			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

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			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
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)		
Finance & Performance Minutes	P&OD Quarterly report		
Finance Report			
Chairs' Assurance Logs			
MAY 2018			
CE Report	Monitor Quarterly Declaration Q4	Annual Report	
Business Intelligence Report	QEC 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	
Finance & Performance Minutes		Mixed Sex Accommodation	
Finance Report			
Chairs' Assurance Logs			

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			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JULY 2018			
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)		
Finance & Performance Minutes	ANCR Minutes		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
AUGUST 2017			
CE Report	QEC minutes	Proposed AMM arrangements	Health and Wellbeing
Business Intelligence Report	ANCR Minutes	Annual Security Report	
Nursing Workforce		Infection Control Annual Report	
MB Minutes		Risk Policy	
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

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 25 July 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
	Richard Parker	Chief Executive
	John Parker	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	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
	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Anthony Fitzgerald	Director of Strategy, Doncaster CCG (part)

ACTION

Welcome and apologies for absence

17/07/1 Apologies for absence were received on behalf of Jon Sargeant, Martin McAreavey and Linn Phipps.

Declarations of Interest

17/07/2 Board was reminded of the need to keep their registers of interests up-to-date.

Actions from the previous minutes

17/07/3 The list of actions from previous meetings was noted.

ACS Memorandum of Understanding

17/07/4 The Board received a report of the Chief Executive that sought approval of the Memorandum of Understanding for the South Yorkshire and Bassetlaw Accountable Care System (ACS).

17/07/5 The Trust's adoption of the MoU was required to give SYB ACS access to the national funds available for first wave ACS. The MoU did not replace the existing legal framework or responsibilities of any of the Partnership's statutory organisations but sat alongside the framework to complement and enhance it.

17/07/6 In signing the document, the Trust became one of the 'parties to' the agreement. 'Parties to' had majority relationships (patient flows and contracts) within and across SYB. Accordingly, DBTH would be subject to delegated NHS powers and a new relationship with other Parties and with both of the NHS regulators.

17/07/7 Board noted the changes in terminology in relation to both the ACS and the emerging Hospital Services Review. The final document had made minor amendments to previous drafts.

17/07/8 The Board ADOPTED the attached Memorandum of Understanding for the SYB ACS.

Doncaster Place Plan

17/07/9 The Board considered a report and presentation prepared by the Director of Strategy, Doncaster CCG that set out details of the Doncaster Place Plan and sought support for its direction of travel.

17/07/10 The joint vision was that: "Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed."

17/07/11 The Place Plan had been approved by Doncaster CCG's Governing Body in October 2016 and, in January 2017, EY had been appointed as strategic partner to facilitate its implementation. A report attached as an appendix to the report was the phase 1 assessment of the Health and Social Care partnerships ability to implement the Place Plan. It included an assessment of readiness across six key areas and described the key areas of focus for Phase 2 of implementation.

17/07/12 The Board endorsed the work undertaken to date, recognising the detail of thinking that had gone into the Place Plan so far. Success, however, would mean delivering on the projects outlined and being clear on the benefits to organisations. The CCG's Director of Strategy outlined some of the projects that would be delivered soon and timescales for delivery.

17/07/13 Board NOTED the report and presentation.

Strategy and Improvement Update

17/07/14 The Board considered a report of the Acting Director of Strategy and Improvement that provided an update on the strategic planning process and quality improvement & innovation work. It was noted that responsibility for the Programme Management Office and effectiveness and efficiency work-streams had transferred over to the Director of Finance and the updates in respect of those work areas would now be provided in his report.

17/07/15 In respect of Strategy, Board was advised of the engagement work that had taken place with governors and the final version of the Strategic Direction was presented to Board for consideration. In relation to a question from John Parker, Board was advised that the key risks would be highlighted within the enabling strategies and board assurance framework.

17/07/16 The Board APPROVED the Strategic Direction and noted the progress made on implementation governance.

Winter Plan

17/07/17 The Board considered a report of the Chief Operating Officer that set out details of the Trust's winter planning process for 2017/18.

17/07/18 The report identified the key elements of the plan that Providers were responsible for and the steps the Trust had taken to ensure preparedness for Winter. This year, NHSI/NHSE had set out the criteria that health and social care systems needed to have in place to support improvement in outcomes over the winter period. The following points were noted during the course of discussion:

- Two pilots of front door streaming would take place during System Perfect between 5-12 September.

- Arrangements were being explored to overcome any issues relating to out of hours cover at Bassetlaw.

- Operational meetings would be taking place on a regular basis to assess bed occupancy.

- A&E Delivery Boards needed to submit their plans in September 2017.

17/07/19 In response to a point raised by Sewa Singh, there was a discussion around the number of beds at Bassetlaw and discussions with NHSI and NHSE would be taking place to ensure they were content with the plan. Staffing remained an issue at Bassetlaw.

17/07/20 Board were advised that last year's occupancy rate was 87% but in some weeks occupancy has been as a high as 96-97%. Achievement of KPIs – particularly those relating to delayed transfers of care and A&E - would be monitored through the Finance and Performance Committee.

17/07/21 The Board NOTED the report and indicated its assurance that the actions identified would improve patient outcomes.

Diversity and Inclusion Action Plan

17/07/22 The Board considered a report of the Director of People and Organisational Development that provided the Board of Directors with an update on the Trust's renewed focus on Diversity and Inclusion.

17/07/23 The Trust's recent Well Led Governance Review emphasised the need for the Trust to formalise its work around equality and diversity. To that end, a group of staff within the Trust had formed a Diversity and Inclusion forum and run a number of drop-in sessions with the aim of engaging with as many staff as possible.

17/07/24 The report provided a general update and highlighted three particular areas of diversity – race, gender and disability with action plans detailed for 2017/18. The action plans would be monitored through the Workforce and Education Committee.

17/07/25 Board APPROVED the action plans contained within the report and publicly confirmed its commitment to diversity and inclusion as detailed within the report.

Committee Assurance Log – Finance and Performance

17/07/26 The Board considered the assurance report of Neil Rhodes, the Chair of Finance and Performance Committee, following its meeting on 20 July.

17/07/27 The Chair reported positive progress in respect of the closure of the CIP gap, which was now down to circa. £1m, but had noted the current financial position had involved using a portion of non-recurrent reserves to achieve receipt of funding. Spend on agency workers continued to be an issue.

17/07/28 Philippe Serna echoed the Chair of Finance and Performance Committee's concern about the Trust being off plan. The Chief Executive undertook to review the situation with the Director of Finance but felt that the Trust had made significant progress in reducing its CIP achievement from £8.5m to £1m within a month. He also reiterated the Trust's risk profile with NHSI, which was low.

17/07/29 The Chair of Finance and Performance Committee also commented on slippage in relation to progress on the catering contract that was required to be approved by Board in September. It was agreed that a copy of the relevant documents would be circulated between the August and September meetings and considered without the need for a separate Finance and Performance meeting.

17/07/30 Board RECEIVED the report for assurance.

Finance Report as at 30 June 2017

17/07/31 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 3, 2017/18.

17/07/32 The month two position was a deficit of £7,993k, which was £15k ahead of the planned year to date deficit of £8,009k. In order to achieve the quarter end target the Trust had used non-recurrent reserves that may put pressure on the delivery of the financial plan. There was a need to maintain strenuous efforts on working efficiently and delivering the agreed efficiency programmes through the remainder of the year.

17/07/33 The main reason for the challenging financial position was due to high levels of medical agency expenditure, under delivered efficiencies and under performance in elective activity. Meetings had taken place with Care Groups and Corporate Directorates in order to understand activity and over spend on agency staff. Junior doctor intake had also reduced by 50% this year.

17/07/34 The Board was advised that the Trust could not maintain the level of reserve utilisation throughout the year and it was therefore extremely important that the organisation was not complacent about the financial position based on last year's performance.

17/07/35 The Medical Director would be chairing new accountability arrangements that would address agency whilst ensuring safe and sustainable services. He reiterated the need for the Trust to take forward its plans for service redesign that would be facilitated through three groups relating to women and families, elective and urgent care. These would report into Management Board.

17/07/36 The Board NOTED that the reported financial position was a deficit of £8.0m, which was £15k ahead of the year to date plan.

Business Intelligence Report as at 30 June 2017

17/07/37 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 3, 2017/18.

17/07/38 Performance against key metrics included:

4 hour access – In June the Trust achieved 92.46% (93.7% including GP attendances) against the 95% standard.

RTT – In June, the Trust performed below the standard of 92% achieving 90.9%, with the trajectory for improvement being met by four of the five specialities.

Diagnostic rates – The Trust achieved 97.8% against the 99% target, with audiology being the main issue.

Cancer targets – In May, two week waits were 91.2% against the 93% standard. A full action plan had been developed with the CCGs to improve two-week wait performance. The 62-day performance achieved 86.2% against the 85% standard.

HSMR – The Trust's rolling 12-month position remained better than the expected level of 100, currently at 92.6.

C.Diff – The number of cases in June reduced and the Trust was now on trajectory. Deep cleaning, hand washing compliance monitoring and antibiotic stewardship all continued.

Falls – Overall, there was good performance in the first quarter with the rate of falls being below trajectory.

Pressure ulcers - Pressure ulcers remained higher than compared to the same time last year. All pressure ulcers were currently being reviewed through an RCA process and it was anticipated that the position would improve.

Appraisal rate - The Trust's appraisal completion rate continued to hover around 57% with a small reduction from 58.51% to 57.59%. The Trust continued to renew 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.

SET training - There had been a further increase in compliance with Statutory and Essential Training (SET) and at the end of June the rate was 70.57% compared to May's figure of 68.41% and generally across most areas the positive upwards trajectory continued.

Sickness absence – The Trust had seen a slight rise in sickness absence in June to 3.5%, resulting in a cumulative figure of 3.83%.

17/07/39 The Business Intelligence report was NOTED.

Nursing Workforce Report

17/07/40 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.

17/07/41 The overall planned versus actual hours worked in June 2017 was 100%, same as May. Care Hours Per Patient Day (CHPPD) stood at 7.6 across the Trust, up 0.1 since May. No wards were assessed red for quality in the month. Agency spend remained within the 3% cap.

17/07/42 The Board of Directors NOTED the content of this paper and SUPPORTED the actions identified to ensure that the risks associated with inappropriate nurse staffing levels were appropriately managed:

Key issues and actions included:

- the continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme;
- exploring recruitment opportunities for nursing and midwifery;
- complete AUKUH data collection from 01 July, ward nurse staffing requirements would be available to the Quality and Effectiveness Committee in September 2017;
- consider the NQB consultation on Midwifery Staffing levels.

Patient Experience and Complaints Quarterly Report – Q1 2017/18

17/07/43 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality that provided information relating to Quarter 1 performance using the information available from Datix and the learning points from the organisation.

17/07/44 Key points from the report were as follows:

- Numbers of complaints remained static and there had been a reduction in the numbers of concerns.
- The highest number of complaints came from Emergency care group followed by MSK and Frailty. In response to a question from Philippe Serna, Board was advised that trends in MSK and Frailty were being monitored.
- The top two reasons for complaints continued to be communication and staff attitude and behaviour. However, both of these areas had seen a significant reduction in complaints.
- Friends and Family data revealed better than national and regional performance in all areas except for the response rate for A&E.

17/07/45 Board commended the work undertaken on the ward-patient surveys. Further analysis on the surveys would be undertaken through Patient Experience and Engagement Committee.

17/07/46 Board NOTED the Quarter 1 Patient Experience and Complaints Quarterly Report.

NHS Undertakings Tracker

17/07/47 The Board considered a report of the Trust Board Secretary that set out progress against the undertakings given to NHSI in February 2015 following the Trust's breach of licence.

17/07/48 The tracker provided a breakdown of those undertakings, and a summary of progress against each one, providing the Board with oversight and highlighting any exceptions or concerns. All actions were on track.

17/07/49 Board NOTED that the NHSI Undertakings Tracker.

Corporate Risk Register and Board Assurance Framework

17/07/50 The Board considered a report of the Trust Board Secretary that presented the revised Corporate Risk Register and Board Assurance Framework at Q1.

17/07/51 The Corporate Risk Register and Board Assurance Framework had been revised following sessions with Finance and Performance and Quality and Effectiveness committees.

17/07/52 Risks had been aligned to each committee. Some risks from last year were mapped over while a number of new risks were also identified. These related to:

- Lack of adequate CT scanning capacity at DRI
- Inability to sustain the Paediatrics service at Bassetlaw
- Failure to ensure adequate medical records system
- Failure to engage with patients around the quality of care and proposed service changes
- Failure to improve staff morale
- Failure to adequately prepare for CQC inspection
- Inability to meet Trust's needs for capital investment

- Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance

17/07/53 To ensure Board and its committees were sighted on all risks it was intended to bring the BAF and CRR on a monthly basis to F&P and QEC and on a quarterly basis to Board and ANCR for review and proposed changes. Both documents were in an evolutionary state and would develop as time progressed.

17/07/54 Board:

(1) NOTED the Corporate Risk Register.

(2) APPROVED the Board Assurance Framework Q1.

Reports for Information

17/07/55 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Committee Annual Report
- Financial Oversight Committee minutes, 23 June 2017
- Minutes of Audit and Non-Clinical Governance Committee on 24 March and 26 and 30 May 2017
- Board of Directors' Calendar

17/07/56 The Chief Executive fed back on two items included within his report. Following the nationally mandated work undertaken to check fire safety compliance of NHS buildings, no suspect cladding was found to be at Montagu Hospital. However, some issues had been raised with regard to the Rehabilitation Centre and this had resulted in a requirement for remedial work that included reducing the bed base until complete. Further refurbishment work was planned utilising the Fred and Ann Green Legacy to develop a Centre of Excellence.

17/07/57 Earlier that day, the Chief Executive and Chief Operating Officer had attended Nottinghamshire County Council's overview and scrutiny committee to update them on staffing within Paediatrics at Bassetlaw Hospital. There was a helpful discussion around what changes constituted a substantial variation. Staffing continued to be an issue. Despite the recent recruitment drive all but one had given back word and a further nurse had resigned leaving one less than currently the case. The Chief Executive and Chief Operating Officer would be attending scrutiny again in October to discuss options. An update was provided in relation to a recent serious incident and the need for critically ill children to be cared for safely

and appropriately.

Items escalated from Sub-Committees

17/07/58 None.

Minutes

17/07/59 The minutes of the meeting of the Board of Directors on 27 June 2017 were APPROVED as a correct record.

Any other business

17/07/60 There was no other business considered.

Governors questions regarding business of the meeting

17/07/61 There were no governors present at the meeting.

Date and time of next meeting

17/07/62 9.00am on Tuesday 29 August 2017 in the Boardroom, Bassetlaw Hospital.

Exclusion of Press and Public

17/07/63 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