Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday 31 January 2017 at 9 a.m.
in the Boardroom, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures
1.	Apologies for absence	(Verbal)
2.	Register of Directors' Interests and 'Fit and Proper Person' Declarations	Enclosure A
3.	To approve the Minutes of the meeting held on 20 December 2016	Enclosure B
4.	Actions from the previous minutes	Enclosure C
5.	Matters Arising	(Verbal)
6.	Chair's Report Suzy Brain England – Chair	Enclosure D
7.	Chief Executive's Report and Progress against Quarter 3 Objectives Richard Parker – Acting Chief Executive	Enclosure E (objectives to follow)

Reports for approval

8.	Hospital Pharmacy Transformation Plan David Purdue – Chief Operating Officer Andrew Barker – Care Group Director - Diagnostic and Pharmacy	Enclosure F
9.	Well Led Governance Review Suzy Brain England - Chair Richard Parker – Acting Chief Executive Matthew Kane – Trust Board Secretary	Enclosure G
10.	Approved Procedural Documents (APDs) Development and Management Policy Richard Parker – Acting Chief Executive	Enclosure H

11. Modernising Board Meetings — Enclosure I
Matthew Kane – Trust Board Secretary

12. Use of Trust Seal — Enclosure J
Matthew Kane – Trust Board Secretary

Reports for assurance

13. Strategy & Improvement Report — Enclosure K
Dawn Jarvis – Director of Strategy & Improvement

14. Finance Report as at 31 December 2016 — Enclosure L
Jon Sargeant – Director of Finance

15. Business Intelligence Report as at 31 December 2016 — Enclosure M
David Purdue – Chief Operating Officer
Sewa Singh – Medical Director
Moira Hardy – Acting Director of Nursing, Midwifery & Quality
Karen Barnard – Director of People & Organisational Development

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

17. People and Organisational Development Quarterly Review — Enclosure O
Karen Barnard – Director of People & Organisational Development

18. Junior Doctors Safe Working Hours Quarterly Report — Enclosure P
Karen Barnard – Director of People and Organisational Development

19. Complaints, Compliments, Concerns and Comments Quarterly Report — Enclosure Q
Moira Hardy – Acting Director of Nursing, Midwifery & Quality

Reports for information

20. Minutes of the Financial Oversight Committee held on 19 December 2016 — Enclosure R
John Parker – Non-Executive Director

21. Report on Clinical Governance Oversight Committee and Committee self-assessment workshop, 16 January 2017 — (Verbal)
Martin McAreavey – Non-Executive Director

22. Minutes of Management Board held on 5 December 2016 — Enclosure S
Richard Parker – Acting Chief Executive

23. Health & Well Being Board Decision Summary – 12 January 2017 — Enclosure T
Richard Parker – Acting Chief Executive

24. STP Collaborative Partnership Board – November and December minutes — Enclosure U
Richard Parker – Acting Chief Executive

25. Items escalated from sub-committees

26. To note: Enclosure V

Board of Directors Agenda Calendars
Matthew Kane – Trust Board Secretary

27. Any other business

28. Governor questions regarding the business of the meeting

29. Date and time of next meeting

Date: 28 February 2017
Time: 2.30pm
Venue: Boardroom, Bassetlaw Hospital

Suzy Brain England
Chair of the Board

25 January 2017

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Register of Directors' Interests and 'Fit and 'Proper Person' Declarations

Register of Interests

Alan Armstrong
Director, Armstrong Logic Limited (consultancy)

David Crowe, Non-Executive Director
Lay Member, Employment Tribunal Panel, Leeds
Member, Central Arbitration Committee
Trustee, Bransby Horses Ltd

Dawn Jarvis, Director of Strategy & Improvement
Assessor, Civil Service Fast Stream
Honorary Lecturer, Academic Unit of Medical Education, University of Sheffield

Martin McAreavey, Non-executive Director
Associate Professor, University of Leeds
Honorary Consultant, Public Health England

John Parker, Non-Executive Director
Senior Lecturer, Sheffield Hallam University
Partner, Aurelius Ltd

Mike Pinkerton, Chief Executive
Non-executive Director, NHS Litigation Authority
Trustee, Well Community Projects, Retford
Board representative for CEO South, Yorkshire & Humber Academic Health Science Network

Linn Phipps, Non-executive Director
Lay member, NICE (National Institute for Health and Clinical Excellence) Highly Specialised Technologies Evaluation Committee (HSTEC) and Indicator Advisory Committee (IAC)
Lay Member, Independent Reconfiguration Panel
Chair, NHS England Patient Online Programme Stakeholder Forum
Associate Lay Member, Leeds Teaching Hospitals NHS Trust
Patient and Public Voice Partner, NHS England Yorkshire and Humber SCOG (Specialised Commissioning Oversight Group)
Deputy Chair, Healthwatch Leeds & Health and Well-being representative on CCG Leeds South and East, GP Commissioning (Conflicts) Committee
Owner and Director, Ceist Consulting

Philippe Serna, Non-Executive Director
Spouse of director, Premier Care Direct Ltd (renal patient transport provider in Doncaster & Bassetlaw)

Sewa Singh, Medical Director
Director, Veincure Ltd (the company currently has no conflict of interest with the Trust)

(as at 20 January 2017)

The following have no relevant interests to declare:

Suzy Brain England	Chair of the Board
Karen Barnard	Director of People & Organisational Development
Moira Hardy	Acting Director of Nursing, Midwifery and Quality
Richard Parker	Acting Chief Executive
David Purdue	Chief Operating Officer
Jon Sargeant	Director of Finance

(as at 20 January 2017)

Fit and Proper Person Declarations

The Trust can confirm that every director currently in post has declared that they:

(i) are not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(ii) are not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(iii) are not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(iv) have not made a composition or arrangement with, or granted a trust deed for, their creditors and not been discharged in respect of it;

(v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

(vi) are not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;

(vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(viii) are able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

(x) are not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(xi) are not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment;

(xii) have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;

(xiii) have not been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals; and

(xiv) have not been dismissed from paid employment otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health.

Directors are requested to note the above and to declare any changes to their position as appropriate in order to keep their declaration up to date.

(as at 20 January 2017)

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Minutes of the meeting of the Board of Directors
Held on Tuesday 20 December 2016
In the Boardroom, Montagu Hospital

Present:	Chris Scholey	Chairman
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	David Crowe	Non-executive Director
	Martin McAreavey	Non-executive Director
	John Parker	Non-executive Director
	Richard Parker	Director of Nursing, Midwifery & Quality
	Mike Pinkerton	Chief Executive
	David Purdue	Chief Operating Officer
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	Mike Addenbrooke	Public Governor
	Yvonne Butcher	Staff Side
	David Cuckson	Public Governor
	Dev Das	Public Governor
	Matthew Kane	Trust Board Secretary
	Moira Hardy	Deputy Director of Nursing, Midwifery and Quality
	Linn Phipps	Non-executive Director (Observing)
	Marie Purdue	Deputy Director of Strategy and Improvement
	Emma Shaheen	Head of Communications and Engagement
	Clive Tattley	Partner Governor

ACTION

Welcome and apologies for absence

16/12/1 An apology for absence was presented on behalf of Dawn Jarvis. Linn Phipps, new non-executive director from 1 January 2017, was welcomed to the meeting in an observing capacity.

Register of directors' interests and 'Fit and Proper Person' declarations

16/12/2 No changes were noted.

Minutes of the meeting held on 29 November 2016

16/12/3 The minutes of the meeting of the Board of Directors held on 29 November 2016 were APPROVED as a correct record, with the following amendments:

16/12/4 16/11/10 – Add the words "it was expected" before "the name change".

16/12/5 16/11/45 – Delete the word "Interim" from "Director of Finance".

16/12/6 16/11/49 – Add the word "Interim" before "Deputy Director of Finance".

Actions from the previous minutes

16/12/7 The actions were noted and updated accordingly:

- Timescales for actions 2 and 4 to be changed to January 2017.
- Actions 7 and 9 to be removed.

Matters arising

16/12/8 There were no matters arising from the minutes.

Chair's correspondence

The Board considered a report of the Chair which outlined the following:

16/12/9 Working Together Partnership Meeting – Earlier in the month, the Chair attended the Working Together Partnership Chairs' and Chief Executives' meeting where the main discussion was around the proposed Committees in Common governance structure. It was also reported that progress was such to enable South Yorkshire and Bassetlaw to be amongst the first wave of Sustainability and Transformation Plan programmes.

16/12/10 Governor Timeout – Governors had enjoyed a successful timeout session on 12 December which had been very well attended. The Chair commended excellent presentations from Ken Anderson, Helen Houghton and Antonia Durham-Hall. Governors also took part in a workshop as part of the Well Led Governance (WLG) Review. The draft report from the WLG Review was now being quality assured and would be sent to the Trust within the forthcoming days.

16/12/11 The Timeout was followed by an extraordinary Board of Governors meeting that authorised the Trust's change of name and appointed the new non-executive directors, Linn Phipps (to take up post from 1 January 2017) and Neil Rhodes (from 1 April 2017).

16/12/12 Exchange visit – The Chair had recently met with a delegation from Xian, China who were looking for UK-based training partners. The Trust's Director of Education, Alasdair Strachan, was representing the Trust in Xian on 7 January 2017 to explore potential opportunities for Chinese doctors and nurses to train and work in the UK.

16/12/13 NHS Improvement – The Chief Executive had contacted NHSI recently to enquire about future meeting arrangements. The Chair reflected on the excellent work that the Executive Team had carried out over the past 14 months to alleviate the Trust's financial issues.

16/12/14 Walkabouts – The Chair had conducted a number of ward visits at the Trust's different hospital sites and there was overwhelming support for the Trust's name change, with nearly all staff seeing the benefits that becoming a Teaching Hospital should bring.

16/12/15 Future Board meetings – The January Board meeting had been moved from 24 to 31 January at 9am at Doncaster. The time of the February meeting had been moved to 2.30pm on 28 February at Bassetlaw.

16/12/16 Philippe Serna praised the work that the Trust was doing to forge partnerships with Chinese hospitals over training and believed there were many financial and reputational benefits to be taken from such work.

16/12/17 The Chair's correspondence was NOTED.

16/12/18 *Karen Barnard joined the meeting at this point in proceedings.*

Chief Executive's report

The Board considered a report of the Chief Executive which outlined the following:

16/12/19 Service performance – Board was advised that, although the Trust remained non-compliant on the four-hour wait target, it was performing well in comparison to other trusts but staff and stakeholders recognised the need, and opportunity, for continued improvement. Infection control issues that had constrained bed capacity on wards over recent weeks had eased.

16/12/20 New targets for mental health access in the ED setting were expected from NHS Improvement. The Chief Executive was confident that working in partnership with DBH and CCGs the responsible Trusts, RDASH and NNHC would be able to deliver in this area and access the funding which was being made available.

16/12/21 The Trust was fully prepared for the forthcoming Christmas holiday period with robust resilience arrangements in place. A Perfect Week had also been planned for the New Year period.

16/12/22 Finance – The Trust had been advised that details of the Sustainability and Transformation Financial Incentive Scheme had been released. Trusts who achieved better than their control total would be funded pound-for-pound with additional revenue to the value of the over-performance against the control total.

16/12/23 Based on current projections the Trust was likely to receive additional revenue support that would contribute to the year-end financial position.

16/12/24 Whilst welcoming the additional support, David Crowe expressed caution. If the support was not recurrent this risked the Trust presenting a backward trajectory in its financial position for 2017/18. Other members of the Board expressed similar reservations but generally felt that it represented external recognition of the Trust's achievements in reducing its deficit.

16/12/25 Strategy – Work was ongoing in relation to the consultations on Stroke and Children's Surgery and proposals were being developed to take forward the STP plans to which all trusts would contribute. In respect of the place plans, the Doncaster version was going through the Council's formal decision-making structure. There was no update on Bassetlaw's Plan.

16/12/26 Within the Working Together Partnership, Andrea Smith had been appointed interim Director of Procurement for Sheffield Teaching Hospitals and Sheffield Children's Hospital, whist remaining permanent Director at DBH.

16/12/27 Work was continuing with local CCGs and NHS England to negotiate and conclude contracts or heads of terms by 23 December. The contract had a number of new provisions, one of the most significant being electronic referrals from primary care by 2018.

16/12/28 Learning, Candour and Accountability Report – The CQC had published a report into the way in which trusts review and investigate deaths of patients in England. Amongst its recommendations were requirements to appoint a board-level leader for patient safety as well as a non-executive director to take oversight of progress.

16/12/29 Whilst welcoming the announcement and positive impact the report would have on improving patient safety, David Crowe and Alan Armstrong emphasised concern over the public relations implications in view of the report's statement that there was not a trust nationally that exhibited all aspects of the correct approach to mortality.

16/12/30 The Medical Director advised that the Trust had been at the forefront of the Yorkshire and Humber AHSN mortality review programme and had been held up as an exemplar for introducing structured mortality reviews.

16/12/31 Governance Review – The draft report from the Deloitte review was expected imminently. Further information had been provided in respect of data quality following discussions with CHKS who had ranked the Trust within the top 40 trusts nationally for overall performance.

16/12/32 Hospital IT Infrastructure – ICT had completed the replacement of its network components and datacentre services without recourse to major periods of downtime. The final element of the upgrade, the new wireless network, was due to be completed by summer 2017. Total cost was around £3.5m which compared well against other trusts.

16/12/33 In response to a question from John Parker, the Board was advised that work was being undertaken to develop the Trust's patient wi-fi solution. The Director of Nursing, Quality and Midwifery advised of opportunities to integrate use of wi-fi in exchange for patient feedback. Martin McAreavey agreed to pass through details of the EduRoam solution. **MM**

16/12/34 Staffing – Simon Marsh was now Senior Information Risk Owner (SIRO). Will Cleary-Gray had been appointed Director of Sustainability and Transformation for the South Yorkshire and Bassetlaw STP. The Trust had received the silver award for Staff Wellbeing at Work from Notts County Council. The Strategy and Improvement Team had won Yorkshire and Humber NHS Leadership Academy's Outstanding Achievement Award and Laura Cliffe and Gill Pickersgill from Communications and Engagement had received special recognition for their work as health champions.

16/12/35 The Chief Executive's report was NOTED.

Strategy & Improvement Report

16/12/36 The Board considered a report of the Director of Strategy and Improvement that included updates on CIP progress, recovery, financial sustainability plans and the strategic planning process.

16/12/37 The report highlighted that savings in month 8 were £1.003m, £177k behind plan and £305k behind the stretch plan. Total CIPs planned for 2016/17 were £11m with internal stretch targets of £13m. Forecast outturn was now £11.433m, a decrease since month 1 of £982k and month 7 of £247k.

16/12/38 This was the first month in 2016/17 the Trust had fallen behind both its plan and stretch target although the Trust was still ahead of plan year-to-date. Some work-streams had not delivered as much as predicted in the current year and some savings targets would be realised in 2017/18.

16/12/39 John Parker reported on the previous day's meeting of Financial Oversight Committee where presentations had been given on medical productivity and estates work-streams. The senior responsible officer for estates would come back to the Committee in three months' time to provide an update.

16/12/40 Non-executives reported that potential savings associated with the Hospital Sterilisation and Decontamination Unit would not be realised as previously advised and soft market testing had, in fact, assumed an additional £900k outlay.

16/12/41 There was a brief discussion around the accuracy of the projected costs reported to the Committee. The Director of Nursing, Midwifery and Quality believed that reported figures were an estimate and definite costs would not be known until detailed work had taken place. In view of recent churn within the estates team, and to avoid possible future issues regarding the accuracy of information given to Financial Oversight Committee, it was felt that the attendance of the Director of Nursing, Midwifery and Quality at future meetings where estates matters were under consideration would be beneficial.

16/12/42 David Crowe, whilst not subtracting from the good work that had taken place, noted that the forecast outturn had reduced from £11.7m in month 7 to £11.433 in month 8. Explanations for the reduction were provided.

16/12/43 Philippe Serna highlighted issues with regard to the management of the new catering contract that could see patient and commercial work split and potential logistical issues arise from the two operating on the same premises.

16/12/44 In response to a question from Martin McAreavey, the Board was advised that all work-streams were risk assessed and further information could be shared if necessary.

16/12/45 The Strategy and Improvement Report was NOTED.

Two Year Operational Plan

16/12/46 The Board considered a joint report of the Directors of Finance and Strategy and Improvement that presented the Trust's financial plans for the forthcoming two years.

16/12/47 Control totals were £16.1m for 2017/18 and £11.4m for 2018/19. The Board was advised that because of the Trust's performance in 2016/17 and its acceptance of its year one control total it was able to identify the expected control total for 2018/19. This may be subject to revision at a later date.

16/12/48 The Director of Finance set out the key issues, changes and areas that were subject to ongoing negotiation. It was noted that Doncaster CCG had highlighted approximately £4m of QIPP cost improvement measures while Bassetlaw CCG were seeking £1.5m.

16/12/49 Activity growth areas within the plan were around orthopaedics and urology. The Trust's portion of activity growth would be approximately 80%. It was anticipated that contracts would be signed off by the end of the week.

16/12/50 The Board:

(1) APPROVED the Plan subject to any changes authorised by the Director of Finance and agreed its submission to NHSI by the deadline of 23 December 2016. **JS**

(2) NOTED that the final plans for 2017/18 and 2018/19 were in line with the control totals of a £16.1m deficit in 2017/18 and a deficit of £11.4m in 2018/19. (This is after receiving S&T funding of £11.5m in both years.)

(3) NOTED the contingency had reduced significantly due to adjustments required to the final plan and was consistent with the feedback from NHSI on the draft plan. The contingency had reduced from £5.5m to £1.3m in 2017/18 and from £1.4m to £0.4m in 2018/19.

(4) NOTED the sensitivity analysis identified more downside risks which totalled £12.2m compared to only £4.3m of upside opportunities. The key risks were the deliverability of QIPP schemes, contracting assumptions, delivery of CIP and control of cost pressures.

Update on Consultation on Hyper Acute Stroke and Children's Surgical Services

16/12/51 The Board considered a presentation of the Chief Operating Officer which advised on the proposals for the future of hyper acute stroke and children's surgical services across the Working Together footprint area and sought Board's views.

16/12/52 Hyper acute stroke services were currently provided within six key centres across the area including Doncaster. However, only a maximum of three centres met the service specifications of receiving more than 600 strokes per year, both now and in the future. Doncaster currently dealt with 677 strokes per year. The upper limit number of stroke patients a stroke unit should plan for in a year was approximately 1,200.

16/12/53 The proposal was to improve outcomes by reducing the number of specialised hyper acute stroke units (HASUs). Doncaster featured in all of the options under consideration whilst Rotherham featured in none. The preferred option (Option 3) and current modelling indicated that approximately 1,200 patients would come to Doncaster under the proposals.

16/12/54 Under option 3, the main impact for Doncaster would be the transfer of patients from Barnsley and Rotherham. The hyper acute stroke phase was defined as the first three days after the stroke event. After this time, patients would be repatriated to their local hospital for the remainder of their care.

16/12/55 The consultation would end on 20 January 2017 with the service planned to begin from September. However, it was recognised that once a decision was taken to move forward with a particular option, changes were likely to evolve immediately.

16/12/56 With respect to children's surgery requiring overnight stay, there were three options with the preferred being Option 2, for children to be directed to Doncaster, Pinderfields (Wakefield) and Sheffield Children's Hospital. This meant that Barnsley, Rotherham and Chesterfield Hospitals would not continue to provide in-patient children's surgery.

16/12/57 It was felt that this option would give all patients in South and Mid Yorkshire, Bassetlaw and North Derbyshire access to the same quality and standard of children's surgery services. It was noted that general surgery was not currently performed at Doncaster for children under 10 years of age and surgeons would need to come from Sheffield Children's Hospital to do the work.

16/12/58 The two proposals were discussed. John Parker expressed concerns that the Trust was likely to breach best practice capacity for the number of stroke patients it should take. Further areas highlighted by the Chief Operating Officer for more consideration were around Ambulance Service pathways, additional capital expenditure for CT scanning and the management and repatriation of patients exhibiting 'stroke mimic' conditions.

16/12/59 The Chair meanwhile highlighted the patient experience risks, particularly in relation to end of life cases where family may find it difficult due to the need to travel longer distances. David Crowe registered his concerns with regard to the lack of clarity around payment and the impact additional cases would have on the Trust's finances and performance/reputation.

16/12/60 The Chief Executive emphasised the feasibility of the proposals in view of the Trust's successful integration of stroke services from Bassetlaw into Doncaster and advised that future proposals would require close partnership working. The importance of assisting Barnsley and Rotherham was emphasised.

16/12/61 The Chief Operating Officer undertook to keep the Board updated on progress of both consultations. An update on Paediatric services at Bassetlaw was provided. Due to unavoidable staffing shortfalls, the number of beds had been reduced and overnight admissions had been suspended in order to ensure patient safety. The Chief Operating Officer **DP**

advised of proposed future arrangements that would ensure safer and improved services.

16/12/62 The Board NOTED the presentation on the future of hyper acute stroke and children's surgical services.

Finance Report as at 30 November 2016

16/12/63 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 8 2016/17.

16/12/64 The Board was advised that in month 8 the Trust made a loss of £1.4m, which was 58k better than plan. Cumulative deficit to M8 was £11.5m against a plan of £16m. Current estimates suggested the end-of-year forecast deficit lay between £17-17.5m. The impact of the Sustainability and Transformation incentive funding was likely to reduce this to approximately £10m.

16/12/65 Key points from the report included:

- Recovery of funds from elective work, particularly Orthopaedics, had yet to happen and the Chef Operating Officer had requested further details.
- Nursing pay spend on agency had risen due to impact from Norovirus but had since reduced in December.
- Medical agency spend had reduced in the month and would be monitored over time.
- There was no requirement to drawdown cash in November. Purchase processes were being worked on to ensure invoices had been properly recorded.

16/12/66 Further to a question from Alan Armstrong in respect of CNST contribution, the Board was advised that the figure was favourable due to an additional discount of £350k negotiated by the previous Interim Director of Finance consequent to the improved risk profile of the Trust. Further discounts were being explored.

16/12/67 The Finance Report was NOTED.

16/12/68 *The meeting adjourned at 11.05am and reconvened at 11.15am.*

Business Intelligence Report as at 30 November 2016

16/12/69 The Board considered a report of the Chief Operating Officer, Medical Director, Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and workforce performance in month 8.

16/12/70 The Trust had achieved a rate of 90.7% of patients being seen within the standard four-hour access time giving a year-to-date performance of 92.85%. Doncaster had achieved 87.85% (rising to 89.72% if Montagu was included) and Bassetlaw 93.04%. Despite pressures, the Trust continued to perform in the top quartile. Ambulance handover times continued to be the best in South Yorkshire.

16/12/71 Referral to Treatment ended the month having achieved 91.1% performance against a 92% target. It was noted the 92% target was against incomplete pathways and fines had been lifted for 2016/17. Issues in dermatology and general surgery had persisted due to staff sickness.

16/12/72 Diagnostic wait performance stood at 99.4% against a target of 99%. The 62-day cancer pathway had not achieved its target of 85%, standing at 81% in the month.

16/12/73 Further to a question from David Crowe in respect of the move to new staffing providers, the Board was advised that meetings were taking place with them on a weekly basis to iron out any issues. Staff provided were of a good calibre and issues relating to fill rate were being addressed.

16/12/74 John Parker reflected on a positive recent visit to Bassetlaw's A&E but expressed concern about patients' experience when the department was under severe pressure. The Board was advised that although some patients had not been able to be accommodated in cubicles during this extremely busy period this was not the norm. The Chair requested further information on the current situation with regard to waits for cubicles and the waiting times for patients moving from Bassetlaw to Doncaster. **DP**

16/12/75 The Trust's rolling 12 month Hospital Standardised Mortality Rate to the end of November 2016 stood at 94.4 and remained better than expected.

16/12/76 Best practice tariff in respect of fracture neck of femur was achieved in 80% of cases due to better access to theatre but the mortality from fracture neck of femur was reported to have increased. Board were provided with greater detail on the increase in fracture neck of femur mortality providing assurance that there was no cause for concern. The Trust remained on trajectory to deliver a significant decrease in serious incidents at year end.

16/12/77 In relation to safety and quality, performance in respect of pressure ulcers, C. Diff and falls continued to be ahead of trajectory and better than last year. Response rates to complaints were in line with previous performance standards and actions were in place to address the issues identified.

16/12/78 Further to a question from Martin McAreavey, the Board was advised of initiatives the Trust had trialled to drive up Friends and Family response rates.

16/12/79 In response to a question from Alan Armstrong, the Board was advised that the restructure of the complaints function was almost complete. A new set of performance standards for different types of complaints were being prepared and tested. Work had been undertaken to reduce the number of formal complaints by, for example, dealing with more issues face-to-face.

16/12/80 In relation to workforce, sickness absence in November 2016 had risen to 4.82% after three months of falling figures, resulting in year-to-date performance of 4.50%. A deep-dive into the reasons for increasing sickness absence was being undertaken. Appraisal compliance rates saw a small increase to 64.51% and SET compliance had risen to 65.37%. **KB**

16/12/81 The Business Intelligence report was NOTED.

Nursing Workforce Report

16/12/82 The Board considered a report of the Director of Nursing, Midwifery and Quality which provided detailed information relating to the nursing workforce, highlighting issues which could impact on the Trust's ability to provide appropriate staffing levels and skill mixes.

16/12/83 The overall planned versus actual hours worked in November 2016 was 99%, an increase of 1% since October. Care Hours Per Patient Day stood at 7.2 across the Trust, down 0.1 from October. Use of agency staff in November stood at 1.11%, a decrease on October and well within the 3% cap.

16/12/84 Details of the quality and safety profile were provided in the report. Respiratory wards continued to trigger red. The action plan produced following the quality summit continued to be monitored. The skill mix had also been reviewed with some external appointments made. Further overseas recruitment opportunities were being explored.

16/12/85 The report in respect of Nursing Workforce was NOTED.

Use of Trust Seal

16/12/86 The Board NOTED use of the Trust Seal on 14 December 2016 in respect of a deed of variation of lease for part of facilities at Montagu and Bassetlaw Hospitals.

WTP Governance - Committees in Common

16/12/87 The Board considered a report of the Trust Board Secretary that sought support to adopt a 'committees in common' model of governance for the Working Together Partnership vanguard.

16/12/88 The arrangements would involve each trust establishing a committee of the Board and appointing to it the Chair and Chief Executive. The committee of each trust would meet in common with the other committees in the Partnership so that seven meetings were held together at the same time. Each committee could only make a decision in relation to its own provider therefore each Trust retained organisational sovereignty. A key point was that the individual committee decisions would be binding on the respective trusts.

16/12/89 A further report setting out the proposed delegations would be brought to Board in March before the new model became operative from 3 April 2017.

16/12/90 The move to a committees in common structure for the WTP Acute Federation under the terms set out in the report was APPROVED in principle subject to further discussion on the following matters: **MP**

- Provision for Governor observers' at meetings.
- Issues around combining executive and non-executive power into a committee of the Board.
- Provision for the committee to rescind and revisit decisions it had previously made.
- The wide-ranging extent of the delegations from the Board.

Change of Trust Name

16/12/91 Board considered a report of the Chief Executive, Director of Education and Trust Board Secretary that sought approval to amend the Constitution to change the Trust's name to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

16/12/92 Following the receipt of official letters of recognition from the University of Sheffield and Sheffield Hallam University, the Board of Directors on 25 October 2016 had approved a four-week consultation period to change the Trust's name.

16/12/93 The consultation took place 14 November to 11 December 2016 and included an article in *Foundations for Health Magazine*, items on the Trust's website and Facebook and Twitter pages and letters to CCGs, other trusts and foundation trusts in the area, local authorities and MPs amongst other stakeholders. The process yielded 156 positive responses, as well as three negative and three neutral responses.

16/12/94 Whilst NHS Improvement no longer had a formal role in approving name changes for foundation trusts, the Trust was required to follow the NHS Naming Principles and Department of Health Brand Guidelines.

16/12/95 The key constitutional and practical implications were set out in the report. The cost of the change would be approximately £5-10k. There was no immediate requirement to change logos, stationery or contracts so this would be carried out on a phased basis.

16/12/96 The Board:

1. NOTED the consultation feedback in the report.

2. APPROVED the name change to *Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust* with immediate effect.

3. APPROVED an amendment to the Trust Constitution to reflect the change of name, in compliance with Schedule 7 of the NHS Act 2006. **MK**

4. DELEGATED power to the Chief Executive to undertake whatever work was required to facilitate the change, in compliance with relevant legislation and NHS Brand Guidelines.

Minutes of Financial Oversight Committee on 7 November 2016

16/12/97 The minutes of Financial Oversight Committee held on 7 November 2016 were NOTED.

Update from the Audit and Non-clinical Risk Committee on 16 December 2016

16/12/98 Philippe Serna reported back on the recent meeting of the Audit and Non-clinical Risk Committee where they addressed historic audit points in respect to IM&T, considered a recent medicines management audit and received an update on the work of Trust's external auditors.

16/12/99 A corporate risk was escalated on cyber security and a request to approve a delay on the audit of the estates strategy was not approved in view of uncertainty around capital investment in clinical areas. A way forward was identified involving the audit being undertaken in two parts – the first around current estates operations to support service delivery and the other following the completion of the estates strategy. The Chief Executive agreed to address this as part of a review of the audit of estates terms of reference. **MP**

16/12/100 The update from the Audit and Non-clinical Risk Committee on 16 December 2016 were NOTED.

Items escalated from Sub-Committees

16/12/101 No items were escalated from sub-committees.

Board of Directors Agenda and Board Brief Calendars

16/12/102 The Board of Directors agenda and Board Brief calendars were NOTED.

Any other business

16/12/103 There were no items of other business.

Governors questions regarding business of the meeting

16/12/104 Mike Addenbrooke asked whether cancelled operations performance included figures from Park Hill and whether figures for those who had not waited were available. Board was advised that data for cancelled operations related purely to the Trust and that 'did not wait' figures were still being worked on. Further to an additional question from Mike Addenbrooke regarding volunteer workers on Bassetlaw's reception being eligible for a concessionary parking pass, the Deputy Director for Strategy and Improvement agreed to follow up with General Office. **MPu**

16/12/105 Dev Das asked whether the reducing contingency funds shown in the Two Year Plan was of concern. The Board was advised that contingency had not reduced but was now ear-marked against specific areas rather than being a generic pot of funding.

16/12/106 Clive Tattley asked about the robustness of studies that a four-hour timescale was sufficient in which to treat stroke patients. The Board was advised that the four hours was maximum time for thrombolysis in which to limit the disability that may be suffered. Staffing to deliver this service across the NHS was a challenge so consolidation of the service as part of the STP arrangements would lead to better patient outcomes. It was noted that stroke services in London were operated across only four main sites.

16/12/107 In respect of a further question from Clive Tattley about the recruitment benefits of Teaching Hospital status, the Board was advised that whilst the number of medical students was increasing medical staffing remained a challenge across the NHS.

16/12/108 David Cuckson asked whether sickness absence figures were based on hours or staff. Board was advised that it related to number of hours. He also suggested that Governors might play a role in conducting the Friends and Family Test. The Trust Board Secretary undertook to place an item about this on a forthcoming Timeout session. **MK**

Date and time of next meeting

16/12/109 9am on Tuesday 31 January 2017 in the Boardroom, Doncaster Royal Infirmary.

16/12/110 Finally, as this was his last meeting, the Chair reflected on his time in office and the achievements of the Trust over the past eight years. He paid tribute to Mike Pinkerton, retiring Chief Executive, particularly his work on research and development, his focus on quality and the achievement of Teaching Hospital status. The Board showed its appreciation for Mike Pinkerton, Chief Executive.

16/12/111 In return, the Chief Executive thanked the Chair, on behalf of the Trust, for his work over the past eight years in particular for leading the Board's focus on quality of care and continuous improvement, his development and visibility of the Board and its positive relationship with Governors and the manner in which he had brought the Board together and stayed resolute during difficult times. The Board showed its appreciation for Chris Scholey, Trust Chair.

Suzy Brain England **Date**
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 20 December 2016

Location: Boardroom, Montagu

Attendees: CS, AA, DC, JC, KB, MM, MP, DP, SS, JP, RP, PS

Apologies: DJ

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**16/7/62**	In relation to follow-up ratios, the Financial Oversight Committee to explore the CIPs in place for urology, cardiology and diabetes.	**DP**	**Ongoing**	Plans in place as part of SDIP and OPD workstream.
2.	**16/7/75**	A discussion on staff engagement be brought to a future Board Brief.	**KB**	**February 2017**	Item on February draft agenda, to include latest staff survey information.
3.	**16/10/13**	Ophthalmology Department post-implementation review to be undertaken.	**DP**	**May 2017**	Action not yet due.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**16/10/22 (b)**	A review of the Intermediate Health and Social Care Review to be brought to a future Board Brief.	**DP**	**February/March 2017**	Action not yet due.
5.	**16/10/59**	A report setting out the steps being taken to address the issues identified with purchase orders to be brought to Financial Oversight Committee.	**JS**	**December 2016**	Action complete, considered at Committee in December.
6.	**16/11/57**	Update to be provided to Board on numbers of patients attending from out of area.	**DP**	**January 2017**	Action complete. Email sent to Board on 25 January 2017.
7.	**16/11/59**	Impact of not meeting best practice tariffs for clinical standards to be provided.	**JS**	**January 2017**	Update to be given at Board meeting.
8.	**16/12/33**	Martin McAreavey to pass through details of an EduRoam solution for students on Trust premises.	**MM**	**January 2017**	Action complete, EduRoam is part of Trust plans.
9.	**16/12/50**	Operational Plan to be submitted to NHSI by 23 December 2016.	**JS**	**23 December 2016**	Action complete.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
10.	**16/12/51**	Board to be updated on consultation regarding future of hyper acute stroke and children's services.	**DP**	**January 2017**	Action complete, item taken to Board Brief on 16 January.
11.	**16/12/74**	Update on waits for cubicles and the waiting times for patients moving from Bassetlaw to Doncaster to be provided.	**DP**	**January 2017**	Waits in Majors at BDGH, escalation process refreshed to ensure external support given to the department. Reviewed at four times daily operational meeting. Inter-hospital transport now increased with private provider. Review of IHT policy being undertaken with EMAS.
12.	**16/12/80**	Deep-dive to be undertaken into the reasons for increased sickness absence.	**KB**	**January 2017**	Action complete, details in this month's People and OD report.
13.	**16/12/90**	CEO to report into WTP points raised at Board relating to committees in common.	**MP/RP**	**January 2017**	Action complete, discussed at WTP meeting and WTP Coordinator sent Board minute extract detailing discussion from January's Board meeting.
14.	**16/12/96**	MK to update constitution in light of Teaching Hospital status.	**MK**	**23 December 2016**	Action complete, just awaiting permission to upload on to DBTH website and NHSI directory.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
15.	**16/12/99**	Terms of reference for audit of estates to be reviewed.	**MP**	**February 2017**	Action not yet due.
16.	**16/12/107**	An item regarding how governors can get involved in undertaking F&F to be placed on an upcoming Timeout.	**MK**	**March 2017**	Item is being considered for upcoming Timeout.
17.	**16/12/104**	Assurance to be obtained that volunteer workers on Bassetlaw's reception have received concessionary parking passes.	**MPu/DJ**	**January 2017**	Action complete.

Date of next meeting: 31 January 2017
Action notes prepared by: M Kane
Dated: 6 January 2017
Circulation: CS, AA, KB, JC, DC, DJ, MM, JP, MP, DP, SS, RP, PS

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's Report**		
Report to:	**Board of Directors** **Board of Governors**	Date:	**31 January 2017**
Author:	**Suzy Brain England, Chair of the Board**		
For:	**Noting**		

Purpose of Paper: Executive Summary containing key messages and issues

The report sets out the Chair's activities since commencing in post on 1 January 2017 relating to:

- Chair's induction
- Appointment of Chief Executive
- Non-executive directors
- Well Led Governance Review
- CCG meetings
- STP
- NHSI Northern Chairs' meeting

Recommendation

That the Chair's report be noted.

Related Strategic Objectives

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

Analysis of risks

None, report is for information only.

Chair's Report – January 2017

Since commencing on 1 January, I have been busy meeting with people from across the Trust including Board members, care group directors and other senior staff and partners in Working Together, the STP, Bassetlaw CCG and the Northern NHS Chairs. I have been pleased and impressed by the energy and commitment of staff so far towards providing top quality care for patients.

I am looking forward to meeting all Governors at our formal meeting. I was pleased to work alongside George Webb, Mike Addenbrooke, Ruth Allarton and Roy Underwood in the selection of the new non-executives. They will also be supporting the process for the recruitment of a new Chief Executive later this month, along with Clive Tattley. I hope to meet other governors at the Teaching Hospital launch on January 27th.

Appointment of Chief Executive

I hope that Mike Pinkerton will be given a fantastic send off on his last working day at the Trust on 27 January. Mike has been asset to DBH and has much to be proud of during his four years as Chief Executive. He has led our elevation to put the Trust in the top 20% of performers for quality measures, being shortlisted for HSJ's chief executive of the year in 2015 and transforming the research and development culture across the Trust. What a fitting send-off that his last day will coincide with our launch as a Teaching Hospital. We wish him many best wishes.

Interviews for Mike's replacement are taking place on 30 January 2017. Over the past three months since Mike announced his departure I have met with a number of candidates and have been grateful to the Trust and NHS Leadership Academy for their support during this process. A recommendation on the appointment of a new Chief Executive will be considered by the non-executives before the appointment is approved by Governors on 31 January. In the meantime, I am looking forward to working alongside Richard Parker as our Acting CEO. I would like to welcome Moira Hardy, Acting Director of Nursing, Midwifery and Quality to the Board Team for that interim period.

Non-executive Directors

I was grateful to Governors who met on 12 December to approve the appointment of Linn Phipps and Neil Rhodes as new non-executives whom I welcomed on 9 January. Linn started on 1 January and Neil starts officially from 1 April however I have agreed that, as part of his induction, Neil will start participating in Board and committee meetings from 1 February.

This earlier start date will enable Neil to contribute to the work on the strategic vision of the Trust and begin attending Financial Oversight Committee where, subject to approval by Board of Directors, he will replace David Crowe as a member and John Parker as Chair from April. It will also be recommended that Linn Phipps replace David Crowe on the Audit and Non-clinical Risk Committee. Linn has also accepted a standing invitation to the Patient Experience Committee where there has been a gap since Geraldine Broderick's departure.

John has also confirmed that he will step down from his position as Deputy Chair at the end of the financial year and will not seek reappointment in 2018 when his term as a NED finishes. I am grateful to John for supporting me until then and look forward to working with him over the next 14 months.

Well Led Governance Review

Deloitte have completed the external review of the Trust's governance arrangements and a report at January's Board of Directors proposes the formation of a working group that will take forward the recommendations in the form of an action plan as well as draft the management response. A representative from the Deloitte review team will be coming to the next Board of Governors' on 27 April 2017 to present the findings and, by that point, we will be able to report on progress against the action plan.

Clinical Commissioning Group meetings

Partnership working is essential to delivering the future vision for the NHS so I was keen to make an early appearance, alongside the Acting Chief Executive, at Bassetlaw CCG's Governing Body, who themselves are undergoing a period of leadership renewal. I plan to attend and meet the leadership team at Doncaster CCG in February.

In the past the Trust has asked non-executive and executive directors to share attendance at CCG meetings. In the future we will recommend attendance as part of directors' induction process, and work with our leadership team to offer attendance to deputies and other senior staff as part of their development. As this unfolds, I am keen to reinforce the process for reporting back into Board.

Sustainability and Transformation Partnership

I attended my first meeting of the Working Together Partnership Chairs and Chief Executives on 9 January to hear more about the Acute Federation's purpose, vision, governance and work plan. Sir Andrew Cash also provided an update on the Sustainable Hospital Services Review and Commissioner Review. As a region that has worked well across organisational boundaries, we are hopeful to be in the first wave of any central support that might become available. The way forward is likely to support the place plans developed for Doncaster and Bassetlaw.

North Chairs' Networking Event

Finally, I attended the NHS Improvement Northern Chairs' networking event on 19 January which included presentations on operational productivity and pathology consolidation. NHSI sees itself as an organisation that wishes to help Trusts achieve their objectives and performance standards. The national productivity work follows the Carter Review and through an IT Portal called The Model Hospital will seek to offer Trusts shared purchasing power and benchmarking data which we can learn from.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chief Executive's Report**		
Report to:	**Board of Directors**	Date:	**31st January 2017**
Author:	**Mike Pinkerton, Chief Executive**		
For:	**Information / Triangulation**		

Purpose of Paper: Executive Summary containing key messages and issues

Standing item setting out information the Chief Executive wishes the Board to be aware of, including key risks and exceptions. The report briefs on the following areas:

- Service Performance Overview
- Finance Performance Overview
- Reference Costs Index Update
- Contracts
- Corporate Objectives
- Strategy
- Commissioning Review
- Working Together
- National Emergency Laparotomy Audit (NELA)
- Paediatric Services Bassetlaw
- Award of JAG Accreditation
- Allied Health Professionals
- Staff & Appointments

Recommendation(s)

The Board is asked to RECEIVE and NOTE the report

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

We always put the patient first
- *By keeping a focus on quality whilst we tackle financial problems*

Everyone counts - we treat each other with courtesy, honesty, respect and dignity
- *By openly and honestly discussing with staff our quality, outcomes and financial position*

Committed to quality and continuously improving patient experience
- *By improving key measure of patient safety*

Always caring and compassionate
- *By focusing on improving the experience of our patients*

Responsible and accountable for our actions – taking pride in our work
- *By working openly with regulators and partners to improve financial governance*

Encouraging and valuing our diverse staff and rewarding ability and innovation
- *By recognising staff efforts through local and national awards*

Related Strategic Objectives

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

Analysis of risks

a. Resource
b. Governance
c. PR & Communications
d. Patient, Public & Member Involvement
e. NHS Constitution

Board Assurance Framework

This report relates to the Strategic Direction as a whole, therefore all risks in the Board Assurance Framework are relevant in addition to the specific ones listed below.

1	Failure to achieve compliance with financial performance aspects of the Monitor Risk Assessment Framework and provider licence, triggering regulatory action	5	4	20
2	Failure to deliver accurate financial reporting underpinned by effective financial governance	4	4	16
3	Failure to deliver financial plan	4	4	16
4	Failure to deliver Cost Improvement Plans	3	5	15
5	Failure to deliver turnaround / cost reduction programme.	3	5	15
8	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	4	4	16
9	Failure to achieve compliance with performance and delivery aspects of Monitor Risk Assessment Framework, CQC and other regulatory standards, triggering regulatory action	4	4	16
10	Failure to sustain a viable specialist and non-specialist range of services.	3	4	12
12	Breakdown of relationship with key partners and stakeholders.	3	4	12

Service Performance Overview

The business intelligence report was not available at the time of writing. The key challenge to the Trust and its partners at this point in the year is winter pressures. The Trust has remained relatively resilient to the demands placed on it, remaining at or around 30th lowest four hour waiting times in the country. Aspects that have challenged waiting times have been the ability to source doctors for ED rotas in particular given the high seasonal demand from multiple employers for agency staff, the impacts of norovirus and then influenza and very high numbers of ambulance patients, often with high acuity patients. Patient flow has been actively managed using high impact interventions such as the Perfect Week and continuing use of good practice measures in part drawn and/or validated from the regional A&E Improvement Programme sponsored by NHSI. However, this has also remained a significant challenge at peak periods. I would like the Board to thank all our staff associated with our emergency services and site teams for their magnificent efforts in maintaining safe access and treatment for patients during this time.

Finance Performance Overview

At the time of writing the M9 finance report was not available however the Board has been briefed on the consolidated and organisation wide validation of the forecast outturn, which is now projected at 17.4M deficit. NHSI have also been briefed on this position, which while a deterioration form earlier forecasts at M4 and beyond indicating a better figure of - 16M, represents a significant advance on the agreed control total for the year and therefore will trigger a multi-million pound incentive award at year end, assuming continued progress in line with forecast. The size of the award will be in part dependent on the progress of other trusts in adhering to their financial plans and delivering their performance trajectories associated with Sustainability and Transformation funding

Reference Costs Index Update

The Department of Health has recently released each Trust's Reference Costs Index for the 2015/16 submission, the publication can be accessed by following this link: https://www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016

The table below shows the 2015/16 reference costs index for this and neighbouring Trusts. This shows that both nationally and compared to our local peers we are relatively efficient.

Org Code	Organisation Name	2015/16	2014/15
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	96.07	90.76*
RCB	York Teaching Hospital NHS Foundation Trust	96.17	99.52
RFS	Chesterfield Royal Hospital NHS Foundation Trust	96.69	97.38
RWA	Hull and East Yorkshire Hospitals NHS Trust	97.04	96.59
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	98.94	100.77
RXE	Rotherham, Doncaster and South Humber NHS Foundation Trust	99.26	106.77
RXF	Mid Yorkshire Hospitals NHS Trust	100.18	101.75

RFF	Barnsley Hospital NHS Foundation Trust	100.19	101.53
RR8	Leeds Teaching Hospitals NHS Trust	100.90	95.59
RJL	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	103.18	96.55
RFR	The Rotherham NHS Foundation Trust	104.90	105.69
RWD	United Lincolnshire Hospitals NHS Trust	107.01	106.35
RCU	Sheffield Children's NHS Foundation Trust	107.60	114.07

**Note: Reference Costs data was not restated. Using the restated annual accounts, the estimated adjusted RCI would be 95.16*

The DoF will be discussing the implications of this position with our local commissioners in Q4 and FOC is briefed on the RCI position, which will in due course feed through to a relatively good Carter Adjusted Treatment Index.

Contracts

Agreement was reached on patient care contracts with local CCGs and NHS England for specialist services by the due date of 23 December. This was a tremendous effort on behalf of the contracting team and key care group and other directors and also testament to the good working relationships with local commissioning bodies. The risk associated with activity increases next year has been a key area within the discussion, with an appropriate balance agreed.

Corporate Objectives

The 2016/17 objectives Q3 position is included as an appendix.

Strategy

Commissioning Review

Since CCG chief officers agreed to undertake a review of commissioning in December, a full scope of the review is currently being worked through and will consider:

- The current commissioning arrangements across South Yorkshire and Bassetlaw and the Joint Committee of CCGs
- Proposing a future model to further enhance joint commissioning in ‘place’ as well as collaborative working at a system level
- Picking up any changes to governance and management that might be needed
- Reflecting the approaches being taken by CCGs at place level for joint commissioning with local authorities
- Exploring the opportunities for a ‘do once’ approach

A draft model is expected by mid-February and partners can expect an update at the next Collaborative Partnership Board. The work is being supported by CCG directors of commissioning and will be aligned to SYB priorities and connected to the sustainable hospital review.

Place level

DMBC and NHS DCCG are working in partnership to develop, test and implement a new integrated model for intermediate care. The project is intended to test a joint approach that promotes a more efficient use of resources across the local health and social care economy to meet rising demand from an increasing ageing population, relieve pressure on acute services and deliver improved outcomes for patients. The Intermediate Care Project is identified as one of three cohorts in the Doncaster Place Plan 2016, in which local health and social care commissioners and providers have agreed a set of principles that support new ways of working across our organisations.

- Organisations focus and collaborate to prioritise interests of patients and people
- Doncaster commissioners, providers, patients, carers and partners shape the future of Doncaster services together
- Work in an open, honest and constructive way
- All partners actively promote a picture of 'One Doncaster' and speak with a single voice for the greater good
- Each organisation actively promotes a culture that facilitates integrated working and empowers staff
- Services developed to meet physical, mental health and social care needs
- Patients access excellent hospital based services when needed but there will be a focus on out of hospital care, enablement, maximising independence, promoting self-care and maintaining social networks
- As a Doncaster partnership we will be prepared to take calculated risks
- The default position will be that organisations share information to support the provision of good care.

The Intermediate Care Project supports these principles and will facilitate the opportunity to develop our ability to deliver against them. The project is also in line with the principles agreed in the Team Doncaster Charter. These approaches are being road tested in Q4 and the approach and governance has been defined in a signed Memorandum of Understanding between all the organisations involved.

Working Together

In addition to the set work programmes, Working Together is continuing the discussion about how to best improve decision making using the Committees in Common approach. The feedback from the last Board meeting has been presented and legal advice is being procured to facilitate the discussion and potential final model for approval. Advisors will:

- Assist in setting up a Committees in Common structure in order that the Trusts respective Boards can delegate the appropriate powers to such committees.
- Prepare the model Terms of Reference to be used for each of the seven Committees in Common;
- Prepare an overarching joint working agreement which will set out details of the working of the Committees in Common including the background, principles of

working, process for joint working and arrangements around termination of the joint working; and

- Check the constitution/SOs/SFIs of each Trust to assess position regarding: Delegation to committees; Reporting of the committee; other provisions that may affect the arrangements.

Trust level

The Board has been recently briefed regarding the ongoing development of the trusts new Strategy and validated a SWOT analysis as part of the contextual element. NHSI have been invited to consider the deliverable required by February 17th, given the current position of the development of the SYB STP, to which the strategy must correlate.

National Emergency Laparotomy Audit (NELA) - Publication of hospital level risk adjusted mortality

Prior to publication, this data is subject to an outlier analysis to detect hospitals where outcomes are statistically different from peer institutions. The national average mortality between December 2013 and November 2015 was **11.4%.** During the analysis of risk-adjusted mortality for patients who received care at Doncaster Royal Infirmary between December 2013 and November 2015, 30-day mortality was found to be below the national average at 7.9%. This continues a positive trend observed in previous NELA audits and again out staff supported emergency laparotomy are to be congratulated in the good outcomes being achieved from the service.

Paediatric Services – Bassetlaw

The Trust has publicised its plans to cease overnight paediatric admissions at Bassetlaw and discussed the new service model in public session of the Nottinghamshire Health Overview and Scrutiny Committee on 23 January 2017.

To ensure that local children have access to high quality and reliable care, the Paediatric Ward at Bassetlaw Hospital is changing to provide an enhanced day time urgent assessment and treatment service, seven days a week. The national shortage of specialist paediatric medical and nursing staff has adversely affected provision of overnight services at Bassetlaw Hospital for a number of months, and despite efforts to recruit to vacancies, these have not been successful.

As our first priority is to ensure safe, high quality services for our patients, the Paediatric Ward A3, is planned to close to admissions from 8pm each day from 30 January 2017. Although the overnight service cannot be maintained, acute paediatrics are being enhanced and will be available from 8am to 10pm, seven days a week, creating a 'consultant-led Paediatric Assessment Unit'. Any children requiring an overnight stay will be transferred to neighbouring Doncaster Royal Infirmary (DRI).

This revised specialist service will deliver urgent assessment, diagnosis and treatment which will reduce the amount of time patients have to spend on the ward and decrease the number of admissions. The number of children who do stay overnight has fallen over recent years with the ward, A3, caring for an average of six children. This model of care is consistent with Royal College of Paediatric and Child Health guidance, and data shows that almost 85% of all patients stay just one night or less and most children will benefit from an enhanced assessment and treatment service. Urgent transport for the children who do require an overnight stay will be available, and is being jointly commissioned by Bassetlaw Clinical Commissioning Group (CCG) and the Trust.

The Trust, in partnership with the CCG, will also continually review the service model put in place to understand the effectiveness of the changes and the impact on local people. The numbers of children requiring transfer will be monitored weekly, to ensure transfers are appropriate and have not increased against the expected number of admissions.

Sheffield Children's Hospital will also be involved in the service evaluation and the Trust will continue to work with the Children's Services across South Yorkshire to develop a recruitment drive in order to meet the standards in the 'Facing the Future' guidelines for Paediatric Care.

Award of JAG Accreditation for 2017 – Doncaster Royal Infirmary

Following submission of a satisfactory GRS census and the review of the Annual Report Card submitted by the Endoscopy Unit at Doncaster Royal Infirmary, I am pleased to confirm that the Unit has met all of the requirements to be awarded JAG Accreditation for 2017. John Green, Chair QA Units Working Group congratulated the staff for their continued hard work in achieving and maintaining JAG standards.

Allied Health Professions join forces to help shape future healthcare

England's 145,000 allied health professionals (AHPs) will be encouraged to innovate and lead within the NHS and wider care system under a new shared commitment published by NHS England.

Rosalind Campbell of NHS Improvement (AHP Professional Lead for workforce productivity) visited the Trust in January and following on from that the Trust has agreed to undertake work on evidencing productivity.

'Allied Health Professions into Action' has bought together the views of the third largest workforce in the health and care system, including chiropodists, dieticians, orthoptists, paramedics, physiotherapists, art therapists and speech and language therapists. It sets out how the 12 Allied Health Professional groups across England can be at the forefront of innovative changes to patient care and shape future health policy by having a full involvement in transformation plans being developed across the country.

The new guidance aims to provide a blueprint for Clinical Commissioning Groups, provider organisations, health leaders and local authorities to fully utilise and involve Allied Health

Professionals (AHPs) in transformation programmes and the delivery of NHS England's Five Year Forward View. It offers 53 examples of AHPs working to drive and support change by working innovatively, and a framework to help utilise AHPs in the development and delivery of transformation planning. The Trust has influenced and supported the development of this work as previously reported.

Staff & Appointments

Suzy Brain England OBE has joined DBH as our new Chair. Suzy joins us from Barnsley Hospital FT where she was a non-executive director to serve a three year term at DBH. Throughout her career Suzy has gained a wealth of experience in both executive and non-executive roles, lending her expertise to the Talent Foundation and The Earth Centre as chief executive. She has previously held a number of Chair posts, including at Kirklees Community Healthcare Services, Connexions and Ofcom's Advisory Committee for England and now offers career mentoring and counselling. She was awarded an OBE in the Queen's 2009 Birthday Honours for her work as Chair of the Standards Committee at the Department of Work and Pensions.

Ros Jones, Mayor of Doncaster, awarded a Commander of the British Empire (CBE) honour for Services to Local Government in the Queen's New Year's Honours List.

Working Together Partnership Vanguard has been shortlisted in the prestigious Health Service Journal (HSJ) Value in Healthcare Awards, in both the Innovative Procurement category and the Value in Support Services category

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I would like to thank all Board members for their individual and collective support and challenge during my time in post. It has been a great honour to serve as your Chief Executive. I wish every Board member and every member of staff the best for the future and thank you all for what you have done, and will do in future, to continue to improve the care and outcomes for our patients.

Mike Pinkerton
Chief Executive

CE Objectives 2016/17

	Q1	Q2	Q3	Q4		Comments
License, Registration, Compliance and Governance						
Maintain CQC Registration without Conditions. Complete the implementation of the action plan post CQC 2015 review and maintain quality and effectiveness in line with CQC domains on a sustained basis between inspections. Prepare for the new risk based inspections expected from 2016/17					**RP**	Routine CQC engagement meeting in September 2016 confirmed that the CQC have no current concerns from their monitoring. Actions from the CQC inspections remain on track to deliver within agreed timeframes.
Deliver NHSI Enforcement Undertakings as set out at instigation and as may be amended from time to time by NHSI. Compliance and progress will be assessed quarterly by NHSI. Key to the enforcement undertakings is the commitment to develop a five year financial strategy for the Trust doing Q3/4 and a board governance review during Q3.					**MP**	NHSI undertakings reviewed externally by NHSI via Performance Review Meetings and internally by NHSI Undertakings tracker. Undertakings substantially delivered in Q1 Q2 amd Q3. There have been no further PRM meetings or PRM teleconferences in quarter 3. Regular updates have been provided to appropriate members of the NHSI Team via DoF and COO contacts and standard portal monitoring. The key Q3 requirement is the delivery of an external governance review against the Well Led Framework and incorporating key focus areas as identified by the Relationship Team. The governance review was delivered to time incorporating the required scope agreed with NHSI. Key Q4 requirement is the delivery of an outline organisational five year strategy as defined by NHSI, consistent with STP content.
Implement the KPMG Misreporting Investigation Report recommendations and Cash Report Recommendations, focussing in particular on rebuilding the Finance Department through permanent recruitment and reviewing options to optimise financial accounting in order to improve the control environment.					**JS**	Board has agreed new structure for finance department. Permanent staff have been appointed to the Financial Accounting Structure. Internal Audit are reviewing the actions completed within the KPMG report to ensure that the actions are becoming embedded.
Maintain Compliance with all NHSI Access Targets and Outcomes Objectives with Sustainability and with Transformation Fund associated Targets (Four Hour Wait and RTT) as a priority.					**DP**	Cancer targets achieved in Q2, Q3 final results not yet available. Currently on plan against trajectory. Key pathways being reviewed for 62 day performance in Head and Neck and lower GI. New 2 ww process being piloted. 4hr access failed Q3 at 90.3% though still nationally performing in top quartile and statistically demonstrated to be one of the most consistent and resilient by NHSi. Key pressures due to medical shortfalls and bed capacity at DRI. RTT failed Q3, key issues in dermatology, urology, GI and T&O, action plans in place to return at target by the end of Q4.
Provide the Safest, most Effective Care Possible						
Reduce SHMI below 15/16 outturn and maintain HSMR and SHMI within the expected ranges after rebasing.					**SS**	The Trust's rolling 12 month HSMR remains better than expected at 93.6 at the end of October 2016 2016 and SHMI is at 100 at the end of June 2016.
Using the Quality Assurance Tool, ensure that all wards and departments undertake an assessment by rolling programme and 95 % of wards improve on previous performance and to then achieve "green" status within the agreed timelines.					**RP**	QAT assessments in 2015/ 2016 identified a normal distribution curve; with 10% of wards rated outstanding, 76% of ward rated good and 14% of wards rated in need of improvement. Work on the assessment standards for 2016/ 2017 fell behind schedule due to the turnaround activities and a full refresh in now being undertaken for 2017/ 2018.
Ensure that complaints are responded to within the Trusts standards and maintain relative performance against the PHSO assessments.					**RP**	Performance has been maintained but is not meeting the standards identified in the Trusts policy. Progress has been made in reducing the maximum times taken to complete the responses. Performance in respect of the PHSO service appears to have been maintained relative to other organisations and the national position.
Reduce avoidable harm from sub optimal hydration leading to Acute Kidney Injury (AKI) and failure to act on diagnostic tests by 50% over 2015 baseline by Q4 16/17 as per the commitments in the Sign up for Safety Plan.					**RP/SS**	There is a multi-disciplinary working group reviewing the documentation, safe practice and protocols for acute hospital care. Monitoring of process measures and outcomes continues. Ward Nutrition accreditation is being reviewed over Q4. QAT process taking account of the outcomes of these reviews.
Lead and Deliver the Length of Stay Turnaround Work stream as SRO - To reduce the overall number of staffed beds at DBHFT. Paediatric model review. MMH review following Integrated Care Outcome. Bassetlaw – development of IRU Reduction in medical outliers.					**DP**	B6 & S12 changes stabilised. Bed plan escalation beds used as appropriate for flex winter capacity. Paediatric pathways reviewed and beds reduced as a result of staffing difficulties
Financial RAG Performance Rating based on Q3 Plan of £1,448,000 (Actual £1,679,000)	4	4	4			
Lead and Deliver Theatres Turnaround Work stream as SRO - Deliver surgical and endoscopic procedures within agreed budget allocation whilst at least maintaining current quality performance. Ensure surgical and endoscopic lists are matched to planned clinical/surgical resource, increasing utilisation of planned lists and list time to >85%. Ensure patients arrive for surgery, fit for surgery, with realistic expectations communicated and understood. Ensure only the most clinically appropriate patients have pre-operative in-patient stays Understand opportunities available within pathways to maximise income and improve quality of care delivered (intra and post-operative).					**RP**	• Final Draft Theatre Policy (inc. Cancellation, 6/4/2, golden patient) • ALTUROS trial in orthopaedics procured, contracted & planned • Development of Communication Plan • Pre-op – May patient journey • Pre-op PDSA Trial • Pre-op Policies & Procedures to be reviewed/developed • Text Reminder Trail • Update Booking with Scheduling Times • Work Stream Resources to be reviewed • Methodology agreed in line with Medical Productivity.
Financial RAG Performance Rating based on Q3 Plan of £220,000 (Actual £295,000)	4	4	4			
Lead and Deliver the Outpatient Productivity Turnaround Work stream as SRO - Stabilise the booking and Medical records services post CaMIS go live. Introduce a clinic scheduling process to maximise use of the assets and reduce waste. Reduce the number of underutilised slots as a consequence of reducing DNA & CNA %. Increase clinic productivity through standardisation of booking rules, time slots & available resources .					**DP**	Centralised booking team in place at DRI, next steps to collate all staff Reviewing clinic utilisation and providing appropriate feedback to care groups Standard Operating procedures developed for clinic cancellations Off-site storage in place, DRI library dormant clearance commenced RFID business plan developed to go to Board in Q4
Financial RAG Performance Rating based on Q3 Plan of £174,000 (Actual £188,000)	4	4	3			
Maintain the 16/17 number of Clostridium Difficile cases at 15/16 outturn for both total cases and those attributed to lapses in care, by setting contributory trajectories for each ward and care group in Q1. Maintain a target of 0 for MRSA cases attributable to lapses in care.					**RP**	Performance at Q3 is ahead of trajectory and better than year to date position in 2015/ 2016 .
Eliminate Never Events. Increase adverse event reporting rates to within or better than the expected rate and reduce the number of Serious Incidents by 5 % over 15/16 outturn.					**SS/RP**	SI numbers have reduced and this is monitored with a harm from falls and pressure ulcers reduced further in year. A second Never Event has occurred in Q3, although no long term impact on the patient.

CE Objectives 2016/17

Complete the key parts of the seven day programme ensuring compliance with all national Seven Day Service recommendations, including the provision of a planned GI bleed rota, Echocardiography and uniform handover process. Any required investments to be made after an approved business case.					SS	Implementation of 7 day echocardiography has been delayed by new staff vacancies. Work continues to implement the 24/7 GI bleed rota. We have recruited an additional endoscopist who will start in May 2017 but staffing remains difficult with ongoing consultant vacancies.
Control and Reduce the Cost of Healthcare						
Lead and deliver the Income Turnaround work stream as SRO - Ensure that all income generating activity is accurately coded to ensure appropriate tariff is collected. Review areas where enhanced tariff is available and amend practice to achieve this where possible. Maximise opportunities to generate private income. Strengthen processes to collect payment from overseas visitors in line with national guidance. Ensure all SLAs for services provided to others are charged for and that the charge is appropriate. Encourage referral into income generating services which generate profit – (market share reports, up to date DOS and positive position on Choose & Book). Review research & development income opportunities.					JS	Contract let for a trial period to support coding in maximising income. Ongoing discussions with Park Hill re contract and charging mechanisms with an aim to resolve issues between parties by the end of February or move to arbitration as per the contract.
Financial RAG Performance Rating based on Q3 Plan of £716,000 (Actual £605,000)	1	2	BAU			
lead and deliver the Procurement Turnaround wok stream as SRO - Multiple schemes within procurement PID.					JS	Good progress being made and ahead of stretch target by £20k and forecast £278k higher than original plan and £176k higher than stretch target.
Financial RAG Performance Rating based on Q3 Plan of £1,244,000 (Actual £1,464,000)	4	4	4			
Deliver Turnaround Programme as Director, ensuring appropriate PMO support to all SROs and work streams and integrating the NHSI Financial Improvement Programme (FIP) (if selected) to maximum impact during Q1 and Q2 16/17. FIP Return of Investment expected to be >2X input cost, beyond existing identified 16/17 CIP plans (£11M) or CIP opportunities being scoped at the point the programme (if approved) starts in Q1. Develop the Turnaround Programme Governance arrangements to include a Programme Board by end Q1. Deliver, Coordinate and Monitor effectiveness of Turnaround. Standardise Project Management and documentation for the Trust. Oversee the Project Management of work streams. Ensure timescales of Turnaround are adhered to Assessment/Monitoring of Project Standards. Provide guidance/advice for Trust wide projects. Keeping an up to date repository of projects. Manage project management resources. Monitor and provide support for accounting and decision making, planning, sharing knowledge and best practice, reporting and evaluation of benefits, Change control, communication and stakeholder management, progress tracking, risk management and escalation, managing dependencies, quality impact control.					DJ	Governance and accountability and all programme structure and processes all in place and running well. Review being undertaken in Q4 by new PMO Manager and enhancements likely as we move into 17/18 Plan delivering overall, much better than predicted and standard ways of working embedded across work streams and projects . Q3 delivery is over the phased £11m plan by £913k and ahead of the stretch target by £166k.
Implement, monitor and maintain the Cost Improvement Programme to deliver in year cash release of £11 M as a key component of delivering a Control Total of -£27.1m. Define and approve a further stretch target as appropriate in early Q1 after the completion of contract negotiations, cost pressure review and budget setting.					DJ/JS	Q3 delivery is over the £11m plan by £466k, under the £13m stretch target by £659k with an end year forecast delivery at M9 of £11.552m.
Implement a new Board Finance report in Q1, linked directly to ledger, that incorporates national best practice and sets Board agreed minimum standards for cash management and creditor payment timescales, as the apex of a revised financial reporting process throughout the Organisation.					JS	Three new finance reports have been produced which are tailored to the needs of the Trust Board, Financial Oversight Committee and Board of Governors. This objective is now completed, however we expect the finance report (s) to be continually modified to reflect the changing information and governance needs of the above groups over time.
Comprehensively implement and maintain processes and procedures to reduce and then maintain staff sickness to < 3.5%, measured as an annual position. Hold corporate directorate and care groups to account by escalating performance issues or failure to use corporate tools and processes designed to manage sickness.					KB/All	Sickness rates are fluctuating this year. We are seeing a reduction in the numbers of staff off for more than 6 months. HR Business Partners are actively working with their Care Groups and Directorates to ensure that cases are being managed effectively. Progress is being made against the Health and Wellbeing CQUIN. Further information is within the P&OD quarterly Board report.
Lead and deliver the Infrastructure Turnaround Work stream as SRO. - This will be achieved through the following projects: 1. Soft FM Review 2. Catering Outsource 3. HSDU Outsource 4. Transport Review 5. Car Parking Income 6. Energy Price Reduction					KEJ	Infrastructure projects re-profiled in Q2 to reflect their complexity are now on track. Slippage against forecasted savings has improved by £52k in Q3. 1. The Soft FM Review is now at mobilisation stage following a lengthy consultation with unions and individual meetings with staff. Go Live date is 27th February. 2. Following the receipt of bids for patient catering only, the catering outsource project has increased the tendering period by 6 weeks to allow for a variant bid to be tendered for one lot which is both patient and retail outlets. The variation being offered is to increase flexibility of open hours of retail outlets in order to encourage combined bids removing any requirement to demarcate main kitchens. 3. The HSDU project has progressed with baseline work, the development of the tender documentation, and the public sector comparator. FastTrack rates have been redefined to the commercial definitions, and work continues to challenge the use of 'FastTrack light' use. Commercial benchmarking work continues and will inform an Outline Business Case to Corporate Investment Group on 28th February providing a 'Go/No Go' decision to test the market by tendering. 4. During Q3 Transport was removed as a project as it had achieved its maximum level of savings of £37,500 within 16/17, and will require a more extensive Qi project to review the entire transport service locally working with partners. 5. Following the implementation of staff permits and enforcement in October, income from both patient car parks and staff has increased. A baseline is currently being established based on actual income in order to project recurrent income once all staff permits are distributed against the maximum cars per space allocations. 6. A contract for energy has been signed through CCS fixed term of one year. The contract commences in April 17, and until then the fixed price cannot be confirmed. However, additional savings have been achieved in Q3 against this line for rebates due to the reclassification of space within which energy is consumed. so far this equates to a non-recurrent saving of circa £20k, with the opportunity to save a recurrent £60k through classification of trust space for long stay patients and research activity.
Financial RAG Performance Rating based on Q3 Plan of £299,000 (Actual £322,000)	4	4	4			

CE Objectives 2016/17

Lead and deliver the Care Group Corporate Directorate Turnaround Work stream as SRO - Ensure all schemes have been identified and agreed within the Turnaround Team (TT). Produce accountability materials for scheduled challenge meetings. Ensure validated financial assurance data produced and updated for each scheme. Adherence to set timeframes agreed with TT. Preparation for 16/17 CIP. Delivery of schemes to produce efficiency savings.					JS	Performance at Q3 are savings of £1.2m which is £40k ahead of the originals plan.
Financial RAG Performance Rating based on Q3 Plan of £1,162,000 (Actual £1,202,000)	1	3	3			
Develop Services Responsibly, delivering the Right Services with the Right Staff						
Lead and deliver the Medical Productivity Turnaround Work stream as SRO. - Complete comprehensive E2E review of Medical workforce its processes and practices to identify and realise opportunities to improve efficiency, effectiveness, remove unnecessary processes/steps and reduce overall costs. This will include a review of the SPA tariff allocation across all Care Groups. It will also complete a thorough demand and capacity review for all specialties.					SS	Job Planning Guidance has been finalised and circulated to all consultants. Job plan reviews are progressing in the specialties where demand/capacity plans have been completed apart from O&G, Paediatrics and T&O where service change has been or will be implemented shortly.
Financial RAG Performance Rating based on Q3 Plan of £255,000 (Actual £1189,000)		4	1			
Lead and deliver the Non-Medical Productivity Turnaround Work stream as SRO. - Reduce dependency on temporary workers to maximise continuity. Improve cost controls. Improve capacity/demand planning and alignment. Reduce overall expenditure. Projects/reviews covered: - Outpatient Nursing - Specialist Nurses (B7 and above) - Skill Mix (Introduction of Band 4 role) - Enhanced Care - Therapies - Clinical Workforce Development					RP	• Some fortuitous savings made. • Non Ward Nurse Review Cap & demand mapping • Specialist nurses standard job descriptions being developed. • Band 4 role being designed. • Therapies review to start
Financial RAG Performance Rating based on Q3 Plan of £88,000 (Actual £117,000)	4	4	4			
Lead and deliver the Management & Corporate Directorate Review Turnaround Work stream as SRO - Identify and evidence genuine opportunities (considering impact). Improve capability of leaders. Refresh managerial structures. Reduce overall cost of Care Group managerial structures. Reduced overall operating costs (10% savings). Improve efficiencies. Consistency of operating model throughout the Trust.					KB	Forecast to achieve original target.
Financial RAG Performance Rating based on Q3 Plan of £556,000 (Actual £661,000)	1	3	4			
Lead and deliver the Clinical/Administration Review Turnaround Work stream as SRO - To be scoped					DP	• Deliverables to be scoped at a workshop with the PMO • Business processes scoped New model for centralised admin processes to be agreed in Q4
Financial RAG Performance Rating based on Q3 Plan of £0 (Actual £68,000)		4	4			
Lead and Deliver the Control and Grip Turnaround Work stream as SRO - Implement Grip and Control Monitoring/Challenge Arrangements. Coordinate Centralised efficiency savings which have been highlighted within Grip and Control meetings. Robust Financial assurance process embedded for the Trust.					DJ	Grip and control meetings have ceased in Q3 though some small projects still remain and will continue delivering. A late non-recurrent entry regarding annual leave accruals means a likely overperformance on the work stream of around £500k. This work stream has therefore fully delivered, as all savings are "in the bag". The third round of grip and control meetings have taken place in September, with around £1m removed from budgets due to a reduction in run rate, however this has already been expressed in the forecast and should not counted twice.
Financial RAG Performance Rating based on Q3 Plan of £918,000 (Actual £754,000)	1	4	4			
To produce workforce planning strategy for all professions and staff groups by end of Q2 16/17 with clear plans to match supply and demand for each profession and staff group by dates as set out in the strategy. The overall Trust wide strategy will be developed and delivered by KB, and each profession or staff groups' plans will in turn be led by the relevant Executive Director.					KB	E workforce plan submitted to HEE based on annual plan submission. Further development through 2 year plan and discussion at Workforce and Education committee.
Deliver set 16/17 Capital Plan of £ 9.369m, focussing on safety, compliance, fire and utilities priorities. Complete and commission Doncaster Ophthalmology Centre during Q3.					KEJ	Ophthalmology centre DRI opening was achieved in Q3. Following the re-profiling of the 16/17 capital programme in Q2 against the Estates and Facilities Risk register, capital expenditure for the remainder of 16/17 has been focused on reducing the highest risks. Projected schemes to year end include the continued work to comply with SYFR Enforcement Notices for the East Ward Block and Women's and Children's building, refurbish/replace water tanks EWB, critical theatre ventilation plant validation and remedial works, new x ray roof DRI, endoscopy BDGH, flow improvement for ED DRI, roof replacement X-ray DRI.
Deliver the Statutory and Essential to Role (SET) training project to ensure that at least 90% of staff access the full programme appropriate to their role, including safeguarding training, by Q2.					KB	Progress continuing on compliance rates. Work taking place across Working Together to review, streamlining and delivery of SET.
Implement key actions arising from the Staff Survey 15/16 and quarterly Staff FFTs. Ensure each care group and corporate directorate has developed a Local Action Plan by end of Q1 to take forward local issues identified in the Staff Survey.					KB	Local action plans developed and being implemented. Trust wide action plan will be monitored via Workforce and Education Committee. 2016 results due shortly.
Refresh the People and Organisational Development Strategy by Q4 to ensure that the Strategy remains fit for purpose and relevant to the future needs of the Organisation over the remainder of the strategy period.					KB	Strategy reconfirmed as one the key underpinning strategies to support the five year plan and strategic direction. Director review of strategy and priorities underway.
Focus on Innovation for Improvement						

CE Objectives 2016/17

Set a new Informatics Strategy to meet the needs of the Organisation over the next five years, aligned to the digital roadmaps within our health and social communities and the Working Together Confederation opportunities and obligations by Q4.					SM	Interviews for Chief Information Officer held on 22/07/16 commenced in post 05/08/16 Base lining of current I Hospital legacy position completed by Sewa Singh to help inform future direction and shared at Board Brief. Digital developments internally, in local places and STP currently being investigated by CIO to provide context for strategy development. Continued cooperation with Working Together programme on scoping back office consolidation opportunities as part of the case for change. UPDATE 24/1/17 - information and IT strategies being developed in Q4 in conjunction with overall Trust strategy. Progress with Interoperability at Team Doncaster and STP level. Likely that strategy will not be complete until May 2017.
Support the Working Together Programme Objectives including the objectives set within the Acute Care Vanguard and the strategy to move to a Confederation. Contribute to the development of Sustainability and Transformation Plans for the South Yorkshire and Bassetlaw STP Area including leading the Cancer Work stream. Support the Doncaster CCG and Bassetlaw CCG STP Footprint plans and ensure maximum consistency with the Trust Five Year Financial Strategy and the development of the Bassetlaw Accountable Care Partnership.					MP/Execs	Trust approved the moved to a confederation form of governance on 28/06/2016. All executives involved in leading or supporting the various STP and Working Together work streams. Progress reported monthly to Board via Chief Executives report. Doncaster and Bassetlaw Place plans supported through executive and senior manager input and now completed. Bassetlaw ACP MOU expectations now changed and ACP board proposed, proposal went to October Board. Doncaster Place plan discussed and approved at October Board. Consultation on stroke and children's surgical services reconfiguration commenced October 2016, completion by January 2017, now extended to February 2017. Internal consultation response timetable agreed and implemented including reporting on progress and risks at Board Brief January 2017. STP second submissions delivered October 21 in line with plan. NHSI/E response expected imminently, stratifying STP plans into Exemplars (or not). Discussions commenced including at Board in December 2016 regarding potential move to Committee in Common decision making for the WT confederation/vanguard.
Review the options for private sector support for future Estates development and place based public sector integration and incorporate outcomes into a new Estates Strategy by Q4.					KEJ	Following informal market testing undertaken in Q2 with 7 companies re SEP's, JV's and Income Strip models, work has progressed in Q3 to twin track options for public and private sector support. This twin track approach will develop both DRI and BDGH sites in line with STP and PLACE based plans, as well as exploring new build opportunities for DRI. DBH and DMBC are working with CHP to develop a bid to SCR OPE in Q4 for financial support to undertake full feasibility for a new build for DRI. A presentation is planned for to Management Board regarding the potential benefits of a JV/SEP model for BDGH, and potentially DRI if required. The tendering of a 'basket' of possible property projects via OJEU to identify a partner would enable to Trust to call off projects as desired, with no commitment to undertake any. In addition, initial talks are about to take place with Bassetlaw Council regarding a potential for them to purchase the Southside plot at BDGH for a social housing project, further updates with be provided as these talks progress. A new Trust Estates Strategy 2017 - 2022 is now in draft ready to respond to the outcomes of STP and PLACE discussions, and the resulting Trust Clinical Strategy.
Develop the Education and Training programme within resources, with the aim of being comparable in quality with teaching hospitals standards by the end of the project period. Clearly define the source and allocation of all funds to ensure full transparency for external and internal stakeholders.					KB	Teaching Hospital status achieved. Launch on 27 January 2017. Work on going in relation to tracking of all funds.

GREEN = On Track/No Major Issues **AMBER** = Delivery Feasible But Significant Issues **RED** Significantly Off Track/Major Issues **WHITE =** Not Started **BLACK** = Completed (Adapted Cabinet Office Major Project Authority Definitions) *Objective relating to Strategy delivery to be reframed in line with changed NHSI requirements.

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Hospital Pharmacy Transformation Plan**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Andrew Barker, Chief Pharmacist and Clinical Director – Diagnostics & Pharmacy Care Group**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

This report seeks Board approval for the Hospital Pharmacy Transformation Plan and authorisation for the Chief Pharmacist to pursue areas of collaborative working with STP partners.

Key messages from the attached report:

- All Acute NHS trusts in England are required to have a Hospital Pharmacy Transformation Plan (HPTP) in place by April 2017, to implement the pharmacy specific recommendations of the Carter Report and the NHS England guidance on seven day clinical pharmacy services.
- The preparation and implementation of HPTPs will be overseen by NHS Improvement and will contribute to segmentation judgements made under their Single Oversight Framework.
- The key deliverable is the provision of a seven day clinical pharmacy service which will result in the safe and optimal use of medicines for our patients and a consequential reduction in their length of stay, improved readmission rate and a decrease in inappropriate medicines expenditure.
- Further actions are detailed that will result in increased efficiencies in pharmacy infrastructure. These include working in collaboration with South Yorkshire & Bassetlaw Sustainability and Transformation Plan (STP) partners and, where appropriate, third party service providers.

Recommendations for Board of Directors

The Board is requested to approve the HPTP and to authorise the Chief Pharmacist to pursue opportunities for collaboration with STP partners.

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

We always put the patient first

- *By recruiting, retaining and developing a skilled pharmacy workforce.*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity

- *By adopting the principles of medicines optimisation*

Committed to quality and continuously improving patient experience

- *By committing to become within the top 10% of the NHS*

Always caring and compassionate

- *By adopting a patient centred approach to medicines management*

Responsible and accountable for our actions – taking pride in our work

- *By having clear objectives and actions to improve the service we offer*

Encouraging and valuing our diverse staff and rewarding ability and innovation

- *By ensuring everyone's ideas count and everyone's views are heard*

Related Strategic Objectives

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

Analysis of risks

1. Delivery of the level of whole system change and collaboration between organisations envisaged by the Carter report is beyond the Trust's direct control.

2. Inability to recruit and retain staff with the knowledge and skills required to deliver the level of transformation required.

3. Wider Service reconfiguration resulting from or implementation of STP and changes in DBH clinical services/site utilisation in line with Trust Patient Service Planning might require the HPTP to be reviewed and amended.

Board Assurance Framework

Implementation of the HPTP may be restricted or delayed.	3 x 3 = 9

Hospital Pharmacy Transformation Plan – 2017 to 2020

1. Executive Summary

This three year plan is Doncaster & Bassetlaw Hospitals NHS Foundation Trust's (the Trust) response to the pharmacy specific recommendations of the Carter Report and the supplementary guidance provided by NHS England on seven day clinical pharmacy services.

All Acute NHS trusts in England are required to have a Hospital Pharmacy Transformation Plan (HPTP) in place by April 2017, to address these recommendations. The preparation and implementation of HPTPs will be overseen by NHS Improvement and will contribute to segmentation judgements made under their Single Oversight Framework.

Section 5 (page 8) contains the details of the actions that are planned to comply with these recommendations together with a timetable for their implementation.

The key deliverable is the provision of a seven day clinical pharmacy service which will result in the safe and optimal use of medicines for our patients and a consequential reduction in their length of stay, improved readmission rate and a decrease in inappropriate medicines expenditure. Further actions are detailed that will result in increased efficiencies in pharmacy infrastructure. These include working in collaboration with South Yorkshire & Bassetlaw Sustainability and Transformation Plan (STP) partners and, where appropriate, third party service providers. Staff resources released from infrastructure activities will partly offset any additional resources required for clinical pharmacy and medicines optimisation.

Once the overall plan is approved, detailed implementation plans including delivery timetables and milestones will be developed for each work stream. Where significant service change is required and/or there are resource implications detailed business cases will be prepared for consideration and prioritisation by the Trust's Management Board. The Project Team will be accountable to a Project Board Chaired by the Chief Operating Officer and including representatives of the Medical Director, the Director of Nursing , Midwifery & Quality and the Director of Strategy and Improvement.

The Trust Board are asked to:

- Review and approve the plan
- Authorise the Chief Pharmacist to pursue areas of collaborative working with STP partners.

2. Introduction

In February 2016 Lord Carter of Cole presented his report on operational productivity and performance in NHS acute hospitals[1]. The report made recommendations on how efficiency could be increased by driving out unwarranted variation.

Lord Carter judged that the NHS could save at least £800million through transforming hospital pharmacy services and medicines optimisation. The majority of these savings falling to NHS England and Clinical Commissioning Groups through reduced acquisition costs for directly commissioned medicines. Other benefits envisaged included improving medicines safety, patient outcomes and value for money by increasing the time available for pharmacy staff to work closely with patients, doctors, nursing staff and independently to deliver optimal use of medicines, make informed medicines choices and contribute to delivering seven day services. The additional resources required for these activities to be made available, at least in part, through disinvestment in the more traditional supply chain pharmacy functions, facilitated by increased collaboration between hospital pharmacy services and/or outsourcing to third party providers.

The Carter Report recommended the development of Hospital Pharmacy Transformation Plans (HPTPs) to deliver those recommendations of the report relating to pharmacy services and medicines optimisation by 2020. The preparation and implementation of HPTPs locally by each acute trust will be overseen by NHS Improvement and will contribute to segmentation judgements made under their Single Oversight Framework[2].

In September 2016 NHS England issued guidance[3] on the provision of seven day clinical pharmacy services, which supplements the Carter recommendations, with the intention that this should be incorporated in to HPTPs.

This document is the Trust's response to the Pharmacy elements of the Carter Report and the seven day clinical pharmacy recommendations. Section 5 contains the details of the actions that are planned to comply with these recommendations together with a timetable for their implementation.

3. National and Policy Context

3.1. <u>Medicines Optimisation</u>

The Carter report builds on the existing concept of 'medicines optimisation'. This can be defined as: *'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'*. Both the Royal Pharmaceutical Society of Great Britain (RPSGB)[4] and the National Institute for Health and Care Excellence (NICE)[5] have provided authoritative guidance on improving medicines optimisation.

Improving medicines optimisation is important because[4]:

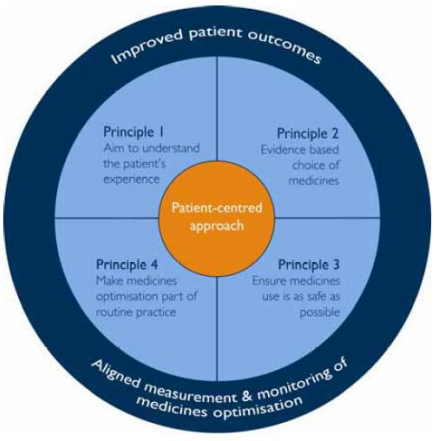
- Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.

- Ten days after starting a medicine, almost a third of patients are already non-adherent to their prescribed regime – of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent.
- Over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.
- In hospitals the General Medical Council's EQUIP study demonstrated a prescribing error rate of almost nine percent.
- In general practice an estimated 1.7 million serious prescribing errors occurred in 2010
- In primary care around £300 million per year of medicines are wasted (this is likely to be a conservative estimate) of which £150 million is avoidable.
- At least 6% of emergency hospital re-admissions are caused by avoidable adverse reactions to medicines.
- Analysis of the NHS Atlas of variation highlights unwarranted variations in the prescribing of some medicines across England

Medicines optimisation is designed to improve the following outcomes:

- harm attributable to errors in medication
- patient satisfaction with outcomes from the use of medicines
- quality of life for people with long-term conditions
- preventable mortality
- preventable morbidity
- life expectancy for people with long-term conditions.

To empower patients and the public to make the most of medicines healthcare professionals need to understand the four principles of medicines optimisation.



Principle 1: **Aim to understand the patient's experience**. To ensure the best possible outcomes from medicines, there should ongoing, open dialogue with the patient and/or their carer about the patient's choice and experience of using medicines to manage their condition; recognising that the patient's experience may change over time even if the medicines do not. This is intended to ensure:

- Patients are more engaged, understand more about their medicines and are able to make choices.
- Patients' beliefs and preferences about medicines are understood to enable a shared decision about treatment.
- Patients are able to take/use their medicines as agreed.
- Patients feel confident enough to share openly their experiences of taking or not taking medicines, their views about what medicines mean to them, and how medicines impact on their daily life.

Principle 2: **Evidence based choice of medicines**. To ensure that the most appropriate choice of clinically and cost effective medicines (informed by the best available evidence base) are made that can best meet the needs of the patient.

Principle 3: **Ensure medicines use is as safe as possible**. The safe use of medicines is the responsibility of all professionals, healthcare organisations and patients, and should be discussed with patients and/or their carers. Safety covers all aspects of medicines usage, including unwanted effects, interactions, safe processes and systems, and effective communication between professionals.

Principle 4 **Make medicines optimisation part of routine practice**. Health professionals should routinely discuss with each other and with patients and/or their carers how to get the best outcomes from medicines throughout the patient's care.

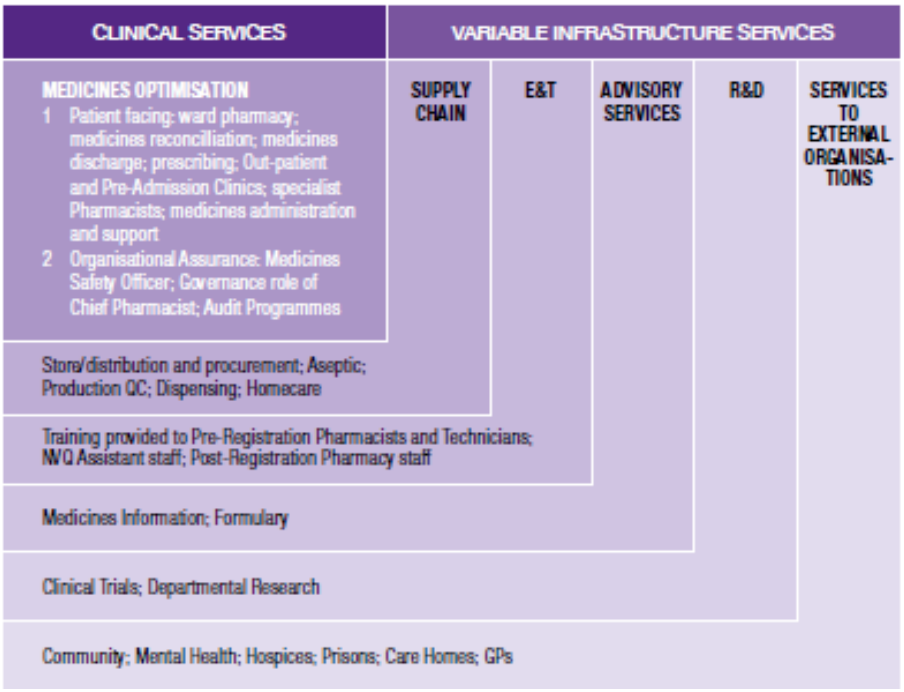
The safe and optimal use of medicines will also contribute to a reduction in length of stay in hospital, improved readmission rate and a decrease in inappropriate medicines expenditure.

3.2. Carter Recommendations

Lord Carter classified the services provided by hospital pharmacy departments into two groups:

- **Clinical Services**: Those, primarily patient facing, concerned with medicines optimisation and providing organisational assurance about medicines use.
- **Infrastructure Services**: Including medicines supply (procurement, preparation, dispensing etc.), education and training, formulary management, research, and provision of services to third parties.

He reported that as a national average only 45% of pharmacy time was spent providing clinical services with the remaining 55% utilised in infrastructure.



His key recommendation was that organisations should prioritise improving clinical services by focusing the time and expertise of the pharmacy team into these areas. Although infrastructure services were acknowledged as essential he recommended that efficiencies should be found from within them to release resource for medicines optimisation. He suggested that this could be achieved via a combination of increased collaboration between neighbouring hospital pharmacy services, outsourcing services and increased use of information technology. In addition he made further recommendations concerning cost efficiencies in medicines use.

Of Lord Carter's eight specific recommendations concerning hospital pharmacy those that apply to Doncaster & Bassetlaw Hospitals (DBH) are:

- Ensuring that at least 80% of Trust pharmacist resource is utilised for direct medicines optimisation activities.
- Implementation of Electronic Prescribing and Medicines Administration (EPMA) systems.
- Ensuring that coding of medicines, particularly high cost drugs, is accurately recorded within NHS Reference Costs.
- Systems to respond to lists of the top 10 medicines with savings opportunities to be published Monthly by the Commercial Medicines Unit (CMU) in the Department of Health.
- Modernising the medicines supply chain to consolidate stock holdings to 15 days, rationalise the number deliveries to 5 per day and ensure 90% of orders and invoices for medicines are processed electronically.

3.3. Clinical Pharmacy

Clinical Pharmacy is best described as those elements of pharmacy practice carried out through face to face interaction with patients. This is where pharmacy staff work on wards and in departments alongside, doctors, nursing staff and other healthcare professionals to optimise medicines processes. This includes: medicines reconciliation, prescription safety review, advising on appropriate medicine and formulation choice, prescribing, ensuring continuity of medicines supply, providing patients with information and advice about their medicines and planning for discharge (including ensuring relevant medicines information is communicated to primary care colleagues).

3.4. Seven Day Working Recommendations

Early in their evolution clinical pharmacy services were only delivered during Monday to Friday. However, as the availability of senior clinicians to make decisions about patients care at weekends increased, it became apparent that there was a need for clinical pharmacy staff to work closely with patients, doctors and nursing staff to choose, prescribe, monitor clinical outcomes of medicines and ensure patients' understanding of their medicines and how to use them, on a seven day basis. As a result some hospitals, including DBH, responded by extending their services into the weekends. However these services were often restricted by the availability of resources.

The September 2016 NHS England guidance[3] makes it clear the weekend clinical pharmacy services should be considered the norm rather than an exception. The guidance differentiates between urgent/emergency and non-urgent/elective clinical pathways. Its key recommendation is that HPTPs should include provision for clinical pharmacy support to patients on urgent/emergency clinical pathways on a seven day basis to be developed as a priority.

4. Local Context

4.1. DBH Pharmacy & Medicines Management Services

The DBH Pharmacy service has a reputation for innovation and quality improvement. It was one of the national exemplar sites for pharmacy skill mix[6] maximising the amount of pharmacist time available for clinical pharmacy (currently 75% using definitions agreed by Yorkshire & Humber Chief Pharmacists - appendix 1). The Trust was an early adopter of electronic prescribing and medicines administration software, was one of the first to appoint Consultant Pharmacists, has developed Technician Practitioner roles, was one of the first few to outsource out-patient dispensing and has adopted robotic dispensing in both its pharmacy departments.

The Trust has a well-developed clinical pharmacy service which includes a limited evening and weekend service. However further development of this service is limited by resources. The latest data available on the NHS Improvement Model Hospital portal indicates that the Trust's pharmacy staff costs are below the national average and significantly below those of

the selected peer group. Currently the service is focused on inpatient ward areas and does not include Clinical Decision Units, Accident & Emergency Departments or Day-case units. KPMG acting as the Trust's Internal Auditors[7] have recently recommended that pharmacy support to these areas should be improved. Although all day (7.5hours) weekend clinical pharmacy services are available on both the Doncaster Royal Infirmary and Bassetlaw Hospital sites these are restricted to Acute Medicine only and no cover is provided to patients on urgent/emergency care pathway admitted to Clinical Decision Units, Frailty Assessment, Orthopaedics, Paediatrics, Renal or any of the surgical specialties.

The Pharmacy service has good working relationships with the Finance Department that ensure coding high cost drugs is accurately recorded within NHS Reference Costs and supports the medicines related elements of commissioning negotiations.

The table below identifies current Trust performance against a range of measures which, as part of the Model Hospital metrics, are likely to be used by NHS England to benchmark performance.

Metric description		**National target**	**Current Trust performance**	**Model Hospital national median**
% available pharmacist resource deployed to undertake core clinical activities		80%	**75%**	**
% Pharmacists actively prescribing		*	**16%**	[14%#]
% medicines reconciliation in 24 hrs		*	**82%**	**
Sunday on ward clinical pharmacy time (medical admissions unit/equivalent)		*	**15 hours**	**
% Pharmacy technician time deployed on ward based activities		*	**40%**	**
% Pharmacy assistant time deployed to ward based activities		*	**20%**	**
Biosimilar uptake	Infliximab	*	**31%**	68%
	Etanercept	*	**11%**	17%
% electronic prescribing	Inpatients	*	**90%**	50%
	Outpatients	*	**0%**	50%
	Discharge	*	**80%**	60%
	Chemotherapy	*	**100%**	50%
Average stock holding	DRI	(15)	**(21)**	([20#])
	BDGH	(15)	**(40)**	([20#])
	Total	15	**26**	[20#]
Deliveries per day	DRI	(5)	**(18)**	**
	BDGH	(5)	**(13)**	**
	TOTAL	5	**31**	**
Orders for medicines sent electronically	All suppliers	90%	**41%**	**
	Alliance+	*	**92%**	90%
	AHH+	*	**88%**	82%
Medicines Invoices processed electronically		90%	**0%**	**
Key: * = not currently set, **= not currently available, # = not currently available but data from Carter Report, + = pharmaceutical wholesalers making data available.				

4.2. Collaboration and Peer review

Hospital Pharmacists have a long history of collaborative working. This is particularly strong in Yorkshire & the Humber where hospital chief pharmacists meet monthly to oversee collaborative projects and share best practice. There are formal arrangements for many of the areas that the Carter Report suggests are suitable for collaboration. These include: medicines procurement, quality assurance, education and training (leading to the recent establishment of the Yorkshire & Humber School of Medicines Optimisation) and pharmaceutical manufacture under MHRA licence. As part of these arrangements initial drafts of HPTPs have been shared across Yorkshire & the Humber to allow peer review.

While the need to continue to work together on this wider basis is recognised, the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) footprint provides an opportunity for more focused operational collaboration and integration. The acute hospital chief pharmacists form Barnsley, Doncaster & Bassetlaw, Rotherham and Sheffield have met informally to review areas of potential collaboration. A memorandum of understanding (appendix 2) has been agreed which identifies the following areas as suitable for collaborative working:

- Aseptic dispensing/preparation*
- Quality assurance
- Medicines information
- Medicines procurement*
- Stock distribution*
- Education and training
- Emergency OOH on-call
- Procurement of outsourced dispensing (subject to the timescales of existing contracts)

(* to include private sector partnerships where appropriate)

As part of the process of HPTP approval, authorisation is sought to proceed to formal discussions with STP partner organisations with the aim of developing firm plans for collaboration and service integration.

5. Planned Actions

Building on these firm foundations, the HPTP identifies the actions that will be required in the period April 2017 to March 2020 to maintain and continually develop the Trust's arrangements to ensure that patients get the maximum benefit from medicines, enhancing safety and improving outcomes. It will deliver the recommendations of the Carter Report and compliance with national guidance for seven day clinical pharmacy services. By promoting the safe and optimal use of medicines it will contribute to a reduction in length of stay in hospital, improved readmission rate and a decrease in inappropriate medicines expenditure.

The HPTP is focused on delivering seven day clinical pharmacy and medicines optimisation services. It will review supply chain and other infrastructure services, exploring opportunities for collaboration with STP partners and third party providers, with a view to increasing efficiency and releasing resources. It will ensure that medicines acquisition costs are minimised delivering benefit to both commissioners, for directly commissioned medicines, and the Trust. It will secure and develop the skilled pharmacy workforce required to deliver this level of transformation.

The HPTP is organised into the following work streams:

- Clinical Pharmacy and Medicines Optimisation
- Review of aseptic dispensing services
- Supply chain modernisation
- Prescribing policy
- Electronic prescribing and medicines administration
- Business support
- Dispensing and ward/departmental stock logistics
- Workforce

A summary of these actions is provided below.

5.1. Summary of Planned Actions

Work stream		Lead	Year 1 (2017/18) activity	Year 2 (2018/19) activity	Year 3 (2019/20) activity

1	Clinical Pharmacy & Medicines Optimisation	Assistant Chief Pharmacist & Chief Pharmacy Technician	Redesign clinical pharmacy & medicines optimisation services to differentiate between support to urgent/emergency pathways and non-urgent /elective pathways. This will include:
			• Response to the national pharmacy 7 day service recommendations
			• Ensuring the at least 80% of pharmacist time is spent on core clinical activities (see appendix 1)
			• Support for early STP initiatives (eg hyper-acute stroke & children's surgery)
			• Enhanced technician roles (Technician Practitioners)
			• IT support to allow improved process, including targeting of resources and paper free working.
			• Integration with primary care & community pharmacy, including:
			  ○ Improved communication and medicines reconciliation on the transfer of care (including arrangements for 'specials')
			  ○ Community pharmacy support for medicines adherence post discharge
			
			A gap analysis between the redesigned service model and current provision will be carried out, leading to preparation of a business case for service change by 31 May 2017.
			
			Implementation of new model by 31 March 2018 including 80% of pharmacist time spent on core clinical activities by December 2017
				Establishment of systems to allow review of new service against original objectives and emerging service requirements, to allow continual quality improvement.
				
				Work with IT to explore options for informatics support for wider medicines optimisation agenda (including systems for alerts and workload prioritisation for medical and nursing staff)
				
				Test the viability of collaboration with STP partners in the provision Medicines Information services.
				
				Identify changes of service required to support implementation of STP and changes in DBH clinical services/site utilisation in line with Trust Patient Service Planning
				
				85% of pharmacist time spent on core clinical activities by 31 March 2019
					Implementation of agreed informatics solutions
					
					Implementation of agreed changes to Medicines Information services
					
					Ongoing evaluation and development

2	Review of aseptic dispensing services	Deputy Chief Pharmacist	Prepare business case for re-provision of chemotherapy preparation capacity by April 2017. This will include: • Adoption of national banded dosing recommendations • Outsourcing preparation to maximise the volume of 'bought in doses' and release staff resource for medicines optimisation. • Replacement of negative pressure isolator facility Review arrangements for the preparation of TPN to identify any potential to release staff resource for medicines optimisation by increasing the volume of outsourced preparation. Business case prepared by 31 March 2018 **Implementation of banded chemotherapy doses & outsourcing chemotherapy preparation in line with NHS England 2017/18 CQUIN targets.**	Assess the impact of STP changes on the provision of chemotherapy and TPN. Test the viability of collaboration with STP partners (and the private sector) in the provision of aseptic preparation services. To reduce costs and release staff resource for medicines optimisation. **Replacement of negative pressure isolator facility by December 2018.** **Implementation of the recommendations of the TPN review by 31 March 2019.**	**Implement viable solutions for collaborative/centralised aseptic preparation by December 2019.** (Viability of some potential solutions will be dependent on broader 'whole system' change, envisaged by the Carter report, which will be beyond local control.)

3	Supply chain modernisation	Deputy Chief Pharmacist	Test the viability of centralising the medicines stock distribution services on the DRI site with the overall objective of reducing daily deliveries by 30% and stock holding to 20 days. Develop plans to increase the efficiency of medicines procurement, to reduce costs/ release staff resource for medicines optimisation by: • Increasing the use of electronic ordering • Introducing electronic invoice processing • Reduce the number of deliveries. This will also include co-locating procurement with the main stock distribution services. **Implement agreed service changes: reducing stock to 20 days, processing at least 80% of orders and 50% of invoices electronically and reducing daily deliveries by 30% by 31 March 2018** (for suppliers that can trade electronically).	Test the viability of collaboration with STP partners (and/or the private sector) in the provision of centralised medicines procurement and stock distribution services. With the overall aim to reduce costs and release staff resource for medicines optimisation and with the overall objective of reducing stock holding to 15 days and reducing daily deliveries by a further 30%.	**Implement viable solutions for collaborative/centralised medicines procurement and stock distribution by December 2019. Including reducing stock holding to 15 days and reducing daily deliveries to 5 per day for each site.** (Viability of some potential solutions will be dependent on broader 'whole system' change, envisaged by the Carter report, which will be beyond local control.)

4	Prescribing policy	Consultant Pharmacist – Evidence Based Practice	Review prescribing policy (including formulary arrangements) to deliver improved patient care, product rationalisation and inventory management. This will include: • Building on existing joint arrangements with primary care • Improved uptake of bio-similar products in line with national guidance • Audit of prescribing against available benchmarking data • Therapeutic switching • Incorporation of the monthly NHS Improvement top 10 medicines with savings in to local policy. • Ensure decisions made by the Regional Medicines Optimisation Committee are incorporated in to local policy. **Implementation of agreed changes to deliver efficiencies in line with NHS England 2017/18 CQUIN targets.**	Explore collaboration with STP partners with a view to harmonising formulary arrangements across the STP foot print. To ensure that the most appropriate choice of clinically and cost effective medicines (informed by the best available evidence base) are made that can best meet the needs of the patient.	
5	Electronic Prescribing & Medicines Administration	Chief Information Officer & Chief Pharmacist	EPMA for inpatients is largely in place but potential for implementation in Clinical Decision Units, Paediatrics, Obstetrics, Critical Care and Day Case Units will be explored. **Implementation of JAC version 2016** Develop option appraisal for out-patient prescribing.	Review possible solutions for integrating EPMA with primary care prescribing data (with a view to improving medicines reconciliation on the transfer of care) and other hospital clinical systems.	

6	Business support	Senior Pharmacy Operations Manager	Work with finance to improve mechanisms for supporting commissioning and income activities. This will include: • Mapping and providing monthly information requirements • Supporting and monitoring BlueTeq arrangements • Appropriate coding of high cost drugs in reference costs. Work with Care Group Management teams to ensure their requirements for medicines use information, as part of their clinical governance and financial management arrangements, are met. This will include exploring increasing the level of medicines use information in the PLICs system. Review rationale for providing services to third parties against the following criteria: 1. Service supported is clinically integrated with DBH clinical services 2. Allows economies of scale 3. Excess income supports DBH service provision Review service contracts and propose negotiated withdrawal from any that do not meet criteria Develop and provide a dashboard of metrics which support medicines optimisation and the delivery of the HPTP.		

7	Dispensing and ward/departmental stock logistics	Chief Pharmacist	Ensure the availability of dispensing and stock supply services to support seven day patient care, clinical pharmacy and medicines optimisation. To include review of: • Opening hours • Staffing • Range of services Review of the range of products supplied via home delivery and further opportunities for use of outsourced dispensing. Review arrangements for ward/department stock holdings and associated logistics (links to supply chain modernisation above) to include: • Stock rationalisation • Secure storage facilities • Supply arrangements Explore potential for community pharmacy dispensing of discharge medicines.	Identify local stock logistics implementation of any collaboration in procurement and stock distribution (see 3 above) Work with IT to explore options for informatics support for dispensing and stock logistics. To include: • Potential links between EPMA and dispensary automation • Electronic ordering of ward/department stock • Automated storage at ward/department level.	Implementation of agreed informatics solutions

8	Workforce	Chief Pharmacist/ Chief Pharmacy Technician/ HR Business Partner	Staff engagement with HPTP including any changes to service provision, skill mix and rotas. (to include formal consultation if required)
			
			Identify skills, competencies required to deliver HPTP to inform a workforce model which will include:
			• Defining the size & structure of the workforce
			  ○ Risk managed/competency approach to pharmacy skill mix
			  ○ Enhanced technical roles
			  ○ Pharmacist prescribing
			  ○ Identification of skill/competencies better delivered external to the pharmacy service (eg at Care Group and Trust level or external to DBH)
			• Redesigned shift patterns and duty rotas
			• Training requirements and provision
			• Recruitment & retention.
			
			Implementation of agreed changes
				On-going staff engagement activities
				
				Review staffing and skill mix in the light of services changes as they are implemented
					On-going staff engagement activities
					
					Review staffing and skill mix in the light of services changes as they are implemented

5.2. Implementation and Accountability

Once the Plan is agreed by the Trust Board, work stream leads will be responsible for developing detailed implementation plans for their areas of responsibility which will include delivery timetables and milestones. Where significant service change is required and/or there are resource implications detailed business cases will be prepared for consideration and prioritisation by the Trust's Management Board.

A project team chaired by the Chief Pharmacist made up of work stream leads and the Deputy General Manager for Diagnostics and Pharmacy will be responsible for day to day management of implementing the plan. The Project Team will be accountable to a Project Board Chaired by the Chief Operating Officer and including representatives of the Medical Director, the Director of Nursing, Midwifery & Quality and the Director of Strategy and Improvement. Further monitoring of implementation will be provided by the Trust's Carter Oversight Group.

6. Risks & Mitigation

While early actions, those included in Year 1 of the plan (2017/18) are entirely within the control of the Trust, many of those included in years 2 and 3 (2018/19 and 2019/20), which are dependent on collaboration with STP partners, private sector partnerships and/or broader 'whole system' change in the external supply chain, are not. The elements of the plan which are beyond the Trust's direct control will influence implementation beyond year one and as such will impact on the Trust's ability to meet the full requirements of the Carter recommendations. In part these risks have been mitigated through early agreement in principle between STP area chief pharmacists, on which areas are considered suitable for collaboration and for which of this private sector involvement may be appropriate.

If current problems with the recruitment and retention of pharmacy staff continue, the lack of staff with the required knowledge and skills may restrict or delay the implementation of the HPTP. Working with Health Education England via the Yorkshire & Humber School of Medicines Optimisation, this will be mitigated by increasing local staff development programmes.

The range and nature of the clinical services provided by the Trust and the way these are be managed could change during the period covered by the plan, as a result of STP implementation and local clinical reconfiguration. This in turn might require significant changes in the way pharmacy services are provided to support the Trust's clinical activity. Where these changes can be anticipated they have been built in to the early stages of the HPTP and the plan will be reviewed in the light of SPTP developments as these become clearer.

Collaboration between hospital pharmacy services will partly be restricted by the legal barriers preventing delivery of services between different legal entities, in the absence of the required Manufacturing, Wholesale Dealing and Controlled Drug Licences. This will prevent

early release of staff from some non-core services that collaboration might otherwise deliver. This will particularly affect the areas of aseptic dispensing/preparation and medicines procurement. Alternative arrangements involving private sector partners (and other NHS organisations holding the required licenses) will be perused and once the changes to the configuration of clinical services and management arrangements that will be brought about by the implementation of the STP are clear a further review of STP partner collaboration (including application for the required licences to facilitate joint working) will be carried out.

Plans to increase the number of pharmacist prescribers are already being affected by restricted access to non-medical prescribing courses (due to both insufficient funded places and the local prioritisation of available places for nurse practitioners). Maximum use will be made of the option to include prescribing qualification as a module in the final year of the Bradford Clinical Pharmacy Post graduate Diploma. However operational considerations will prevent all diploma students being offered this opportunity.

Appendix 1

Yorkshire & Humber Clinical Pharmacy Group

Summary of Hospital Pharmacy Core Clinical and Infrastructure Services, September 2016

This table summarises the range of activities recommended by the Yorkshire & Humber Clinical Pharmacy Group for classification within each of the service areas defined in the Lord Carter Report.

Clinical Services	Variable Infrastructure Services				
	Supply Chain	**E&T**	**Advisory Services**	**R&D**	**Services to External Organisations**
Clinical pharmacy on wards, ward rounds and MDTs	Stock distribution	Teaching	Medicines Information	Clinical Trials	Community (if not part of the organization)
Ward pharmacy medicines ordering, discharge and near patient dispensing	Dispensing	Learning	Medicines Commissioning	Research	Mental health
Checking patient's own drugs	Accuracy checking		Formulary		Hospices
Clinical pharmacist prescription validation in any environment including homecare, clinical trials and other relevant settings	Procurement		Out of hours medicines advice		Prisons
Prescribing in any environment	IT & Equipment				Care Homes
Medicines administration and support	QA & QC				GP practices
Audits	Production				
Teaching or learning whilst delivering or contributing to direct patient care activities	Out of hours medicines supply				
Governance & risk activities					

Managerial activities related to the individual services (e.g. service development, policy and procedure development, human resources, financial management) will be included as activities within that specific service area.

Appendix 1

MEMORANDUM OF UNDERSTANDING – AGREED AREAS OF POTENTAIL COLLABORATION BETWEEN THE ACUTE HOSPITAL PAHRAMACY SERVICES IN THE SOUTH YORKSHIRE & BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN AREA

The Chief Pharmacists of South Yorkshire and Bassetlaw Acute Hospitals have met and agreed areas of potential collaboration to be included in the individual organisations Hospital Pharmacy Transformation Plans. These are:

- Aseptic dispensing/preparation*
- Quality assurance
- Medicines information
- Medicines procurement*
- Stock distribution*
- Education and training
- Emergency OOH on-call
- Procurement of outsourced dispensing (subject to the timescales of existing contracts)

(* to include private sector partnerships where appropriate)

Subject to the approval of individual Trust Boards (and or the STP Board where appropriate) the chief pharmacists have undertaken to work together during 2017/18 to develop detailed plans for collaboration for delivery in 2018/19 and beyond

Parties to this agreement are:

Barnsley Hospital NHS Foundation Trust	Michael Smith	Chief Pharmacist
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	Andrew Barker	Chief Pharmacist
Rotherham NHS Foundation Trust	Osman Chohan	Chief Pharmacist
Sheffield Children's NHS Foundation Trust	Joanne Wragg	Director of Pharmacy
Sheffield Teaching Hospitals NHS Foundation Trust	Damian Child	Chief Pharmacist

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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Well Led Governance Review**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Matthew Kane, Trust Board Secretary**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

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

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

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

Evidence was gathered over an eight-week period from a variety of sources including a Board self-assessment, interviews with Board members and other senior staff, workshops with care group directors, governors and staff, and telephone conversations with key external stakeholders.

A copy of the summary report of the review is attached as an appendix to this report. The report makes eighteen recommendations on how the Trust could enhance its governance arrangements.

In response to the report the Trust is now required to formulate an action plan to address the findings and recommendations from the review. The action plan will be agreed with NHS Improvement to comply with the licence undertakings.

The proposal in this report is to carry out that work through a working group of the Board.

Recommendation

That:

(1) the Board of Directors approve the establishment of a working group consisting of the Chair of the Board, Acting Chief Executive, Chair of Clinical Governance Oversight Committee, Linn Phipps and the Trust Board Secretary to develop a management response to the Well Led Governance Review and formulate an action plan.

(2) The action plan be subject to quarterly monitoring by Board of Directors.

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

We always put the patient first
- *By ensuring a high quality of care*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity
- *By ensuring that staff at all levels have an input into the running of the Trust*

Committed to quality and continuously improving patient experience
- *By ensuring that clinicians assess and authorise any changes to services*

Always caring and compassionate
- *By living the We Care values in everything we do*

Responsible and accountable for our actions – taking pride in our work
- *By recognising, owning and taking forward recommendations for improvement*

Encouraging and valuing our diverse staff and rewarding ability and innovation
- *By having in place excellent mechanisms for staff engagement*

Related Strategic Objectives

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

Analysis of risks

The main risk surrounds the danger of not implementing the recommendations from the review or implementing but not embedding them. Measures in place to mitigate those issues include the establishment of the working group charged with driving forward the action plan and regular monitoring by the Board.

Board Assurance Framework

8	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards, triggering regulatory action	4x4=16

Deloitte.

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Doncaster and Bassetlaw NHS Foundation Trust

Independent review of governance arrangements

Private and confidential

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Board of Directors
Doncaster & Bassetlaw Hospitals NHS Foundation Trust,
Doncaster Royal Infirmary
Armthorpe Road
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DN2 5LT

11 January 2017

Dear Board of Directors

Independent review of governance arrangements

In accordance with our Letter of Appointment dated 4th October 2016 (the 'Contract'), for the independent review of governance arrangements at Doncaster & Bassetlaw Hospitals NHS Foundation Trust (the 'Trust'), we enclose our final report dated 11 January 2017 (the 'Final Report').

The Final Report is confidential to the Trust and is subject to the restrictions on use specified in the Contract. No party, except the addressee, is entitled to rely on the Final Report for any purpose whatsoever and we accept no responsibility or liability to any party in respect of the contents of this Final Report. This report is prepared for the Board of Directors as a body alone, and our responsibility is to the full Board and not individual Directors.

The Final Report must not, save as expressly provided for in the Contract (including, inter alia, clause 5 of the call-off terms) be recited or referred to in any document, or copied or made available (in whole or in part) to any other person.

The Board is responsible for determining whether the scope of our work is sufficient for its purposes and we make no representation regarding the sufficiency of these procedures for the Trust's purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to the Trust.

We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability. In particular, no detailed testing regarding the accuracy of the financial information has been performed.

The matters raised in this report are only those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the strengths or weaknesses that may exist or all improvements that might be made. Any recommendations for improvements should be assessed by the Trust for their full impact before they are implemented.

Yours faithfully

Deloitte LLP

Deloitte LLP

Executive Summary

Executive Summary

Context and background

Doncaster & Bassetlaw Hospitals NHS Foundation Trust (hereafter "the Trust" or "DBHFT") was one of the first ten NHS trusts to become a Foundation Trust in 2004. DBHFT is a multi-site acute district general hospital, serving a population of approximately 420,000 people in the areas covered by Doncaster Metropolitan Borough Council and Bassetlaw District Council and also parts of North Derbyshire, Barnsley, Wakefield, Rotherham and North-West Lincolnshire. Approximately 6,500 staff are employed by the Trust.

In addition to DGH services, the Trust also provides a number of specialist services, including renal services, bariatric surgery, vascular surgery and neonatal care.

Having originally forecast a small surplus for 2015/16, a significant misreporting of the financial position was discovered in October 2015. Revised accounts for the year reported a substantial deficit of £46.7m, £36.4m of which related to the routine operations of the Trust.

In response, the Trust established a Directorate of Strategy and Improvement, along with a small team to lead the financial turnaround. During this challenging period, the Trust has concurrently achieved a number of key strategic and operational objectives. These include the recent awarding of Teaching Hospital status, which was a core aim of the 2013 – 2017 strategic direction.

Throughout the turnaround period, the Trust has also maintained, and in some cases improved, many of its key quality indicators, including for example in relation to falls, pressure ulcers and the hospital standard mortality ratio.

Equally, operational performance has remained strong, with national standards in relation to referral to treatment and access to emergency care benchmarking among the best regionally.

The Trust is now set to undergo a further period of change as the Chairman and CEO leave the organisation in December 2016 and January 2017 respectively. Alongside this, a number of planned changes to the NED composition will also take place.

We have undertaken an independent review of governance arrangements at the Trust against NHS Improvement's Well-led Framework. This review has been commissioned in part as a response to requirements set out by the regulator in February 2016 in relation to its enforcement undertakings.

In addition to the review against the Well-led Framework, NHS Improvement specified eight areas of focus for the review which are outlined in the Introduction and Appendix 2 of this report.

During our review we have noted a number of areas of good practice, including:

- The Board has led the response to the financial turnaround internally which has earned the respect of the wider workforce and has been a key factor in the delivery of financial improvements whilst maintaining a focus on quality and performance;
- The wider culture of the Trust is clearly focussed around the quality of service provided, with good levels of awareness of the 'We Care' values amongst staff;
- There is good support for the ongoing training and development of the workforce, which is recognised and valued by staff; and
- The Trust is effectively engaged in system-wide strategic discussions across the broader healthcare system, although broader executive team visibility with some other stakeholders could be improved.

We have also noted a number of areas where further progress and improvements are required. These include:

- The Trust is aware of the need to refresh its corporate strategy, including the development of key aspects such as the clinical services strategy and the supporting capital and financial plans. Alongside this, there is scope to increase the level of focus and Board time on strategic development and formal monitoring of strategic delivery;
- The format of the BAF and CRR should be revisited, ensuring that that more effective use is made of them to drive the agenda and focus of the Board and committees. In addition risk management arrangements need to be further embedded within the Trust;

Executive Summary

- There is scope to improve the focus and impact of debate, which has inevitably become more operationally focussed over the last twelve months. Alongside this the Board should consider a programme of Board and Executive team development under the direction of the new Chair and CEO;
- There is an opportunity to broaden the scope of committees to encompass areas of assurance such as quality impact assessments, capital, financial planning and performance, and service line reporting. This should include addressing duplication between both the Board and executive committees;
- We also found scope to strengthen the consistency and rigour of governance and reporting arrangements within Care Groups, including accountability meetings and clinical governance meetings; and
- Assurances around data quality (DQ) are in the process of being implemented, including proposals to revise the data quality kite marks provided to the Board. There remains, however, a number of concerns in relation to the new e-systems which need to be addressed.

Overall, we found that the Trust's self-assessment demonstrates a positive level of self-awareness in a number of areas, including the need to strengthen risk management arrangements at a corporate level and to refocus and broaden the work of operational accountability fora and committees as the Trust begins to exit the turnaround phase.

There are, however, a number of further areas of variance between the Trust's self-assessment, and our own view, particularly in relation to the materiality of the work yet to be undertaken to refresh strategy, and the strength of the assurances in place around data quality.

Our review findings set out within this report are grouped under the four theme areas outlined within the NHS Improvement Well-led Governance Framework, namely:

1. **Strategy and planning;**
2. **Capability and culture;**
3. **Process and structures; and**
4. **Measurement**

1. Strategy and planning

1A Over the last fourteen months the Board has understandably placed significant focus on responding to the financial position and the transformation agenda. Alongside this, the Board has increasingly been a key participant in broader strategic discussions across the region, including the development of the Sustainability and Transformation Plan.

- Within this context there is now a need to increase the level of focus on strategy by the Board. This was acknowledged by a number of Board members who noted that debate had become too operationally focussed. As a result the incoming Chair should revisit the Board agenda and its development time to increase the focus in this area.
- Work is currently ongoing to refresh the five year plan and there is active involvement of Care Groups in this process. The Trust also recognises the need to further develop several key supporting strategies such as the clinical services, long term financial and capital strategies which are not yet in place.
- The Trust is able to demonstrate a number of achievements against long standing strategic objectives, the most recent being achievement of teaching hospital status. Monitoring of strategic delivery is currently undertaken at Executive level, however we found scope for more formal tracking of progress at Board and committee level.

1B There is scope to strengthen risk management processes at all levels of the organisation. In particular, the Board has recognised a need to increase the value added by the BAF by reviewing both its format and content, but also in improving how it is used to stimulate strategic debate.

- While we found positive awareness at a frontline level of risk and incident reporting, there is a need to formalise risk management through Care Group governance meetings by ensuring the consistent debate and escalation of risk in line with the Risk Management Policy. Staff should also be given timely feedback to risks and incidents raised.

Executive Summary

- The Trust is currently delivering against the turnaround plan, and clear processes are in place to govern schemes and assess their quality impact. We did however find mixed awareness of these processes at Care Group level, in part as processes have recently been changed due to turnaround.
- This extends to the ongoing monitoring of schemes and post implementation reviews which need to be more consistently undertaken and reported against at all levels within the Trust.
- The former Corporate Investment Committee was suspended when the financial misreporting was uncovered, with these duties discharged between the Executive Team and Management Board in the interim. The processes previously in place have been revised and re-instated from January 2017 under the direction of the new DoF, following interim suspension during Turnaround.

2. Capability and Culture

2A The Board made a conscious decision to maintain its composition throughout the turnaround period, leading the response to this internally. This has earned the respect of the wider workforce and has been a key factor in the delivery of the programme whilst maintaining a focus on quality and performance.

- The executive team are highly regarded by staff and are seen as accessible, displaying the values of trust, and setting a culture of collective ownership amongst the wider workforce in relation the Trust's performance.
- During our observations, we observed some good, effective examples of challenge. However a number of BMs noted that debate needs to be more focussed on priority areas and less operational in order to have a greater impact. In particular there is scope for greater contribution from both NEDs and EDs in the role of the corporate director.
- The Board is about to enter a period of significant turnover, most notably in the positions of CEO and Chair. External stakeholders in particular stressed the need for the new leadership to focus on maintaining momentum both in internal improvements and in continued progression of strategic discussions across the patch.
- There is scope to increase the degree and structure of Board and Executive Team development activity undertaken. There is also a recognition of the need to develop Board succession planning and increase Board diversity, both of which are being addressed as part of recent NED and Chair appointments.

2B The Board has a strong focus on the quality of services, which has led to improvements in a number of quality priorities, including for example in falls, pressure ulcers and mortality.

- We also found the wider culture of the Trust to be clearly focussed around the quality of services provided, with good levels of awareness of the We Care values amongst staff.
- A number of effective mechanisms for staff engagement are in place which have contributed to the sense of pride and belonging amongst staff we interviewed as part of our service visits.
- There is however a recognition that there is a need to maintain appraisal rates at previously achieved levels amongst staff to ensure that the alignment of objectives to strategic priorities is meaningful in practice.
- Our review placed a particular focus on the arrangements for whistleblowing and raising concerns. We found policy to be fully aligned with national policy and guidance, and staff to be aware of these and comfortable escalating concerns with an expectation that they would be treated fairly.

2C Ward level quality and safety profiles are used effectively to identify and escalate services where quality and safety metrics trigger cause for concern. There is good awareness and ownership of this tool by staff.

- There is good support for the ongoing training and development of the workforce, and during our fieldwork staff highlighted examples of how the Trust has supported their personal and professional development.
- There is however inconsistency among teams as to the frequency of meetings to discuss learning, performance and improvement, with some areas meeting monthly and others not having met for over six months. This is combined with a lack of awareness among some staff of how their team or ward is performing.

Executive Summary

3. Structures and processes

3A The Trust responded promptly to the review of the financial misreporting to introduce a Financial Oversight Committee. This is a Board assurance committee, and brings DBHFT into line with the majority of Trusts in this area.

- However, Board members are aware of a need to review and refresh the role of committees to ensure their fitness for purpose. In particular, we would highlight a need to ensure that the focus and remit of committees is sufficiently broad to cover all elements of good practice, and to ensure they are effectively providing assurance to the Board on key areas of strategic risk, including through their use of the Board Assurance Framework.
- More specifically we noted a need: to continue the progress made by the Audit and Non Clinical Risk Committee on the strengthening of the focus on internal audit; for more analysis of dashboard and performance against key quality metrics at the Clinical Governance Oversight Committee, and for the Financial Oversight Committee to adapt and broaden its focus to include a greater focus on financial planning and performance, capital and quality impact assessments.

3B Management Board has a congested agenda with a significant proportion of its time spent considering and approving business cases to the detriment of time available for other important items. This has been recognised by the Trust which is in the process of establishing capital and business planning structures to manage this aspect of Management Board's agenda, following processes put in place during the Turnaround.

- We found scope to streamline the accountability structures at Care Group level to avoid duplication and introduce a degree of earned autonomy for sustained high levels of performance and delivery. There is also a need to strengthen the consistency and rigour of governance and reporting arrangements at Care Group Accountability meetings.
- There are a number of strengths in relation the reporting and escalation arrangements in place for quality and safety issues. In particular, the Quality and Safety Profiles were observed to work effectively to identify and escalate issues up from services to committee and ultimately Board level.
- There is however a need to revisit the effectiveness of service level clinical governance structures as we found these to be variable in terms of frequency, leadership and effectiveness; this already noted as an issue by CGOC.
- The Trust has appointed new Internal Auditors as part of their response to issues identified following financial misreporting. Our review of the Internal Audit forward plan found broad and appropriate coverage and risk focus incorporating financial controls, clinical governance, risk and data quality.

3C The Trust is viewed by all stakeholder groups as being open and transparent in its communications.

- A range of mechanisms to involve and engage Governors are in place, and these compare favourably to those we have seen in other Foundation Trusts.
- Most external stakeholders highlighted positive engagement with the Trust, noting effective contribution in broader system debate. However, engagement with some stakeholders is less frequent or is primarily based upon contact with the CEO. Given the imminent change in CEO leadership, this will need to be a key area of focus for all executives moving forward.
- In preparation for the forthcoming change in leadership at the Trust, the Board should review engagement with all key stakeholders to enable a smooth transition and to develop broader engagement across the executive team.

4. Measurement

4A The Trust's key performance report has responded and adapted to the needs of the business over time, including the recent addition of key workforce metrics. There remains however a need to introduce a fully integrated performance report, including financial indicators, to enable the triangulation and impact of performance in different areas, namely across quality, performance, finance and workforce.

Executive Summary

- We have observed a strong focus on quality reporting at Board level and, as referenced, some of this good practice should now be reflected at the Clinical Governance Oversight Committee.
- A number of recent changes have also been made to Board and committee level finance reporting to bring this more into line with regulatory expectations. We understand that further enhancements in this area are a priority of the new Director of Finance, and should include greater analysis of key risks and trends within performance, highlighting relevant divisional variances.
- While performance information is readily available at a team and service level, the extent to which frontline staff in different areas are aware of this is mixed. We also found scope to develop more macro-level Care Group dashboards to aggregate the wealth of specialty level data currently in place.

4B The Trust has historically performed well in relation to national and externally tested data quality audits, however interviewees reported some concerns in this area including issues arising from key e-systems (being ESR and CAMIS) and also the case of financial misreporting.

- The Trust can evidence that plans have been put in place to address these, including bringing additional capacity into the coding department, trialling new methodology to reintroduce data quality kite marks to the Trust performance report, and also strengthening the internal audit focus in this area. More specifically, a data quality improvement plan is also in place to address the recent anomalies found in relation to referral activity.
- An Informatics Strategy is in place, dated 2014. Work to refresh this, bringing some of the aforementioned workstreams together, has been identified as an early priority of the new Chief Information Officer.

Next steps

We suggest that the Chair and Chief Executive, in consultation with the Board and incoming Chair, consider the findings outlined within this report and write a management response in relation to the matters raised. This response should clearly outline how the Board proposes to implement our various recommendations, and describe how the Board will monitor progress going forward.

Appendix 1:
Recommendations

Appendix 1: Recommendations

Key: Designed / Implemented

Rec	Ref	Recommendation	Timescale (J F M A M J J A S O N D)
R1	**1A**	The new Chair should revisit the Board calendar to enable greater time to focus on strategic development and monitoring. As part of this process, there needs to be collective agreement amongst the Board on the gaps and priorities for debate in this area.	
R2	**1A**	Ensure that there is consistent and explicit review of progress against strategic objectives, including a focus on impact and outcomes, at Board and committee level.	
R3	**1A**	Ensure that the annual planning process is clearly documented, is fully understood by all involved, and enables sufficient interaction between the Board and Care Groups throughout the year.	
R4	**1B**	The format and use of the BAF and CRR need to be revised to take into account the commentary made in 1B.1	
R5	**1B**	Further develop the CIP planning and execution process by: • Ensuring that all CIPs have sufficient clinical engagement at both the identification, QIA and sign-off stage; • That all major schemes are subjected to a post-implementation review which incorporates staff and patient feedback (e.g. through surveys); • Strengthening CIP assurance reporting from the Turnaround Programme Board to the FOC and CGOC	
R6	**2A**	There is scope to improve the focus and impact of Board debate and scrutiny. This includes a greater focus on the role of the corporate director and making the best use of the diverse skills around the table.	
R7	**2A**	Implement a programme of development for the executive team and Board. This should focus on the points outlined within this report, and build in greater time for strategy as well as team development.	
R8	**2B**	As part of its refresh in 2017 ensure that the People and Organisational Development Strategy includes a more explicit focus on equality and diversity.	
R9	**2B**	Reconsider how NEDs and governors engage meaningfully with staff and gain assurance within their current time allocation at the Trust, including through refreshing the existing NED service visits.	
R10	**2C**	Undertake a review of the frequency and effectiveness of service and speciality level clinical governance meetings, addressing any findings and reporting assurance on progress to the CGOC.	
R11	**2C**	Alongside recommendation 11 to review specialty level CG structures the Trust should also review the arrangements for ward teams to meat to discuss learning and improvement alongside introduction of a standard agenda for discussion which should include team level quality performance data.	

Appendix 1: Recommendations (continued)

Key: Designed / Implemented

Rec	Ref	Recommendation	Timescale (J F M A M J J A S O N D)
R12	**3A**	To further increase the effectiveness of ANCRC, the Trust should: • Update the committee work plan to reflect the revised terms of reference, incorporating the elements of good practice referenced in 3.A.1; • Maintain the more concerted focus on follow-up of internal audit recommendations in line with the proposals made in September 2016; • Increase the level of focus and scrutiny on the effectiveness of risk management arrangements; and • Review the reporting lines for the ANCRC sub-groups.	
R13	**3A**	CGOC should: • Consider ways in which it can better align its agenda to the Quality Strategy goals to increase focus in this area, and also awareness of the strategy; • Using the BIR as a starting point, introduce a CGOC dashboard to direct debate towards key areas of exception and redress the balance of committee reporting between analysis and narrative; • Ensure that items which are not relevant to the ToR are appropriately referred to FOC or ANCRC; and • Update the ToR and work plan to reflect the good practice areas discussed in this report.	
R14	**3A**	Revise FOC to expand the focus of the committee, including greater focus on: capital and investment priorities and plans; performance against plan, and SLR. As part of these changes, the Trust should seek to reduce any existing duplication between the work of FOC and other forums.	
R15	**3A**	Revise reporting lines for WEC so that quality aspects of its business are reported to CGOC, and workforce transformation and efficiency aspects are reported to FOC.	
R16	**3B**	The Trust should look to rationalise its performance and structures at Care Group level, where possible creating a single forum for holding each Care Group to account for delivery and performance. These should have consistent ToR, agendas and governance structures and should take place at a frequency appropriate to the track record of performance and delivery in each group.	
R17	**3C**	In preparation for the forthcoming changes in the Board, a stakeholder mapping exercise should be undertaken to ensure clear responsibility and transition of relationships.	
R18	**4A**	Update the BIR to incorporate the elements of good practice defined in 4A.1.	

Deloitte.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Approved Procedural Documents (APDs) Development and Management Policy**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Richard Dickinson – Acting Deputy Director of Nursing, Midwifery and Quality**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The Board of Directors is responsible for the management and governance of the Trust. The Executive Directors are accountable for the management of the services they manage.

The Board of Directors is the approval body for key organisation strategies and policies, in line with the Standing Orders and Standing Financial Instructions.

The context of the APD policy is for policies, procedures, guidelines and standard operating procedures (SOP's), and does not include strategies, which are approved by the Board of Directors. The APD policy sets out the process for the Trust to follow and provide an appropriate management and governance process. Delegated authority is managed through Executive sponsorship and approval at appropriate committees of the Trust.

Staff are supported to adhere to the process using templates that are to be published with the policy, designed to adopt the standardised style, formatting and main headings. Checklists for demonstrating Equality and Diversity Policy considerations and consultation processes compliment the process and enable utility.

Recommendation

The Board of Directors is asked to APPROVE the Approved Procedural Documents (APDs) Development and Management Policy.

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

We always put the patient first
- *By providing a structured approach to the way our services are managed*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity
- *Considering the views of staff through consultation processes*

Committed to quality and continuously improving patient experience
- *Identifying the purpose of why policies and procedures exist in designing quality systems*

Always caring and compassionate
- *Demonstrating the Trust values and objectives*

Responsible and accountable for our actions – taking pride in our work
- *Defining the duties of staff clearly to set out expectations*

Encouraging and valuing our diverse staff and rewarding ability and innovation
- *Considering equality and diversity impacts for staff*

Related Strategic Objectives

- Provide the safest, most effective care possible
- Control and reduce the cost of healthcare
- Focus on innovation for improvement

• Develop responsibly, delivering the right services with the right staff		
Analysis of risks		
The policy, when implemented, will contribute to the mitigation of risks associated with Well Led requirements for NHS Improvement and CQC regulations. Staff and managers are provided with decision making support and principles to work within.		
Board Assurance Framework		
8	Failure to achieve compliance with performance and delivery aspects of Monitor Risk Assessment Framework, CQC and other regulatory standards, triggering regulatory action	4 x 4 = 16

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Approved Procedural Documents (APDs) Development and Management Policy

[APDs include: Policies, Procedures, Guidelines and Standard Operating Procedures (SOPs)]

This procedural document supersedes: CORP/COMM 1 v.6 – Approved Procedural Documents (APDs) - Development and Management Process.

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.**

Executive Sponsor(s):	Moira Hardy – Acting Director of Nursing, Midwifery and Quality and Sewa Singh – Medical Director
Author/reviewer: (this version)	Richard Dickinson –Acting Deputy Director of Nursing, Midwifery and Quality
Date revised:	January 2017
Approved by (Committee/Group):	Board of Directors
Date of approval:	To be inserted when approved
Date issued:	To be inserted when issued
Next review date:	January 2020
Target audience:	All staff, Trust-wide

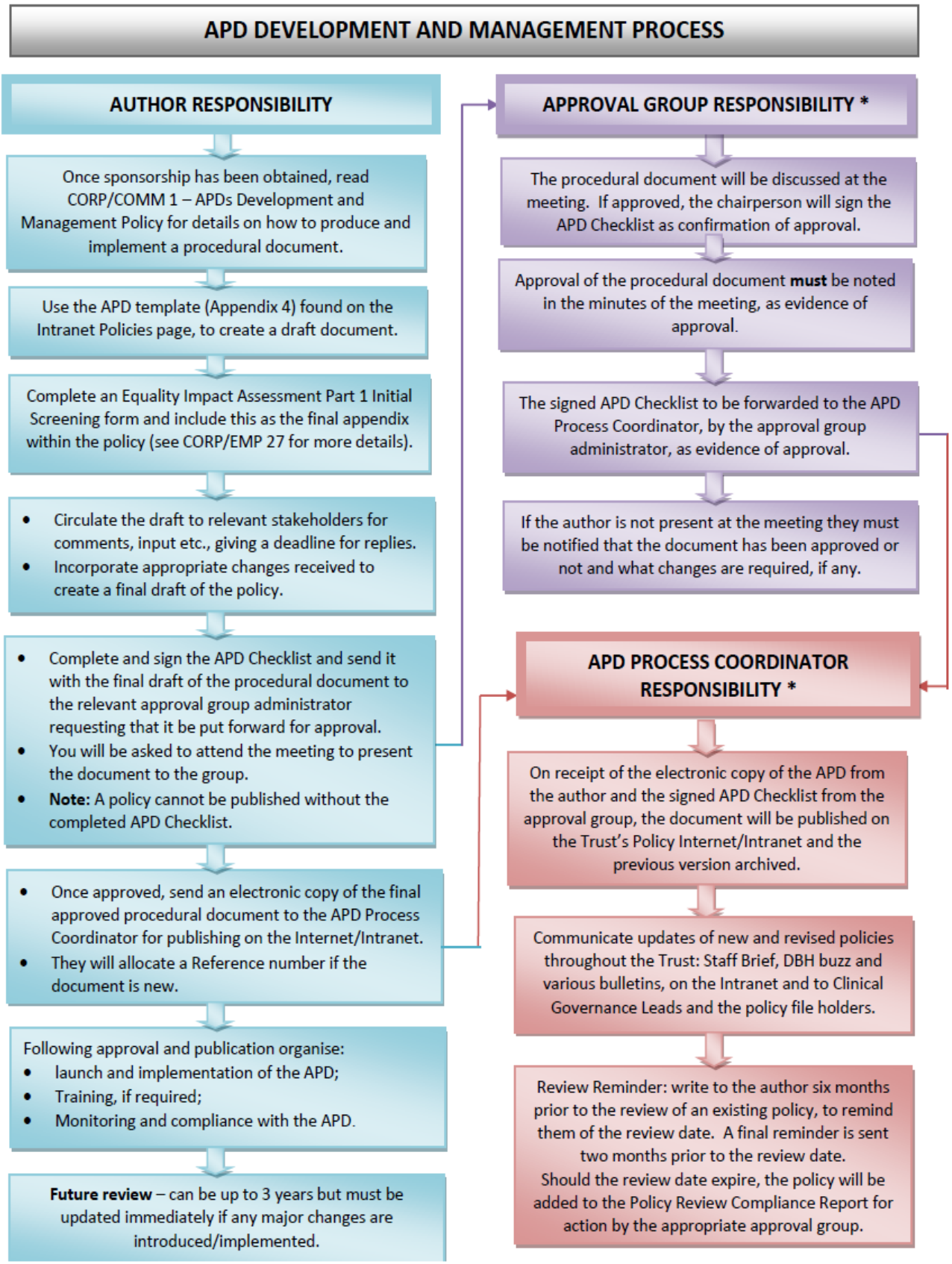
Amendment Form

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 7	To be inserted when issued	• Updated restructure terminology. • Updated Duties and Responsibilities. • Adjusted Policy Approval Committee and Groups. • Updated Equality and Diversity assessment principles and links to Ethics Committee. • Refreshed Monitoring Compliance principles. • Overdue review process described. • Implementation added to Dissemination section. • Updated format and use of Style function in MS Word on the template.	R Dickinson
Version 6	February 2012	**Major changes made throughout, including:** • Title change • New APD Process Flow Chart – Appendix 2 • Format and style change and order of contents re-arranged. Always use 'Align Left' margins. • 'Warning' statement replaced by 'Did you print this document yourself'? • New section 'Training and Support' added. • Monitoring Compliance section substantially revised. • Updated approval group list and locations of paper copy files. • APD template reviewed and updated in line with the above changes.	APD Process Co-ordinator and APD Process Group
Version 5	February 2010	• **Major changes made throughout - PLEASE READ IN FULL.** • Title changed to: Development and Management of Procedural Documents within the Trust • Updated in line with the NHS Litigation Authority guidance. • Reference made to the NHS Constitution • APDs referred to as 'procedural documents' • Numbering and order of contents changed for greater clarity. • Mental Capacity Act and Privacy and Dignity Policy to be considered and referred to when writing or revising procedural documents regarding patient care. • **Appendix 1** - Procedural Document Development Checklist – title changed, updated and condensed onto one page. • **Appendix 3** - List of Approval Groups updated. • New **Appendix 5** - Allocation of Unique Reference Numbers for Procedural Documents. • New **Appendix 6** - Procedural Document Format	Mandy Dalton

Contents

Link to APD Template <hyperlink to be inserted when published>
Link to SOP Template <hyperlink to be inserted when published>



*** CARE GROUP PROCESS FOR LOCAL PROCEDURAL DOCUMENTS -** The same principles above should also be followed for 'local' procedural documents by Care Groups. However, these will be approved at the relevant Care Group Clinical Governance meetings and an administrator should be nominated to carry out the duties of the APD Process Coordinator at 'local' level.

1 INTRODUCTION

An **'A**pproved **P**rocedural **D**ocument' (APD) is a procedural document which has been approved by the relevant body within the organisation. APDs are developed to inform staff on how they must proceed to meet professional organisations' and the Trust's goals. They also form an important strand of the Trust's Governance framework. In order to provide safe and effective care, a robust mechanism for the management of APDs must be in place.

For the purpose of this document, Approved Procedural Documents (APDs) include: policies, procedures, guidelines and Standard Operating Procedures (SOPs). See definitions below:

Policy - a prudent course of action, a principle of action adopted by a government party, business or individual. In general, policy defines what an organisation expects to do whilst procedure and guidance define how the organisation wants to do it.

Procedure - a set of actions which is the official or accepted way of doing something. Reasons for deviation from the procedure must be recorded.

Guideline/Standard Operating Procedure (SOP) - a document setting out the process steps required for the preferred method and process of operation. Other methods are not prohibited but a reason for deviation from guidance must be fully justifiable and line management agreement sought in all cases of any doubt.

The APD process does not cover Trust Strategy documents. The Board of Directors is the approval body for key organisation strategies, in line with the Standing Orders and Standing Financial Instructions.

2 PURPOSE

The purpose of this document is to inform and support all staff who are involved in writing or reviewing a procedural document, describing how to develop and manage Corporate, Care Group and departmental (local) policies. It has been developed to unify the processes involved and to ensure that every member of staff throughout the Trust has easy access to consistent, up-to-date, relevant and evidence-based documents.

This document outlines:

- best practice guidelines for developing and writing procedural documents;
- the process to be followed in developing, disseminating, implementing, reviewing and archiving procedural documents;
- the management and review of procedural documents;
- access to procedural documents.

3 DUTIES AND RESPONSIBILITIES

3.1 Board of Directors

The Board of Directors is responsible for the management and governance of the Trust. The Executive Directors are accountable for the management of the services they manage.

The Board of Directors is the approval body for key organisation strategies and policies, in line with the Standing Orders and Standing Financial Instructions.

3.2 Executive Directors

An Executive Director is required to sponsor the development of any new policy and procedure. The process of policy development and management is delegated to the Director of Nursing, Midwifery and Quality and the Medical Director.

3.3 Director of Nursing, Midwifery and Quality/Medical Director

The Director of Nursing, Midwifery and Quality/Medical Director are accountable for ensuring that APDs are in place and accessible to staff and delegates the responsibility to the Deputy Director of Quality and Governance.

3.4 Deputy Director of Quality and Governance

The Deputy Director of Quality and Governance is responsible for ensuring that the management and process of APDs is in place.

3.5 Sponsorship

Every APD will be sponsored by the appropriate level of management within the organisation. Sponsorship must be sought and agreed with the relevant director (see appendix 2). The sponsor must be involved in the review of policies and agree to changes, extensions or making no change to a policy.

3.6 Authors of Approved Procedural Documents (APDs)

Once sponsorship has been agreed, the author is responsible for developing the procedural document in line with the requirements of this document (see section 4 – 'Procedure for Writing a Procedural Document' for details).

Before creating a procedural document; determine whether it is Trust-wide, Care Group specific or for multiple Care Groups. The grid below clarifies the requirements; follow the APD

Development and Management Process flowchart at the front of this document and use the APD Template to create your procedural document:

Requirements
• Consider and apply as necessary the requirements of the Freedom of Information Act 2000, the Mental Capacity Act, the Equality Analysis Policy (CORP/EMP 27) and the Privacy and Dignity Policy (PAT/PA 28).
• Contact the APD Process Co-ordinator for a unique APD reference number, determined by the subject matter of the document. See Appendix 2.
• Carry out literature review demonstrating the checks for best practice/latest evidence.
• Consult and communicate with stakeholders and groups or committees relevant to the subject matter, including the Ethics Committee where applicable (See sections 4.3 & 4.4)
• Complete the APD Checklist (see Appendix 1) which is available on the Intranet. The checklist **must** accompany the final draft copy of the APD at the approval group**.** APDs will **NOT** be published without a completed and signed Checklist.
• Complete the Equality Impact Assessment Part 1 Initial Screening form (see CORP/EMP 27) and include it as the final appendix to the APD.
• Obtain approval from the relevant committee by submitting the final draft of the APD, along with the completed and signed Checklist to the group administrator, requesting it to be put forward for approval.
• Where appropriate, provide a summary of the key points of the APD which will be accessible at the front of the APD (e.g. flowchart showing procedure/process – policy on a page principle).
• Once confirmation of approval has been received from the approval group, forward the final approved version electronically to the APD Process Co-ordinator for publication and distribution.
• Ensure implementation of the APD (includes identifying training requirements and raising awareness with appropriate staff groups etc.)
• Ensure there is a process in place for monitoring compliance with the APD.
• The review and approval of APDs **MUST** be completed no later than the next review date. When new national or international guidance is received or newly published evidence demonstrates the need for change to current practices, the document must be revised immediately.

No specific format for 'guidance' or SOP is stipulated but the format chosen must be appropriate to the subject matter and the intended audience. See example SOP Template <hyperlink to be inserted when published>.

3.7 General Managers, Heads of Nursing/Midwifery/Therapy and Care Group Directors

The Care Group Management Team are responsible for ensuring that:

- there is a process in place for the management and review of all Care Group and department specific procedural documents.

3.8 Line Mangers

All line managers are responsible for ensuring that:

- staff are made aware of the Trust's APDs at 'Corporate' and 'Local' induction – see CORP/EMP 29 – Statutory and Essential Training (SET) Policy;
- staff receive appropriate training in order to comply with the Trust's APDs;
- staff are compliant with the Trust's APDs;
- APDs are accessible to all staff;
- staff are informed of new APDs and any revisions;
- staff are aware of the location of the 'emergency access' paper copy files.

3.9 All Staff

All staff and volunteers working within the Trust are expected to comply with approved procedural documents to ensure their own safety and that of patients, colleagues, visitors and any other person who may be affected by their actions at work.

3.10 Clinical Governance Leads & Heads of Nursing, Midwifery, Therapies

These roles have leadership responsibilities for quality and clinical governance in Care Groups and are responsible for ensuring that:

- All APDs are complied with and are audited as per the requirements in the APD – Link in with each Care Group annual audit calendar.
- Care Group and Specialty Guidelines are consulted on and approved in line with the principles of this policy.

3.11 APD/Policy Approval Committees and Groups

The Trust has a structured approach to the approval of APDs which is illustrated in Appendix 2. Each approval forum is authorised to approve the allocated range of documents. The Policy Approval and Compliance Group has the overarching duty for monitoring and tracking of each approval forum and has approval rights for any APD though it would not usually approve key organisational strategies or policies (see Appendix 2). The duties of the Policy Approval and Compliance Group are:

- Review of policy for approval, following appropriate consultation with the relevant committees/members of staff, by the author;
- Determine that the key steps have been taken with regard to policy structure, consultation depth and linked to relevant committees and work-streams within the Trust;
- Ensure the policies put forward for approval meet the criteria of the Approved Procedural Document (APD) Checklist prior to approval;
- Provide specialist knowledge to inform the policy approval process and ensure appropriate cross reference to other approved policy documents, in order to fulfil any regulatory or organisational requirements;
- Provide an appropriate level of critique on the principles of plain English to enable ease of use by staff;

- Ensure the author is informed when the policy is approved and published and ensure they are aware of the need to implement it and monitor compliance with it;
- Ensure the author is informed of any rejected policy and the reason for rejection. Ask author to make necessary changes and re-present the policy at a future meeting;
- Monitor compliance of review of all Trust-wide policies through tracking systems;
- Provide reports to the Patient Safety Review Group on the policy approval status for the Trust and escalate concerns when necessary.

The group or committee approving the procedural document is responsible for:

- ensuring completion, signature and compliance with the APD Checklist (see Appendix 1),
- ensuring the content is compatible with the Trust's obligations under the Freedom of Information (FOI) Act 2000.
- ensuring that adequate resources have been identified for implementation,

The Chair of the group is responsible for:

- signing the Checklist, as confirmation of approval, and forwarding a copy to the author of the document and to the APD Process Co-ordinator, (paper or electronic completion is accepted);
- ensuring formal, minuted approval. The minutes may be used as evidence of approval;
- agreeing the withdrawal of any procedural document with the appropriate sponsor of the document and notifying the APD Process Co-ordinator;

3.12 APD Process Co-Ordinator

The APD Process Co-ordinator is responsible for:

- coordinating the approved procedural document process;
- advising and supporting staff on the APD process;
- APD update distribution;
- maintaining/updating the APD database;
- updating and maintaining the APDs on the policy website and removing any superseded APDs;
- communicating monthly updates of new and revised APDs in Staff Brief, DBH buzz and other Trust bulletins and notifying Clinical Governance Leads;
- archiving superseded APDs on the Trust's network.
- Providing paper copies of new/revised/amended policies to the Emergency Access policy file holders?

4 PROCEDURE FOR WRITING A PROCEDURAL DOCUMENT

4.1 Justification

The need for a new procedural document must be justified; linked with service priorities and must not duplicate or conflict with those already in existence. Authors must satisfy themselves that implementation is achievable within available or identified resources and demonstrate this on request. Sponsorship must be sought and agreed with the relevant director.

4.2 Style and Format

Use the standard APD Template for policies and procedures which is available on the Policies Intranet page.

To enable all procedural documents to have a 'corporate' appearance, the document must be produced using 'Calibri' font, 12 point and use 'Align Text Left' margins. Authors must follow the Trust's 'House Style' when writing a procedural document. This is detailed in CORP/COMM 5 - Developing Information for Service Users and Visitors Policy and Guidelines.

All new and revised procedural documents must be developed using the APD Checklist at **Appendix 1** and written using the standard APD Template format. Headers and footers must be populated appropriately and updated with each version change as a suffix to the APD reference number. The main body text of the document must be written in a style which is concise and clear, using unambiguous terms and language.

4.2.1 Guidance/SOPs

No specific format for 'guidance' or SOP is stipulated but the format chosen must be appropriate to the subject matter and the intended audience. See example SOP template.

4.2.2 Abbreviations and Definitions

Abbreviations and definitions must only be used after they have been fully clarified. Explanation of terms used must be listed alphabetically under the 'Definitions' section of the template.

4.2.3 Associated Trust Procedural Documents

Where appropriate; any associated Trust procedural documents must be listed under the 'Associated Trust Procedural Documents' section of the template.

4.2.4 References

Any supporting references must be listed alphabetically, using the Harvard style, under the 'Reference' section of the template.

4.2.5 Cross-Referencing

Cross referencing to other APDs is encouraged when applicable. When cross-referencing another APD within a procedural document, the version number must not be used as that will change periodically.

4.3 Identifying and Communicating with Stakeholders

Whether writing or revising a procedural document, authors must identify and liaise with all stakeholders who will be included in the consultation process. This will include all areas/groups where the procedural document will have an impact e.g. heads of department, clinical management teams and specialist groups as well as external organisations etc.

4.4 Consultation

Authors must ensure that new and revised procedural documents undergo an appropriate review and consultation process. Draft procedural documents must be circulated widely, e.g. Management Teams, Care Group Directors, representation of staff groups affected by the policy, specialist staff groups and any other identified stakeholders, giving clear deadlines for feedback and comments, to ensure that they are complete, correct and acceptable. Comments generated from this consultation must be considered by the author responsible for developing the procedural document. The membership of the policy approval committee relevant to the sign off of the policy will be consulted as a routine part of the consultation process.

4.5 APD Approval Process

Following consultation, when the final draft has been agreed, the author will complete and sign a copy of the APD Checklist and submit this with the procedural document to the relevant committee or group for approval/ratification. Approval groups are shown at **Appendix 2**. The approval of the procedural document must be noted in the minutes of the meeting which may be used as evidence of approval. **NOTE:** an APD will not be published without the completed and signed APD Checklist.

4.6 Monitoring Compliance

The author is responsible for completing the monitoring compliance section within the document under review. Evidence as set out in the monitoring compliance section must be agreed by any contributor prior to APD approval.

The author must use the framework below to identify and detail the key issues within the policy which need to be monitored to ensure compliance.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Example: List identified key issues relevant to this policy…….	Include title of person or group carrying out the monitoring …	Include the frequency e.g. weekly, monthly, quarterly, annually etc…	Include how reviewed, where reported and who will address any shortfalls …

5 REVIEW AND REVISION ARRANGEMENTS, INCLUDING VERSION CONTROL

5.1 Process for Reviewing an Approved Procedural Document

All APDs must be dated and include a review date. The review date is the date by which the APD must be reviewed, approved and in place by. The author responsible for each procedural document will ensure the review is carried out. The 'review date' can be up to a maximum of three years from the approval date, with the exception of those APDs where there is a requirement for them to be reviewed annually. However, any changes in practice, legislation, national guidance, health and safety, risk issues etc., that affect the APD must be implemented and the APD reviewed immediately, irrespective of the next review date, using the full approval process.

Six months prior to the documents review date the APD Process Co-ordinator will write to the author responsible for the review to remind them of the due date. A **FINAL REMINDER** will be sent to the author two months prior to the due date if there has been no correspondence.

The author is responsible for reviewing and sending the revised document to the Sponsor. When they are in agreement to the changes, it will need to be sent to the relevant approval group (see **Appendix 2).** Following approval the group will forward a copy of the signed APD Checklist to the APD Process Co-ordinator as confirmation of approval. The author will send an electronic copy of the approved procedural document to the APD Process Co-ordinator for publishing on the Trust's Policy Website and for distribution to the emergency access policy file holders. **NOTE:** an APD will not be published without the completed and signed APD Checklist.

Reviewed, no changes needed - If, after consultation and review, no changes are required, this should be agreed by the Sponsor. The review dates and approval dates etc. must be included on the front of the document and 'revised without change' must be logged on the amendment form. **Note:** The document still needs approval and must be sent to the relevant group for approval, along with a completed APD Checklist. Once approved, the author must send an electronic copy to the APD Process Co-ordinator for publishing on the Policy Website and for distribution.

Extension of Review Date

Occasionally the review of a policy may be delayed, e.g. awaiting receipt or implementation of National guidance, which will affect the review. In such circumstances, the author must first obtain agreement from the sponsor to extend the review date and then write to the APD Process Co-ordinator giving the reasons and outcome of the agreement to extend the review date rather than allow the policy to lapse.

Overdue reviews

The chair of the relevant approval committee will receive a monthly tracking document (Policy Review and Compliance Report) of all pending and overdue policies. They will be expected to discuss this at their committee meeting and to note it in the minutes. They will document on the action log for that committee the action points being taken to resolve the overdue APDs, including any escalation to the author's line manager when initial actions have not resolved the completion of the APD review. The Policy Approval and Compliance Group will monitor and report on the overdue status, based on feedback provided from the relevant approval committee. The Chair can and will be required to escalate non-compliance to the relevant Director for their intervention should the situation persist.

5.2 Version Control

The APD Process Co-ordinator will allocate a Trust-wide reference number and version number for each APD to facilitate document control. Version numbers will be recorded on the policy and procedure database.

A summary of changes from one version to the next must be recorded in the procedural document 'Amendment Form'. If there are no changes then 'No changes' must also be recorded and the version number will remain the same.

6 DISSEMINATION & IMPLEMENTATION

6.1 Dissemination

The APD Process Co-ordinator is responsible for distributing details of new and revised APDs electronically, via the following mechanisms:

- Publish new and revised APDs on the Trust's Policy Website (Internet)
- Trust Intranet
- DBH buzz
- Staff Brief
- Clinical Governance Leads
- Distributing paper copies to the 'Emergency Access' policy file holders.

Managers are responsible for ensuring dissemination of APD updates to their members of staff (see 3.6).

6.2 Implementation

The author will be responsible for undertaking the appropriate implementation planning and delivery of the change. It is recommended that the author describes their process and uses the Trust management structures to cascade specific changes. The dissemination methods of Buzz, Trust Intranet may provide opportunities for highlighting changes required. Spot-check processes are recommended when there are potential compliance issues or risks identified by approval committees and the author.

7 ACCESS TO PROCEDURAL DOCUMENTS

The Trust's APDs are available on the Policy Website and can be accessed and viewed by clicking on the 'Policies/APDs' link on the top right of the home page on the Intranet – see http://intranet/documents/policies.aspx. It is a requirement that all staff have access to them, either directly or via their line manager. Staff must not print paper copies of APDs for long-term retention and use.

Individual Trust-wide APDs **must not**, under any circumstances, be published on other local Intranet pages. However it is permissible to create an electronic link from other local Intranet pages to the Trust's policy Website. The 'local' Web page owner will be responsible for establishing a process to check the ongoing patency of the hyperlink.

7.1 Policy File Holders (Emergency Access Files)

A set of paper copy policy files are available on the three main Hospital sites; they are held in the following locations for use in the event of an IT system downtime:

Area	Location of Files	Responsible Person
DRI:		
Clinical Site Management Office	Operations Room Suite, Level 4	Clinical Site Manager
Pathology	Pathology - Quality Manager's Office	Pathology Quality Manager
Montagu Hospital:		
Rehab 2 (Adwick Ward)	Rehab 2 (Adwick Ward)	Ward Sister/Charge Nurse
Bassetlaw Hospital:		
Clinical Site Management Office	Management Suite	Clinical Site Manager
Audit and Risk, Education Centre	APD Process Co-ordinator's Office (Master copy)	APD Process Coordinator

Each location has a nominated post-holder who is responsible for maintaining/updating the files and monitoring the contents. The files must be stored in a place that is accessible by staff 24 hours a day, and must not be locked away.

Managers are responsible for ensuring that staff are aware of the nearest location of the 'emergency access' policy files.

8 DOCUMENT CONTROL AND ARCHIVING ARRANGEMENTS

8.1 Register/Library of APDs

The APD Process Co-ordinator will maintain a database of all Trust APDs. The active list of APDs are located on the Internet/Intranet under their relevant sections. See http://intranet/documents/policies.aspx.

8.2 Archiving Arrangements

Withdrawn and superseded procedural documents are retained electronically by the APD Process Co-ordinator. Some historical procedural documents may only be available in hard copy. A paper copy archive is also maintained by the APD Process Co-ordinator, along with the corresponding documentation.

8.3 Process of Retrieving Archived APDs

Archived approved procedural documents can be obtained on request from the APD Process Co-ordinator. These may be relevant to historical investigations.

9 TRAINING AND SUPPORT

No specific training is required, however, you can contact the APD Process Co-ordinator for support and advice.

10 MONITORING COMPLIANCE

The author must complete an APD Checklist for all new and revised APDs, this must be presented along with the APD for approval.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Completion of APD Checklist (signed by author and chair of approval group)	Relevant approval group APD Process Co-ordinator	At the monthly * group meeting * some groups meet quarterly Prior to publishing approved APDs	If the author has not followed the APD process, follow-up with author and approval group.
Timely review of APD. (Email sent to the author as a reminder to review the APD.)	APD Process Co-ordinator	Email sent 6 months prior to review. Final reminder at 2 months prior.	If the review date expires, add to the 'Policy Review and Compliance Report' for action by the relevant approval committee/group.
Receipt of APD updates distributed to the 5 nominated 'emergency access' policy file holders.	APD Process Co-ordinator	Approximately once a month	If acknowledgement slip not received, follow-up with policy file holder and action.
Content of 'emergency access' policy files.	Nominated Policy File Holder	Approx. monthly to coincide with APD updates	Logged on monitoring form which is kept alongside the files.
Audit of contents of the 5 paper copy policy files.	APD Process Co-ordinator	Annually	Report back any shortfalls to the policy file holder.

11 CARE GROUP SPECIFIC PROCEDURAL DOCUMENTS

All Care Group specific (local) procedural documents must be consistent with the Trust's APD process. Each Care Group or Corporate Directorate must identify someone to take responsibility for the management and review process and dissemination, and to link with the 'local' Website Administrator.

The following must be in place within each Care Group or Corporate Directorate:

- an index/database or spreadsheet which includes the name of the 'local' procedural document, reference number, the name of the author, date implemented, date revised and the date of the next review;
- a 'bring forward' mechanism to facilitate the review;
- a robust dissemination and implementation process;
- a local system for archiving and retrieval.

'Local' and Care Group specific reference numbers must avoid any confusion with the Trust's APD unique reference numbers – see **Appendix 2**.

12 DEFINITIONS

APD – Approved Procedural Document
Clinical Management Teams – Care Group Directors, General Managers, Heads of Nusing/ Midwifery/Therapies and Quality
Corporate Senior Managers – Direct reports to the Executive Team
EIA – Equality Impact Assessment
PA&CG – Policy Approval and Compliance Group
SOP – Standard Operating Procedure
Strategy - A plan of action designed to achieve a long-term or overall aim

13 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

Each procedural document must be screened by the author/manager responsible for its development, to consider whether there is an equality dimension or whether it is applicable to the Trust's duty to promote equality.

An Equality Impact Assessment (EIA) form must be completed for all new and revised procedural documents (see policy CORP/EMP 27). 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. [Note: please include completed form and insert as the final appendix to your document].

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). No detriment was identified - See Appendix 3.

14 ETHICS, CAPACITY AND RIGHTS OF PATIENTS AND STAFF

All procedural documents must be developed and reviewed in line with the statutory duty contained within the NHS Constitution to have regard for the rights and pledges for both staff and patient. (ref: The Handbook to the NHS Constitution. DoH Jan 2012).

When writing or reviewing a 'Patient Care' procedural document, please ensure you consider the Trust's Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – (see PAT/PA 19) and the Privacy and Dignity Policy (see policy PAT/PA 28) and refer to them, if relevant.

We have an ethical duty towards patients and should consider if there is any impact or conflict between the principles of doing good, doing no harm, promoting patient autonomy and being just and fair to all. Where there is an 'Equality and Diversity' assessment that identifies a potential equality issue, patient capacity or choices that impact on patients welfare, and these cannot be adequately resolved or mitigated, the Ethics Committee should be contacted for advice as part of the consultation.

15 OTHER ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Equality Analysis Policy (CORP/EMP 27)
- Statutory and Essential Training (SET) Policy (CORP/EMP 29)
- Freedom of Information (FOI) Policy (CORP/ICT 15)
- Information Records Management – Code of Practice (CORP/ICT 14)
- Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) (PAT/PA19)
- Developing Information for Service Users and Visitors Policy and Guidelines (CORP/COMM 5)
- Privacy and Dignity Policy (PAT/PA 28)
- Clinical Records Policy (CORP/REC 5)
- Fair Treatment for All (CORP/EMP 4)

16 REFERENCES

- Department of Health (2012) *The Handbook to the NHS Constitution (2012) [online]:* last accessed 1 May 2012 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

- Great Britain (2000) *Freedom of Information Act 2000.* London, HMSO

- NHS Litigation Authority (2013) *NHSLA Risk Management Standards 2013-14 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care.* http://www.nhsla.com/safety/Documents/NHS%20LA%20Risk%20Management%20Standards%202013-14.pdf

- NHS Executive (1996) *Promoting Clinical Effectiveness: A Framework for Action in and Through the NHS*. London, HMSO

APPROVED PROCEDURAL DOCUMENT (APD) CHECKLIST

Author MUST complete sections 1 to 3 of this checklist and attach it to the final draft copy of the new/revised procedural document/policy when submitting it for approval to the relevant approval group. **Chair of the approval group MUST** sign and date section 4 as confirmation of approval.

Procedural Document Title:		**Reference No:**	

Criteria to consider when developing a procedural document/policy:

1. STYLE, FORMAT AND STRUCTURE Indicate compliance with each aspect by marking a ✓ or X in the relevant box. Where X is marked, the reason **must** be given in the comments box.		**Yes ✓**	**No X**
a	Document developed using the style and format of the Approved Procedural Document (APD) Template.		
b	The front sheet is fully completed with the relevant details.		
c	Definitions of terms used are provided.		
d	Relevant duties of directors, managers, employees and other workers are described.		
e	The content is clearly and concisely written.		
f	The process for monitoring implementation and effectiveness is described within the monitoring table.		
g	I have got evidence of monitoring compliance.		
h	Other relevant associated procedural documents or information sources and references are included.		
i	Completed Equality Impact Assessment Part 1 Initial Screening form is included as the final appendix in the policy. (See CORP/EMP 27)		
j	The Mental Capacity Act 2005 (see policy PAT/PA 19) and the Privacy and Dignity Policy (see policy PAT/PA 28) has been considered.		

COMMENTS:

Continue on reverse, if necessary

2. CONSULTATION List individuals and committees consulted:
(Where there may be an impact on equality or patient choice, then the consultation should also include the Ethics Committee Chair.)

3. AUTHOR/REVIEWER APPROVAL:
Author to sign and date below and forward, with the final draft copy of the procedural document/policy to the appropriate committee/group for approval. You may be asked to supply evidence to support the above.

Name of Author: (please print name)	Department:
Signature:	Date:

4. COMMITTEE/GROUP APPROVAL:
Chair of approval committee/group to sign and date below and forward to the APD Process Co-ordinator as confirmation of approval.
NOTE: Approval of the document MUST be noted in the minutes of the meeting.

Name of Chairperson: (please print name)	Committee/Group:
Signature:	Date:

Following Approval: **Approval Group MUST** send the completed checklist to the APD Process Co-ordinator at the Education Centre, Bassetlaw Hospital as confirmation of approval. **Author MUST** send an electronic copy of the approved document to the APD Process Co-ordinator at the Education Centre, Bassetlaw Hospital to enable the document to be published on the Trust's Internet/Intranet and for the historical copy to be archived. Please contact ext. 2916 if you have any queries.

APPENDIX 2 – APPROVAL COMMITTEES AND GROUPS

Sponsors of policies are set out below:

Type of Document	Sponsor
Corporate policies (any document covering more than one Care Group)	Executive Director
Procedures (any document covering more than one Care Group)	Executive Director
Guidelines/Standard Operating Procedures (SOPs)	Care Group Management Teams and Corporate Senior Managers.

Following consultation, the author will submit the final draft of the procedural document, along with a signed copy of the APD Checklist to the relevant group or committee for their approval. The author will be asked to attend the meeting to present the policy. Approval must be noted in the minutes of the meeting and the APD Checklist signed off by the chair of the group.

The approval group administrator will inform the author that the document has been approved and return the signed APD Checklist to the APD Process Co-ordinator as confirmation of approval. If the document has not been approved, the administrator must notify the author of the reasons.

NOTE: Some documents may need the approval of more than one approval group e.g. if a patient safety related document has medicines contained within it then it must go to the Patient Safety Review Group and to the Drug and Therapeutics Committee.

Allocation of Unique Reference Number for Procedural Documents

Every APD is allocated a unique reference number which is determined by the subject and content of the document, in accordance with the list below.

APDs are divided into two streams: 'Corporate' policies (prefix CORP) and 'Patient Care' policies (prefix PAT). These are then divided into sections by specific subject and given the next available number. For example, CORP/COMM 1 is a 'Corporate' document found in the 'Communication/General' section and PAT/IC 1 is a 'Patient Care' document found in the 'Infection Control' section.

CORPORATE DOCUMENTS

KEY ORGANISATIONAL POLICIES

Overarching Trust policies would usually be approved by the Board of Directors and any new such policies should be considered first by the Board who then may delegate approval to one of its governance committees. Examples of key organisational and policies include:

- MAJAX – Major Incident Policy
- Access Policy
- Health and Safety Policy

- Organisation Change Policy
- Security Management Policy
- Bed Plan
- Operational Plan
- Operational Resilience Plan

Below these key organisational documents sit a number of policies and procedural documents whose approval routes are set out below.

Prefix	Document Subject	Most Appropriate Approval Committee/Group
CORP/HSFS	Health and Safety, Fire and Security (depending on content)	• Health and Safety Committee • Optical Radiation Safety Committee • Radiation Safety Committee • Decontamination and Water Safety Group
CORP/EMP	Employment and Work Life Balance	• Workforce and Education Committee
CORP/ICT	Information Communication and Technology (ICT)	• Information Governance Group
CORP/FIN	Finance	• Audit and Non-Clinical Risk Committee
CORP/RISK	Risk Management Emergency Planning (depending on Content)	• Clinical Governance and Quality Committee • Management Board
CORP/FAC	Facilities	• Facilities Management Committee • Health and Safety Committee
CORP/PROC	Procurement	• Medical Equipment Sub-Committee
CORP/REC	Records Management	• Clinical Records Committee • Policy Approval & Compliance Group (PA&CG)
CORP/COMM	Communication/General	• PA&CG

PATIENT CARE DOCUMENTS

Prefix	Document Subject	Approval Committee
PAT/IC	Infection Control	• Infection Prevention and Control Committee
PAT/T	Treatments/Investigations (depending on content)	• PA&CG • Blood Transfusion Committee
PAT/EC	Emergency Care	• PA&CG
PAT/MM	Medicine Management	• Drug and Therapeutics Committee
PAT/PS	Patient Safety	• PA&CG • Resuscitation Committee • DBH Strategic Safeguarding People Board
PAT/PA	Patient Administration	• PA&CG

Prefix	Document Subject	Approval Committee
Note: For any policies where there is a high profile issue - there may be an overriding need for management or Board approval.		• Trust Board • Executive Team • Management Board • Clinical Governance and Quality Committee • Audit and Non-Clinical Risk Committee

Note: Some APDs may need to go to more than one approval group e.g. where medicines are referred to these will need to go to the Drug and Therapeutics Committee in addition to the approval group.

'Local' APDs – Care Groups

Prefix	Document Subject	Approval Committee
Specific to each Care Group	Care Group specific documents (depending on content)	• Relevant Care Group Clinical Governance Committee • Cancer Management Group • Strategic Safeguarding People Board • Maternity Guideline Group

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
APDs – Development & Management Process	*Director of Nursing, Midwifery & Quality*	*Richard Dickinson*	*Existing Policy*	*September2016*

1) Who is responsible for this policy? Name of Care Group/Directorate: *Directorate of Nursing, Midwifery & Quality*

2) Describe the purpose of the service/function/policy/project/strategy? Who is it intended to benefit? What are the intended outcomes? *To support the authors in the development and review of APDs and create a unified process*

3) Are there any associated objectives? Legislation, targets national expectation, standards: *Trust standard*

4) What factors contribute or detract from achieving intended outcomes? – noncompliance within services

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? Details: [see Equality Impact Assessment Guidance] - *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? [any actions to be taken] *No*

7) Are any of the following groups adversely affected by the policy? No

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 – see CORP/EMP 27

Date for next review: ***January 2020***

Checked by: ***Richard Dickinson*** **Date: 22 January 2017**

APPENDIX 1 - APD CHECKLIST

APPROVED PROCEDURAL DOCUMENT (APD) CHECKLIST

Author MUST complete sections 1 to 3 of this checklist and attach it to the final draft copy of the new/revised procedural document/policy when submitting it for approval to the relevant approval group. **Chair of the approval group MUST** sign and date section 4 as confirmation of approval.

Procedural Document Title:	**Approved Procedural Documents (APDs) Development and Management Policy**	**Reference No:**	**CORP/COMM1**

Criteria to consider when developing a procedural document/policy:

1. STYLE, FORMAT AND STRUCTURE Indicate compliance with each aspect by marking a ✓ or X in the relevant box. Where X is marked, the reason **must** be given in the comments box.		**Yes ✓**	**No X**
a	Document developed using the style and format of the Approved Procedural Document (APD) Template.	✓	
b	The front sheet is fully completed with the relevant details.	✓	
c	Definitions of terms used are provided.	✓	
d	Relevant duties of directors, managers, employees and other workers are described.	✓	
e	The content is clearly and concisely written.	✓	
f	The process for monitoring implementation and effectiveness is described within the monitoring table.	✓	
g	I have got evidence of monitoring compliance.	✓	
h	Other relevant associated procedural documents or information sources and references are included.	✓	
i	Completed Equality Impact Assessment Part 1 Initial Screening form is included as the final appendix in the policy. (See CORP/EMP 27)	✓	
j	The Mental Capacity Act 2005 (see policy PAT/PA 19) and the Privacy and Dignity Policy (see policy PAT/PA 28) has been considered.	✓	

COMMENTS:

Continue on reverse, if necessary

2. CONSULTATION List individuals and committees consulted: (Where there may be an impact on equality or patient choice, then the consultation should also include the Ethics Committee Chair.)

Executive Directors, Care Group Management Teams. PACG membership.

3. AUTHOR/REVIEWER APPROVAL:

Author to sign and date below and forward, with the final draft copy of the procedural document/policy to the appropriate committee/group for approval. You may be asked to supply evidence to support the above.

Name of Author: (please print name) *Richard Dickinson* Signature:	Department: *DNS* Date: *23/1/17*

4. COMMITTEE/GROUP APPROVAL:

Chair of approval committee/group to sign and date below and forward to the APD Process Co-ordinator as confirmation of approval.

NOTE: Approval of the document MUST be noted in the minutes of the meeting.

Name of Chairperson: (please print name) Signature:	Committee/Group: Date:

Following Approval: **Approval Group MUST** send the completed checklist to the APD Process Co-ordinator at the Education Centre, Bassetlaw Hospital as confirmation of approval. **Author MUST** send an electronic copy of the approved document to the APD Process Co-ordinator at the Education Centre, Bassetlaw Hospital to enable the document to be published on the Trust's Internet/Intranet and for the historical copy to be archived. Please contact ext. 2916 if you have any queries.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Modernising Board Meetings**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Matthew Kane, Trust Board Secretary**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

This report proposes a move to paperless Board meetings from 1 April 2017. It also proposes an amendment to the Board of Directors' Standing Orders to permit directors joining meetings remotely via telephone or video link and forming part of the meeting's quorum.

Recommendations

That:

(1) the Board approves the move to 'paperless' Board meetings from 1 April 2017; and

(2) the Board amends its Standing Orders to add the following additional sentence at paragraph 5.15 (Quorum):

Directors can participate in meetings by telephone or through the use of video conferencing facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

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

Everyone counts – we treat each other with courtesy, honesty, respect and dignity

- *By ensuring that our Board arrangements accommodate people's circumstances and commitments*

Encouraging and valuing our diverse staff and rewarding ability and innovation

- *By ensuring our processes and procedures make the best use of modern technology*

Related Strategic Objectives

- Focus on innovation for improvement

Analysis of risks

The main risks in this paper relate to the failure of electronic solutions leading to their abandonment and reliance back on traditional ways of doing business. Mitigation measures include procurement of appropriate hardware and software, testing and ongoing support from IT.

Board Assurance Framework

15	Risks from board leadership transition including new Chair and Chief Executive, DoF and non-executive directors	2 x 4 = 8

Modernising Board Meetings

This report is in two parts. The first part deals with a proposal to move to paperless Board meetings from April 2017. The second concerns a proposal to enable directors to join Board meetings via telephone or video-conferencing facilities and for directors who participate in such a way to be counted as part of the meeting's quorum.

The proposals refer exclusively to meetings of the Board of Directors and its six committees as defined in its standing orders:

- Audit & Non-clinical Risk Committee
- Charitable Funds Committee
- Clinical Governance Oversight Committee
- Financial Oversight Committee
- Fred and Ann Green Legacy Committee
- Nominations and Remuneration Committee

<u>Paperless meetings</u>

Standing Orders require the Trust to deliver the agenda of Board meetings to each director, or to send it by post, so that it is available at least three clear days before the meeting.

'Deliver' is not defined statutorily or within the Standing Orders but, based on the wording of the provisions, should be interpreted as a method other than 'sent by post', e.g. sent by email.

Accordingly, the Corporate Secretariat sends all directors copies of the Board agenda and papers by email and, in addition, a number of hard copy agenda packs are also produced and sent to those who have requested a copy. It is estimated that approximately 300 hard copy packs are produced each year for meetings of the Board and its committees with the average copy containing approximately 250 pages.

The Chair of the Board has consulted informally with executive and non-executive directors about the possibility of moving to a paperless meeting solution whereby directors access papers by electronic means only via their existing I-Pads or laptops. A number of electronic reading devices would also be procured and supplied for use by Governors/the public so that they could follow the agenda while they observe the meeting. One hard reference copy would be made available at the meeting. In addition, any performance dashboards may be printed in hard copy.

A number of benefits would be derived from the proposed change:

- In addition to the savings from paper and toner costs, there would be a significant saving in staff time from not printing hard copy packs. A conservative cost saving would be approximately £5-7k depending on the grade of staff engaged in the work.

- The risk of confidential information being left in meeting rooms is much reduced by going paperless (although there is no evidence that this has been a problem in the past). If electronic devices are lost or stolen they can be remotely tracked and information can be wiped.

- Key documents can be bookmarked and stored for easy retrieval at a later date.

- There will be a reduced physical burden from having to cart spare hard copy packs from vehicles to Board meetings where meetings are held off DRI's premises.

In addition, the Trust is exploring whether the purchase of a meeting management system to further enhance directors' access to information would be of benefit.

The proposed changes would not require any amendment to the Standing Orders as they already provide for the agenda and papers to be delivered electronically. Effectively by passing a resolution in line with recommendation (1) in the covering report, the Board is making it their policy to hold paperless meetings.

Video-conferencing

The Standing Orders require at least a third of the whole number of the Board of Directors (i.e. seven) to be present including at least one executive director and one non-executive director. The quorum for a Board sub-committee is included in the committee terms of reference and is at least two non-executive directors plus one executive director.

'Presence' at a meeting is not defined but, typically, the provisions have been interpreted as meaning 'physically present in the room'. This means that directors who have wished to participate remotely could not contribute towards the quorum. This leads to a risk that meetings get cancelled if they cannot secure a quorum.

Whilst the preference would always be for people to attend meetings in person, it is recognised that there may be occasions where Board members are unable to do so due to other commitments.

The Trust already supports video-conferencing from on its own premises to internal/external meetings and staff have recently been reminded of this facility and the savings that its use will generate. This report builds on that initiative by supporting the use of video conferencing for Trust Board meetings from external premises.

In order to facilitate this change, two things are required. The first is capacity. IT has confirmed that the Boardrooms at all sites could support the use of Skype, subject to testing. The second issue is constitutional. To give effect to the proposal an amendment to the Standing Orders is required to allow directors who participate remotely in Board meetings to be counted within the quorum.

The proposed wording, to be added at the end of Standing Order 5.15, is:

> *Directors can participate in meetings by telephone or through the use of video conferencing facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.*

A number of trusts already have such provisions within their standing orders.

Board should note that its Standing Orders may be amended only if:

- there are two-thirds of Directors present;
- a majority of those present, including no fewer than half of the total of the Trust's non-executives, vote in favour of the amendment;
- the variation proposed does not contravene any statutory provisions or direction made by NHS Improvement.

The change, if approved, would take effect immediately.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**31 January 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
80	Transfer of registered title in respect of 9 St David's Close, Worksop, S81 0RP	Mike Pinkerton Chief Executive Jon Sargeant Director of Finance	5 January 2017
81	Transfer of registered title in respect of 21 St David's Close, Worksop, S81 0RP	Mike Pinkerton Chief Executive Jon Sargeant Director of Finance	22 December 2016

Recommendation(s)

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Strategy and Improvement Update**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Dawn Jarvis – Director of Strategy and Improvement**		
For:	**n/a**		

Purpose of Paper: Executive Summary containing key messages and issues

This paper seeks to provide:-

a) CIP Programme 16/17 progress – paragraph 2
b) 2 year Operational Plan and CIPs – paragraph 3
c) Strategic planning process led by the Directorate of Strategy and Improvement paragraph 4
d) Moving beyond Turnaround into Transformation – paragraph 5

Recommendation

Board is asked to receive the contents of the update for assurance purposes.

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

We always put the patient first
- *By focusing on efficiency and financial stability to deliver care going forward*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity
- *By having clear and transparent processes and policies and by living our values*

Committed to quality and continuously improving patient experience
- *By ensuring we are continuously improving our financial position*

Always caring and compassionate
- *By protecting the future of the Trust by caring about how we become more efficient*

Responsible and accountable for our actions – taking pride in our work
- *By having clear objectives and actions to improve our financial performance*

Encouraging and valuing our diverse staff and rewarding ability and innovation
- *By ensuring everyone's ideas count and everyone's views are heard*

Related Strategic Objectives

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

Analysis of risks

The main risk of not moving to a new way of working is that we will not have a credible and supported plan to deliver the savings necessary to reduce the financial deficit of the Trust. As a subset of this our key stakeholders and partners may lose faith in our ability to manage our own response to this issue and will take more direct ownership and control.

Board Assurance Framework

1	Failure to achieve compliance with Monitor Risk Assessment Framework, CQC and other regulatory standards, triggering regulatory action.	5x4 = 20
3	Failure to deliver financial plan.	5x5 = 25
4	Failure to deliver cost improvement plans	4x5 = 20
5	Failure to deliver turnaround/cost reduction programme	4x5 = 20

1 Introduction

1.1. This paper seeks to provide:-

a) CIP Programme 16/17 progress – paragraph 2

b) 2 year Operational Plan and CIPs – paragraph 3

c) Strategic planning process led by the Directorate of Strategy and Improvement – paragraph 4

d) Moving beyond Turnaround into Transformation – paragraph 5

2. 16/17 Cost Improvement Programme – Month 9 and cumulative delivery

2.1. The detail is shown in the enclosed power point slides attached as annex 1. In headline terms Board of Directors will want to note the following:-

- The planned delivery for the Improvement Programme for FY16/17 is £11.0m, with an internal stretch target to £13.0m, and a reported delivery assumption at M1 of £12.415m against a reported forecast delivery to NHSI of £12.380m.

- The forecast outturn for the Improvement Programme is now £11.552m a decrease since M1 of £863k and an increase since M8 of £119k.

- The plan required delivery of £1.186m in M9 (Dec '16). Actual delivery in M9 was £1.024m, behind plan in month by £162k, and behind stretch by £317k.

- YTD £7.078m plan, £7,544m actual, ahead of plan by £466k, and behind stretch by £659k

2.2. We are forecasting a delivery of around £11.5m for the year with a high level of certainty.

2.3. As previously reported some work streams have not delivered as much as predicted in the current year but we have pushed that delivery in to 17/18. We are continuing to drill down into the detail of delivery plans for 17/18 and 18/19 as described in the 2 year plan, this is shown in the annex at the final slide – for each year we have committed to a £12m CIP. Currently there is a high proportion of each year that is still under development, without detailed plans, but that is not of concern at this time given we have a robust governance and accountability process and a fully functioning Programme Management Office, both things we did not have this time last year and which have served us well in the delivery of our CIP targets this year.

2.4. We will be changing the names of some of the work streams, adding some new projects and some enabling work streams over the coming months to better represent the delivery needs for the next two years. However, the overall structure, use of work streams, SROs at Exec or Director level, and the running of the accountability meetings will remain to ensure a clear focus on delivery.

2.5. We have delivered the final set of grip and control meetings as we begin to move into a transformation programme rather than a turnaround plan. We will take the best of what we have learned from turnaround to reset our business as usual approach to governance and accountability, learning from the "well led governance review" as it reports. It is pleasing to note that the process of grip and control meetings has had a positive effect on the knowledge, understanding and

accountability for financial management across the Trust, with this final round of meetings being very different from the first. A narrowing in the run rate can in some part be attributed to the speedy set up of "grip and control" at the start of turnaround and in large part to the focused actions of financial decision makers across the Trust in their efforts to be more efficient. However it should be noted that we are still spending over one million pounds each month more than we get in, but this has dropped from a high point of that gap being over three and a half million pounds.

3. 2 Year Operational Plan – timetable, content and sign off

3.1. As the Board is aware we submitted our final two year Operational Plan on time by 23 December 2016, which include confirmation we agree our contracts and signed up to our two year control totals. We may expect to receive some feedback at our Performance Review Meeting on 24 January, an update on this will be provided verbally at the Board meeting.

4. Strategic Development

4.1. We have continued the work to produce our clinical strategy (coordinated in Strategy and Improvement but led by the Chief Operating Officer). This will lead to a revision of our strategic framework to build on prevailing NHS, STP and Trust conditions. This will also form the basis of some of the more transformational CIPs for 17/18 and beyond, and be the foundations of our part of STP. At Board brief on 16 January we agreed the main themes, and suggest we present these formally to the Board of Directors at February meeting.

5. Moving beyond Turnaround into Transformation

5.1 The Executive Team are currently considering the internal and external communications and stakeholder engagement plans that will be developed for a more formal announcement and/or move out of "Turnaround" and once developed this will be shared with the Board for input and comment on tone, timing and content. We need to be mindful that while great progress has been made, all efforts still need to be focused on the underlying financial position and that we should not seek to gain or portray any complacency brought about by our potential end of year, non-recurrent position.

6. Summary

6.1. M9 continues to see steady delivery with some slippage against plan and stretch in month but we are still ahead of the original plan year to date. An outturn forecast ahead of plan is still predicted, which given where we started in December 2015 is a remarkable outcome. Dates for delivering our strategic vision will be discussed with NHS Improvement and updated verbally at the Board.

Improvement Programme Forecast Out turn 2016/17 – M9 position

Improvement Programme FY16/17 as at December 16

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

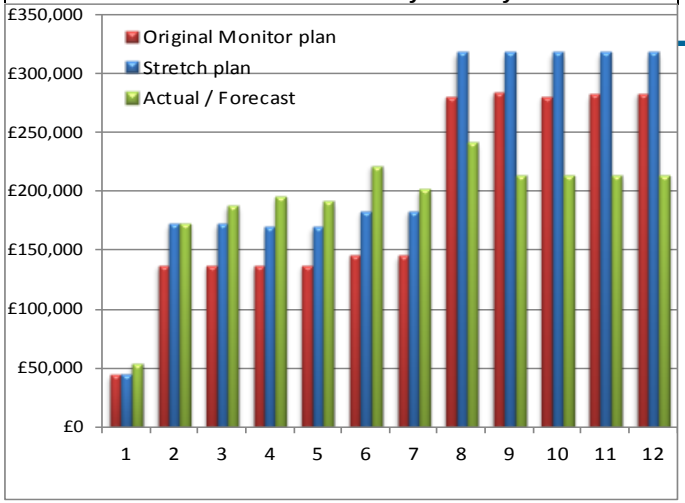
	Original Plan for the Year £'000	Stretch Plan for the Year £'000	Original Plan in Month £'000	Stretch Plan in Month £'000	Actual in Month £'000	Variance to Original in Month £'000	Variance to Stretch in Month £'000	Original Plan YTD £'000	Stretch Plan YTD £'000	Actual YTD £'000	Variance to Original YTD £'000	Variance to Stretch YTD £'000	Forecast CYE (16/17) £'000	Forecast FYE (Recurrent) £'000
Analysis by Workstream														
Theatres	443	520	73	87	62	-11	-25	220	260	295	75	35	482	1,219
Outpatient Productivity	287	259	31	24	23	-8	-1	174	187	188	14	1	278	276
Medical Productivity	413	441	72	74	22	-50	-51	255	200	189	-66	-10	257	966
Non Medical Clinical	261	261	43	44	47	4	4	88	88	117	29	29	190	281
Management & Corporate Services Review	761	987	66	89	90	24	1	556	708	661	105	-47	924	1,038
Bed Plan / LOS	2,293	2,683	284	318	214	-70	-104	1,448	1,729	1,679	231	-50	2,320	3,962
Procurement	1,901	2,003	216	186	183	-33	-3	1,244	1,446	1,464	221	18	2,163	2,610
Clinical Admin Review	250	250	0	42	4	4	-38	0	125	68	68	-57	79	120
Infrastructure	531	894	53	94	72	19	-22	299	514	322	24	-192	565	1,371
Income	1,058	1,325	107	140	85	-21	-54	716	906	605	-111	-302	868	1,035
Care Group & Corporate - Local	1,578	1,779	138	163	136	-2	-26	1,162	1,307	1,202	40	-105	1,616	1,419
Grip & Control	1,224	978	102	82	86	-16	3	918	731	754	-164	23	1,811	897
TOTAL	**11,000**	**12,380**	**1,186**	**1,341**	**1,024**	**-162**	**-317**	**7,078**	**8,203**	**7,544**	**466**	**-659**	**11,552**	**15,194**
Rec	11,000	11,768	1,186	1,312	983	-203	-329	7,078	7,661	7,002	-76	-659	10,102	15,194
Non rec	0	612	0	29	41	41	12	0	542	542	542	1	1,450	0
	11,000	**12,380**	**1,186**	**1,341**	**1,024**	**-162**	**-317**	**7,078**	**8,203**	**7,544**	**466**	**-659**	**11,552**	**15,194**

The Plan and Forecast for Month 9 – November 2016

The planned delivery for the Improvement Programme for FY16/17 is £11.0m, with an internal stretch target to £13.0m, and a reported delivery assumption at M1 of £12.415m against a reported forecast delivery to NHSI of £12.380m.
The forecast outturn for the Improvement Programme is now £11.552m a decrease since M1 of £863k and an increase since M8 of £119k.
The plan required delivery of £1.186m in M9 (Dec '16). Actual delivery in M9 was £1.024m, behind plan in month by £162k, and behind stretch by £317k.
YTD £7.078m plan, £7,544m actual, ahead of plan by £466k, and behind stretch by £659k

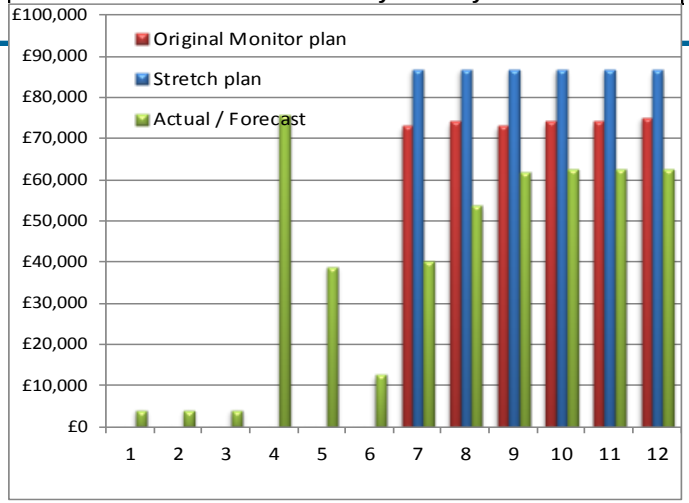
Improvement Programme FY16/17

Bed Plan / LOS Monthly Delivery



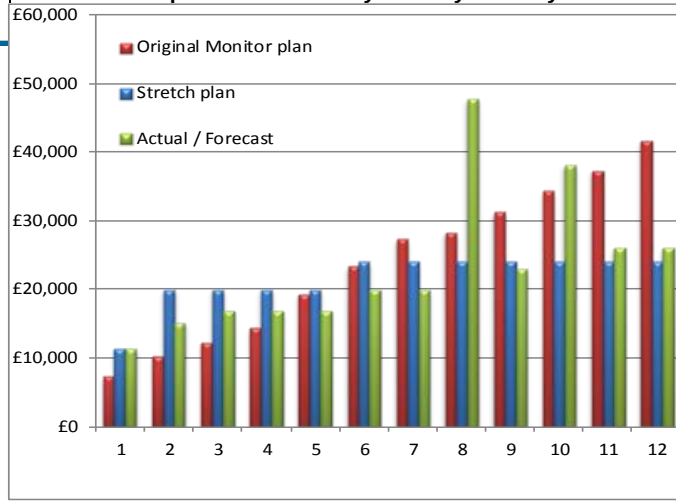
Bed Plan / LOS

Theatres Monthly Delivery



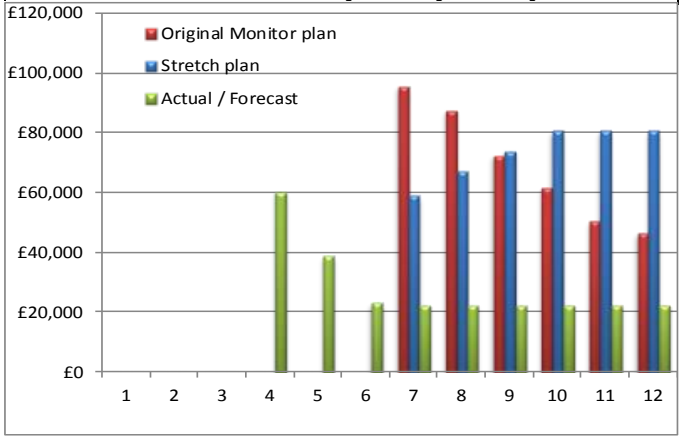
Theatres

Outpatient Productivity Monthly Delivery



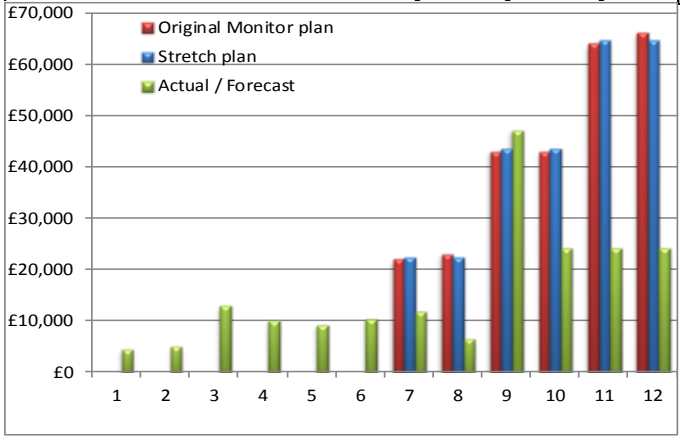
Outpatient Productivity

Medical Productivity Monthly Delivery



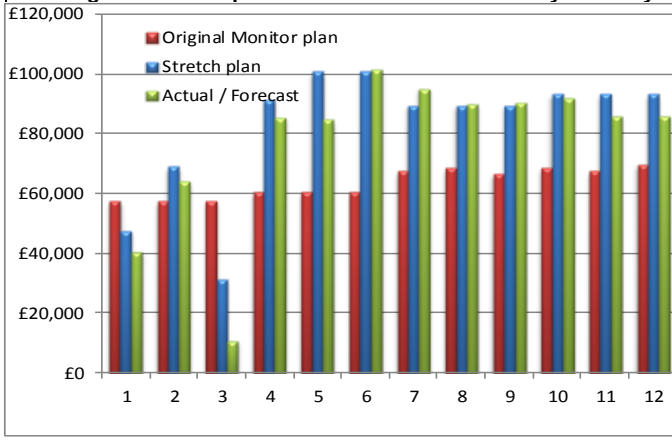
Medical Productivity Monthly Delivery

Non Medical Clinical Productivity Monthly Delivery

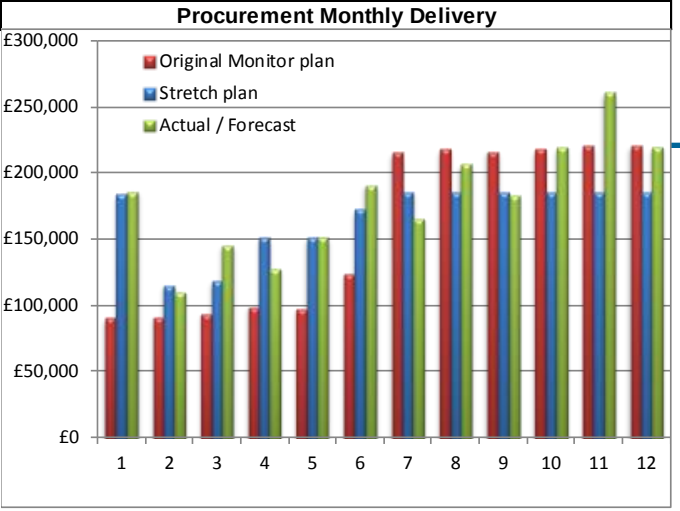


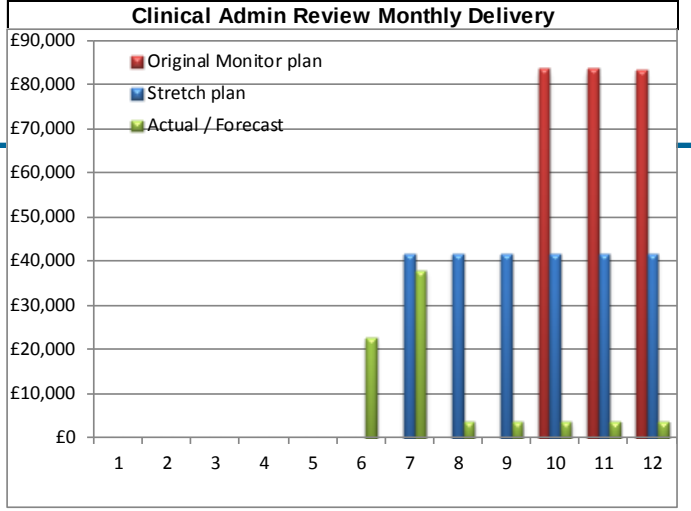
Non Medical Clinical Productivity Monthly Delivery

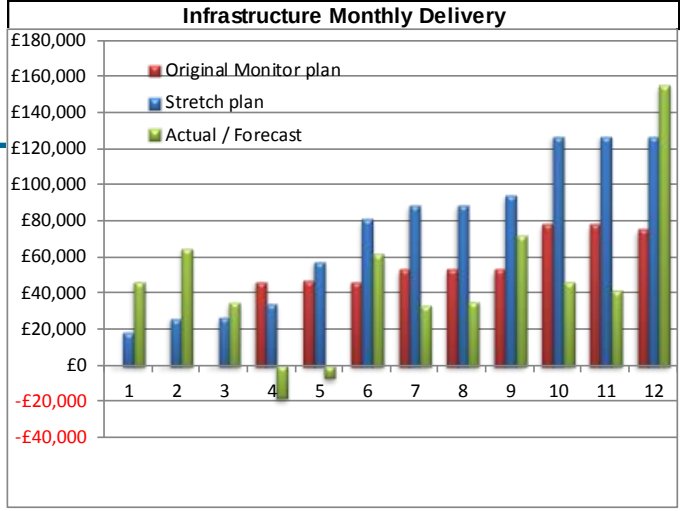
Management & Corporate services review Monthly Delivery



Management and Corporate services review



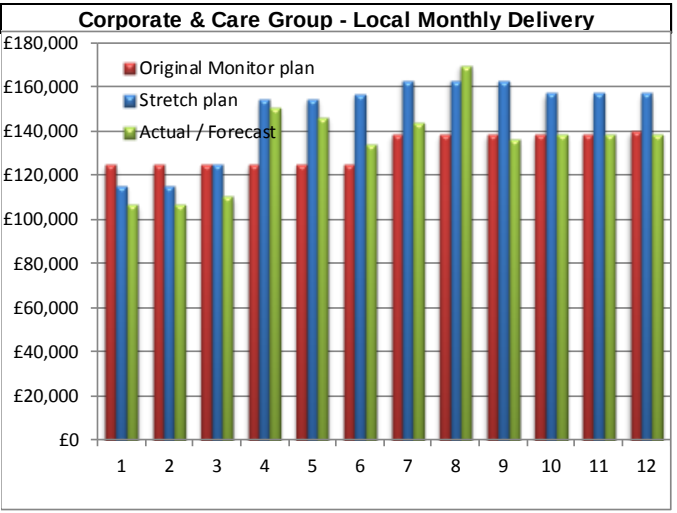


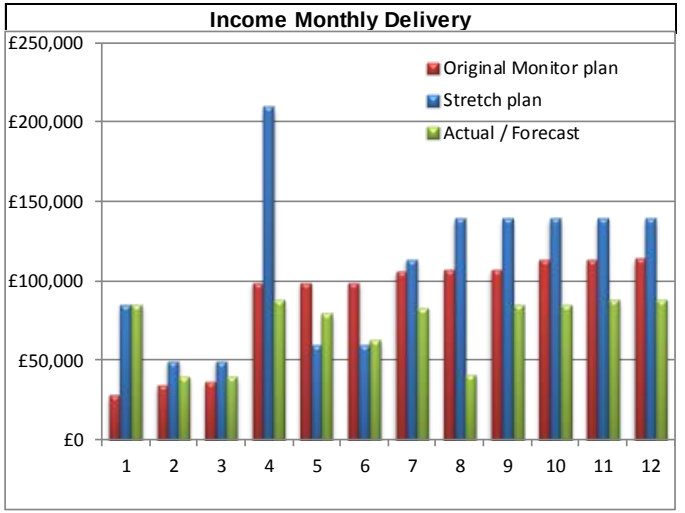


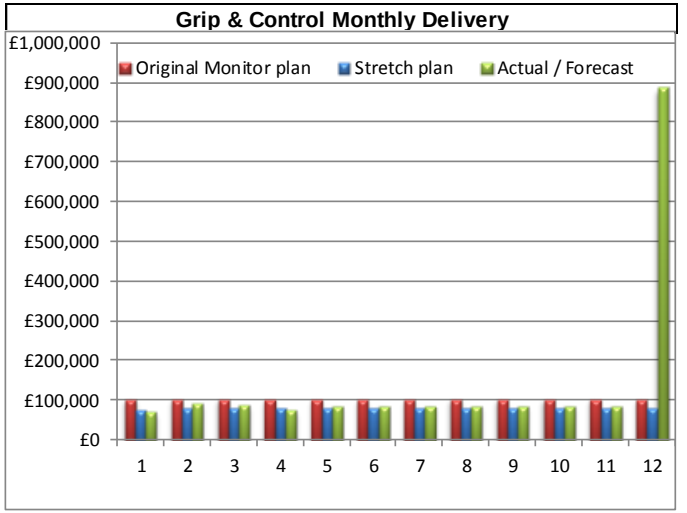
Procurement Monthly Delivery

Clinical Admin Review Monthly Delivery

Infrastructure Monthly Delivery







Corporate & Care Group - Local Monthly Delivery

Income Monthly Delivery

Grip & Control Monthly Delivery

17/18 and 18/19 draft CIP planning

Doncaster & Bassetlaw Hospitals NHS Foundation Trust

CIP 2 Year Plan - 2017/18 & 2018/19

	17/18				18/19			
	Rolling element £'000	Identified new £'000	Potential further scope £'000	Total 17/18 CIP £'000	Rolling element £'000	Identified new £'000	Potential further scope £'000	Total 18/19 CIP £'000
Analysis by Workstream								
Theatres	526	575	0	1101	500	0	500	1000
Outpatient Productivity	0	202	0	202	355	0	0	355
Medical Productivity	747	279	0	1026	279	0	0	279
Non Medical Clinical	1041	0	0	1041	0	0	0	0
Management & Corporate Services Review	0	1070	0	1070	0	0	1000	1000
Bed Plan (Including clinical site & service review)	1402	750	0	2152	250	0	5000	5250
Procurement	406	1884	0	2290	0	0	2000	2000
Clinical Admin Review	0	911	0	911	0	0	250	250
Infrastructure	468	349	0	817	242	0	1000	1242
Income	0	0	0	0	0	0	0	0
Care Group & Corporate - Local	0	0	500	500	0	0	250	250
Grip & Control	0	0	889	889	0	0	374	374
TOTAL	**4590**	**6021**	**1389**	**12000**	**1626**	**0**	**10374**	**12000**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – December 2016**		
Report to:	**Board of Directors**	Date:	**31st January 2017**
Author:	**Jon Sargeant - Director of Finance**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

To update the Board on the financial position for the Month of December 2016.

Recommendation(s)

The Board is asked to NOTE that the reported financial position is a deficit of £12.8m.

The variance against plan to Month 9 is £6.3m favourable.

CIP performance is £7.5m year to date and is £0.7m behind plan against the YTD CIP target

Delivering the Values – We Care

- Not applicable

Related Strategic Objectives

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

Analysis of risks

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

Board Assurance Framework

1	*Failure to comply with the Monitor Risk Assessment Framework, CQC and other regulatory standards, triggering regulatory action.*	*5 x 4 = 20*
2	*Failure to deliver the financial plan*	*5 x 5 = 25*
3	*Failure to deliver the cost improvement plan*	*4 x 5 = 20*

Doncaster and Bassetlaw Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P9 December 2016

31st January 2017

DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST

FINANCE SCORECARD DECEMBER 2016

1. Income and Expenditure

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	(1,374)	1,789 F	(12,836)	6,340 F	(24,684)	(17,398)
Income	30,002	149 F	280,222	(1,073) A	375,048	373,189
Expenditure	(30,463)	1,337 F	(283,173)	6,580 F	(385,337)	(377,110)
Pay	(19,899)	1,120 F	(185,840)	3,691 F	(252,555)	tbc
Non Pay	(10,565)	218 F	(97,332)	2,889 F	(132,781)	tbc

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000	YTD Performance Actual £'000	YTD Performance Variance £'000	Annual Plan £'000	Forecast £'000
Employee Expenses	672	(106) A	4,778	(41) A	7,467	7,589
Drugs	13	(2) A	183	53 F	176	229
Clinical Supplies	88	(32) A	931	(9) A	1,457	1,348
Non Clinical Supplies	26	(4) A	140	(50) A	280	219
Non Pay Operating Expenses	23	(146) A	126	(306) A	599	194
Income	201	(27) A	1,387	(305) A	2,401	1,974
Other						
Total	**1,024**	**(317)**	**7,544**	**(659)**	**12,380**	**11,552**

3. Statement of Financial Position

All figures £m		Opening Balance 01.04.16	Current Balance 31.12.16	Movement in year
Non Current Assets		**193.2**	**191.2**	**(2.0)**
Current Assets	Stock and WIP	5.5	5.6	0.1
	Trade and Other Receivables	16.0	23.2	7.2
	Cash	2.2	4.4	2.2
Current Liabilities	Trade and Other Payables	(32.0)	(44.0)	(12.0)
	Borrowings	(2.8)	(2.7)	0.1
	Provisions	(0.5)	(1.1)	(0.6)
	Other Liabilities	-		-
Net current Assets		**(11.7)**	**(14.6)**	**(2.9)**
Total Assets less current Liabilities		**181.5**	**176.6**	**(4.9)**
Non Current liabilities		(59.8)	(67.9)	(8.1)
Total Assets Employed		**121.7**	**108.7**	**(13.0)**
Tax Payers Equity	Public Dividend Capital	128.8	128.8	0.0
	Revaluation Reserve	29.9	29.7	(0.2)
	Retained Earnings	(37.0)	(49.8)	(12.8)
Total Tax Payers Equity		**121.7**	**108.7**	**(13.0)**

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	4,354	1,900	4,354	1,900	1,900
Capital Expenditure	817	402	7,394	6,044	9,406	9,898

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE	Under / (over)
Current Month	5,982	5,542	133	81	5,756	226
Previous Month	5,983	5,614	156	135	5,905	78
Movement	1	72 0	23	54 0	149	(148)

1. Context/Background

The Trust's original financial plan for 2016/17 was to deliver a deficit of £24.7m, this included an in year CIP target of £12.38m.

Following deterioration in the run rate the previous year-end forecast deficit of £16m was felt to be too low. Over the last two months a process of review and challenge with the Care Groups and Corporate departments has led to a revised forecast deficit of £17.4m. The position to month nine is in line with this trajectory.

2. Executive Summary

I&E Position	Monthly Position			Cumulative position to M9			Cumulative position to M9 Previous Year			Plan	Forecast
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income	29,852	30,002	149	281,296	280,222	(1,073)	270,906	267,536	(3,370)	375,048	373,189
Costs	(31,801)	(30,463)	1,276	(289,753)	(283,173)	6,519	(259,326)	(283,699)	(24,374)	(385,337)	(377,110)
Capital Charges	(1,215)	(912)	303	(10,719)	(9,886)	833	(12,254)	(11,852)	402	(14,396)	(13,477)
Total Position before Impairments	**(3,163)**	**(1,374)**	**1,728**	**(19,176)**	**(12,836)**	**6,279**	**(674)**	**(28,015)**	**(27,340)**	(24,684)	(17,398)
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	0	900	900	0	0
Total Position after Impairments	**(3,163)**	**(1,374)**	**1,728**	**(19,176)**	**(12,836)**	**6,279**	**(674)**	**(27,115)**	**(26,440)**	(24,684)	(17,398)

At month nine the Trust is showing a £6,279k favourable variance to budget. Shortfalls in income of £1,073k are being more than mitigated by underspends across pay and reserves.

The position prior to STF funding is £6,771k favourable to plan but we are providing for £492k risk in relation to M8 and M9 for both RTT and A&E. We are assuming we will be able to argue we were YTD compliant at M7 for A&E and RTT performance against the trajectory.

	Cumulative Position			2016/17	Previous
	Plan	Actual	Variance	Plan	Months Var
	£'000	£'000	£'000	£'000	£'000
Position before STF	(28,026)	(21,194)	6,771	(36,484)	4,797
STF	8,850	8,358	(492)	11,800	(246)
Reported Position	**(19,176)**	**(12,836)**	**6,279**	**(24,684)**	**4,551**
Less Donated Income	2,673	2,487	(186)	(2,294)	(154)
Less Donated Depreciation	375	308	(67)	510	2
Monitor Control Total	**(16,128)**	**(10,041)**	**6,026**	**(26,468)**	**4,398**

Total Income at month nine is below plan by £1,073 as shown in the table below.

Income Position	Monthly Position			Cumulative position to M9			Cumulative position to M9 Previous Year			Plan	Forecast
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Patient Income from CCG's	23,659	24,215	556	223,105	224,328	1,223	223,465	222,770	(695)	297,951	
S&T Monies	983	737	(246)	8,850	8,358	(492)	0	0	0	11,800	
Drugs income from CCG's	2,010	1,866	(144)	18,214	17,459	(755)	17,435	17,803	367	24,547	
CCG Income	**26,652**	**26,818**	**166**	**250,169**	**250,145**	**(24)**	**240,900**	**240,573**	**(327)**	**334,298**	**0**
Trading Income	**3,200**	**3,184**	**(16)**	**31,127**	**30,078**	**(1,049)**	**30,004**	**26,963**	**(3,041)**	**40,750**	
Total Income Position	**29,852**	**30,002**	**149**	**281,296**	**280,222**	**(1,073)**	**270,904**	**267,536**	**(3,369)**	**375,048**	**373,189**

Expenditure is £6,519k favourable to plan as shown in the table below:-

Expenditure Position	Monthly Position			Cumulative position to M9			Cumulative position to M9 Previous Year			Plan	Forecast
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	(21,018)	(19,899)	1,120	(189,532)	(185,840)	3,691	(179,536)	(185,635)	(6,100)	(252,555)	
Non-Pay	(9,507)	(10,293)	(785)	(88,450)	(89,103)	(653)	(78,722)	(89,453)	(10,731)	(116,728)	
Recharges, Contingency & Reserves	(1,275)	(272)	942	(11,771)	(8,229)	3,481	(1,068)	(8,612)	(7,545)	(16,054)	
Total Expenditure Position	**(31,801)**	**(30,463)**	**1,276**	**(289,753)**	**(283,173)**	**6,519**	**(259,326)**	**(283,699)**	**(24,374)**	**(385,337)**	**(377,110)**

3. Income position and trend

3.1 Income

NHS Clinical Income in Month 9 is £166k ahead of plan (£24k less than plan YTD) as shown in the following table by Commissioner and by Point of Delivery;

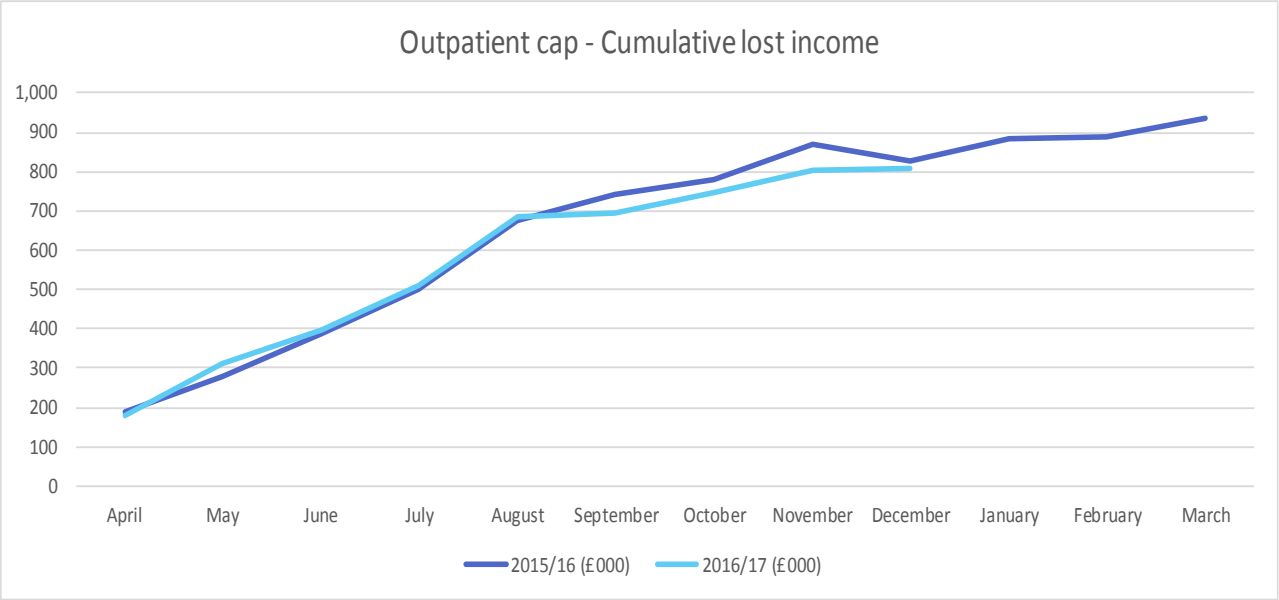
	Current Month					Year to date				
	Internal Plan		Actual		Variance	Internal Plan		Actual		Variance
Income by Commissioner	**%**	**£'000**	**%**	**£'000**	**£'000**	**%**	**£'000**	**%**	**£'000**	**£'000**
Doncaster CCG	54.96%	14,649	55.34%	14,842	193	55.99%	140,069	56.24%	140,680	611
Bassetlaw CCG	18.63%	4,965	19.08%	5,116	151	18.63%	46,600	18.65%	46,652	52
Rotherham CCG	3.05%	813	2.77%	742	(71)	3.07%	7,681	3.04%	7,596	(84)
Barnsley CCG	2.00%	532	1.75%	470	(62)	2.05%	5,128	1.88%	4,690	(437)
NHS England	8.47%	2,257	9.14%	2,450	193	8.54%	21,367	8.49%	21,241	(126)
Other Associates & NCAs	12.89%	3,436	11.92%	3,197	(239)	11.72%	29,324	11.71%	29,286	(38)
Total	**100.00%**	**26,652**	**100.00%**	**26,818**	**166**	**100.00%**	**250,169**	**100.00%**	**250,145**	**(24)**

By POD	Current Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Elective	2,041	2,022	(20)	21,177	19,997	(1,180)
Daycase	2,177	2,348	171	21,736	21,998	262
Emergency and Non-Elective	7,144	7,128	(17)	61,856	62,487	632
Emergency Threshold Reduction	(124)	(145)	(21)	(1,069)	(1,374)	(306)
Outpatient First	1,254	1,362	108	13,028	13,709	681
Outpatient Follow Up	1,580	1,525	(55)	16,351	16,530	178
Outpatient Procedure	846	894	48	8,624	8,161	(464)
A&E Attendances	1,316	1,491	175	12,676	13,882	1,206
Critical Care	1,122	1,140	18	9,768	9,640	(128)
Other (inc Maternity)	6,746	6,707	(39)	62,963	64,123	1,160
Contract Penalties & Risks	0	(4)	(4)	0	(827)	(827)
CQUINS	538	484	(54)	4,843	4,359	(484)
Non PbR Drugs	2,010	1,866	(144)	18,214	17,459	(755)
Total	**26,652**	**26,818**	**166**	**250,169**	**250,145**	**(24)**

Cumulative income includes £8.4m in respect of STF income which is after providing for £492k lost income in relation to A&E and RTT performance against trajectory in December.

3.2 Income Issues

- Elective income was £20k lower than planned levels in December, which is a significant improvement on the trend so far this year. Target activity dropped significantly in month 9, but actual activity did not reduce to the same extent, leading to a significant movement towards contract target. T&O reached contracted levels of activity for only the second time this year.
- Daycase activity was significantly over planned levels in month 9 – income was £171k higher than target.
- A&E activity also continued to be significantly over planned levels – leading to a year to date over performance of £1,206k.
- Within the 'Other' income category within NHS Clinical Income, there is a full year effect Commissioner QIPP reduction of £1.75m (YTD impact of £1.3m). This negative line in the contract is showing as an income over performance but is offset by underperformance on other lines such as Elective and Emergency activity. Discussions with Commissioners would suggest that these activity reductions are due to non-recurrent capacity issues rather than the result of recurrent delivery of QIPP plans.
- CQUIN – the income performance shown above assumes achievement of 90% of CQUINs income. Based on the performance in Q1 and Q2, there is the potential for actual income to be secured above the 90%.
- The number of first attendances compared to plan increased significantly in month 9, leading to a much improved first to follow up ratio for the month. Only £4k of income was lost in December relating to the cap, £96k improvement compared to run rate. £806k of income has been lost YTD due to the Outpatient Cap.



- The NHS Clinical Income forecast position assumes activity continues at current levels with the exception of T&O and Ophthalmology elective activity which is forecast to move back towards contracted levels for the rest of the year after significant underperformance in the year to date position. An allowance has also been made for elective cancellations in January due to bed pressures.

3.3 'Other Income' Variances

Non NHS Clinical Income and 'Other' Income is £1,049k below plan at the end of Month 9 as broken down in the table below;

Trading Income	Monthly Position			Cumulative position to M9			Cumulative position to M9 Previous Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Private Patient Income	92	76	(17)	802	634	(168)	622	697	75
Education Income	769	816	47	6,919	7,355	436	6,769	6,472	(297)
Research & Development	31	47	16	281	479	198	304	258	(45)
RTA's	130	177	47	1,172	1,326	154	2,000	1,116	(883)
Miscellanous Contract Income	25	30	5	222	265	43	65	154	89
Overseas Visitors	2	51	49	222	172	(50)	0	0	0
Provider to Provider	604	646	42	5,439	5,795	356	4,528	4,887	359
Internally Generated Income	495	374	(122)	4,200	3,569	(631)	4,172	3,819	(353)
ParkHill Income	138	107	(31)	1,239	1,086	(153)	1,061	1,124	63
Other Staffing Income IB	55	62	8	491	404	(86)	235	527	292
Fred & Ann Green Reserve	0	53	53	0	96	96	0	125	125
Recharges	830	749	(81)	7,468	6,409	(1,059)	8,104	7,328	(776)
Donated Assets	29	(3)	(32)	2,673	2,487	(186)	600	265	(335)
Govt. Assets, Sale of Assets & Land Sale Grant	0	0	0	0	0	0	1,547	0	(1,547)
Total	**3,200**	**3,184**	**(16)**	**31,127**	**30,078**	**(1,049)**	**30,004**	**26,771**	**(3,233)**

Over £1m of the £0.8m underperformance on 'Other' Income relates to recharges, with a corresponding underspend in expenditure and no bottom line impact for the Trust.

The other large variance is an underperformance of £631k relating to Internally Generated Income. £299k of this variance relates to secondments that have now ceased and there is a corresponding expenditure underspend. £103k of the underperformance relates to Catering income. £91k relates to P&OD salary sacrifice due to changes in the calculation methodology.

4. Expenditure position and trend

4.1 Pay

Pay	Monthly Position			Cumulative position to M9			Cumulative position to M8		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Medical & Dental	(6,377)	(5,533)	845	(56,870)	(55,012)	1,858	(50,493)	(49,479)	1,014
Nurses & Midwives	(7,759)	(7,658)	101	(70,200)	(70,236)	(36)	(62,441)	(62,578)	(138)
Other Clinical Staff	(2,827)	(2,738)	89	(25,620)	(24,730)	890	(22,793)	(21,992)	801
Ancilliary & Maintenance Staff	(1,342)	(1,225)	117	(12,165)	(11,572)	593	(10,823)	(10,347)	476
Admin & Clerical	(2,071)	(2,117)	(46)	(19,073)	(18,834)	238	(17,002)	(16,717)	285
Managers and Board Members	(641)	(627)	14	(5,604)	(5,456)	148	(4,962)	(4,828)	134
Total	**(21,018)**	**(19,899)**	**1,120**	**(189,532)**	**(185,840)**	**3,691**	**(168,513)**	**(165,942)**	**2,572**

Pay was below plan by £1.1m in month right and £3.7m below plan for the year to date. Variances of note within this position are as follows;

- Medical & Dental pay benefited from two significant credits in December totalling £798k both related to Agency spend. Excluding these credits expenditure for the month was £20.7m, a reduction of £186k compared to November and in line with the 12month rolling average cost. This is supported by a drop in the number of WTE worked which also fell by 149 from last month. Although substantive vacancies across the Trust continue to be filled by more expensive Agency and Bank staff, low fill rates in December resulted in the reduced level of expenditure.
- Nursing expenditure dropped back under budget in December after the spiked seen last month leaving a YTD variance to plan of just £36k.
- Ancillary & Maintenance staff costs remain well below budget at £593k YTD but should show some negative movement in the next two month as recruitment progresses towards the new service assistant structure due to be implemented at the end of February.
- Admin & Clerical costs have increased month on month by £136k largely due to a one-off benefit last month from an accrual release however the number of WTE worked has risen by 5, but still remains nearly 30WTE below budget.

The table below shows external agency costs and the monthly profile for the last twelve months. As previously mentioned Decembers figures benefited from two significant credits. A one-off benefit of £453k due to the release of over-accruals as estimated by our previous supplier, NLMS, and a planned release of £345k of balance sheet flexibility carried forward from 2015/16. The £345k release will continue for each of the remaining periods this year until the £1.38m is fully released.

Agency Pay	M9	YTD	M9	YTD	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8
	16/17		15/16		15/16	15/16	15/16	16/17	16/17	16/17	16/17	16/17	16/17	16/17	16/17
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical & Dental	404	**7,407**	1,327	**11,609**	1,176	1,043	1,234	952	944	1,034	453	854	775	1,015	974
Nurses & Midwives	45	**680**	193	**2,565**	241	118	207	87	41	69	73	94	74	107	90
Other Clinical Staff	98	**744**	143	**1,058**	55	63	95	62	72	49	103	54	123	78	104
Ancilliary & Maintenance Staff	18	**116**	5	**139**	18	38	20	23	- 3	4	2	31	11	4	26
Admin & Clerical	110	**931**	32	**260**	(5)	78	131	95	184	96	90	92	107	165	- 6
Managers and Board Members	22	**189**	20	**42**	46	34	35	32	35	32	13	- 70	93	10	21
Total	**697**	**10,066**	**1,720**	**15,672**	**1,530**	**1,374**	**1,722**	**1,250**	**1,273**	**1,284**	**733**	**1,056**	**1,184**	**1,379**	**1,209**

As a result of these releases our position comparative to the ceiling has improved. Comparing against the pro-rated straight line basis we are better than target by £71k and comparing to the 2015/16 profiled spend we are £369k better than target. As a result of the continued release of the £1.4m balance sheet flexibility we are now forecasting our year end spend will be £12.9m, £600k better than ceiling. It is important to note though that this is an in-year benefit only and without proper cost control of our underlying spend levels we will face difficulties achieving our ceiling in 2017/18.

	£'000
Medical & Dental	7,407
Nurses & Midwives	680
Other Clinical Staff	744
Ancilliary & Maintenance Staff	116
Admin & Clerical	931
Managers and Board Members	189
Total Spend	**10,066**
YTD Ceiling Target (straight line basis)	**10,137**
Variance (straight line basis)	**71**
YTD Ceiling Target (15/16 spend basis)	**10,435**
Variance (15/16 spend basis)	**369**

4.2 Non-Pay

The table below details the non-pay position as at the end of December 2016.

Non-Pay	Monthly Position			Cumulative position to M9			Cumulative position to M9 Previous Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Drugs	(791)	(796)	(5)	(7,057)	(6,950)	107	(6,236)	(7,523)	(1,286)
Non-Pbr Drugs	(1,962)	(1,752)	210	(17,776)	(17,023)	753	(16,725)	(17,159)	(433)
Clinical Supplies & Services	(2,349)	(2,792)	(443)	(21,300)	(22,127)	(826)	(20,851)	(22,954)	(2,103)
Other Non Pay	(4,405)	(4,953)	(548)	(42,317)	(43,004)	(687)	(34,909)	(41,817)	(6,908)
Total	**(9,507)**	**(10,293)**	**(785)**	**(88,450)**	**(89,103)**	**(653)**	**(78,722)**	**(89,453)**	**(10,731)**

Non-pay was £785k worse than plan in month nine and £653k worse than plan year to date. A summary of the position is outlined below;

- Non pass- through drug costs continue to be better than budget for the year to date.
- Non-Pbr drugs are £753k better than budget YTD but this is off-set by a corresponding shortfall on income.
- Clinical supplies and services are £826k worse than budget year to date, the main areas of overspend remain lab costs and MSSE in Diagnostic & Pharmacy and Surgery respectively.
- Other non-pay is £687k worse than budget year to date (£50k better than budget excluding Grip & Control savings) and £548k worse than budget in month. The main variances in month are; Unachieved CIP £392k worse than budget, Facilities expenses £61k worse than budget, other consumables and services £61k worse than budget and staff related expenses £70k worse than budget.

5. Divisional Performance

	Cumulative position to M9				Net Contribution	Net Contribution	Net Contribution
	Income	Pay	Non-Pay	Other	Actual M9	Plan M9	Variance M9
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Children & Families Care Group	39,028	(23,212)	(4,815)		11,001	10,444	557
Diagnostic & Pharmacy Care Group	10,476	(18,626)	(7,152)		(15,302)	(15,425)	122
Emergency Care Group	50,506	(30,523)	(6,162)		13,821	10,063	3,758
MSK & Frailty Care Group	52,954	(26,325)	(15,676)		10,953	11,261	(308)
Specialty Services Care Group	46,786	(21,337)	(11,854)		13,594	13,548	46
Surgical Care Group	49,677	(38,105)	(13,460)		(1,887)	(1,237)	(650)
Corporate Directorates *	30,795	(27,712)	(29,984)	(8,229)	(35,129)	(37,111)	1,982
	280,222	**(185,840)**	**(89,103)**	**(8,229)**	**(2,950)**	**(8,457)**	**5,508**

** includes Recharges, contingency & reserves*

The table above shows the Trust position by Care group at a net contribution level. With the exception of MSK and Surgery all Care groups are positive to budget at a net contribution level.

Children's and Families are still the only care group ahead of plan on both income and expenditure by £38k (or 0.10%) and £519k (or 1.82%) respectively.

Diagnostic & Pharmacy and Emergency Care are both over performing on income (3.53% and 10.23% respectively) and are overspent on costs but to a lesser extent (0.92% and 2.60% respectively), leaving them with net positive contribution variances of £122k and £3,758k.

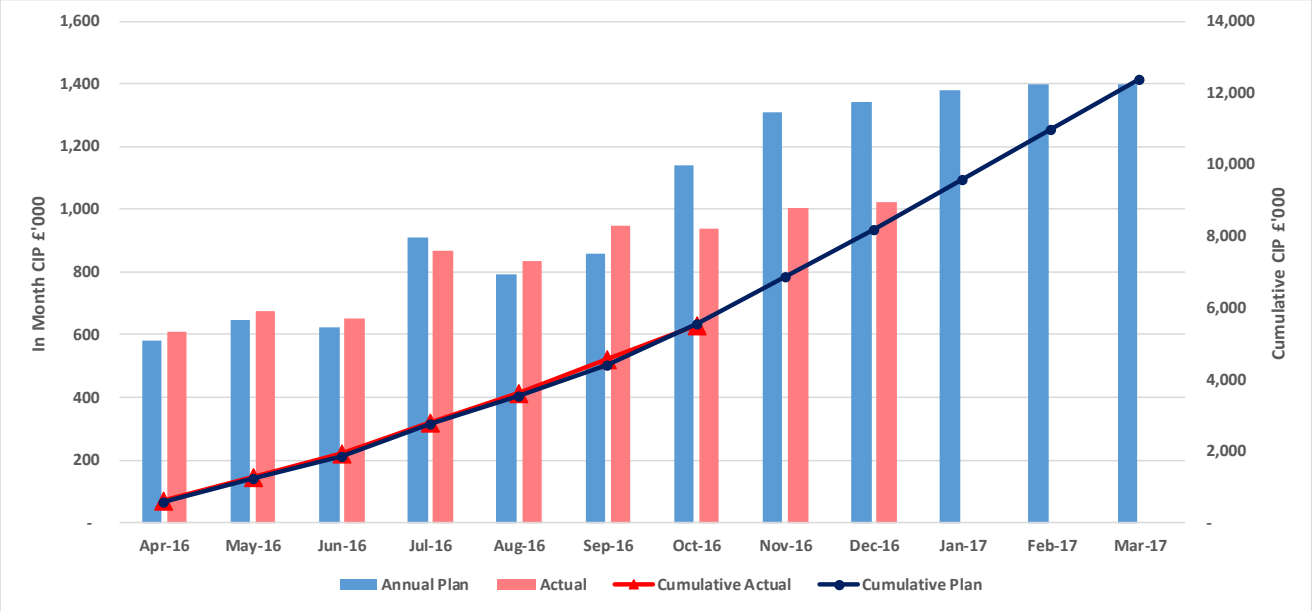
MSK and Surgery are both behind plan on income (3.07% and 3.15% respectively) and although their shortfalls are being mitigated by lower than plan expenditure (3.15% and 2.62% respectively) this isn't enough to deliver a positive net contribution variance. MSK has a YTD net negative contribution variance of £308k and Surgery £650k.

Speciality Services is currently £1,131k behind plan on income but underspent on costs by £1,178k, giving a small positive variance to net contribution of £46k.

Corporate directorates excluding recharges & contingencies are behind plan on income (£250k) and overspent on costs (£247k), leaving them with a negative variance to net contribution of £498k.

6. Cost Improvement Programme

The graph below shows actual monthly performance against plan and the monthly targets for future months. For the year to December we have delivered £7,544k of savings, £659k behind plan.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Annual Plan	580	647	624	911	794	858	1,139	1,308	1,341	1,378	1,400	1,399
Actual	608	674	650	866	835	945	940	1,004	1,024			
Cumulative Actual	608	1,281	1,931	2,797	3,632	4,577	5,517	6,520	7,544			
Cumulative Plan	580	1,228	1,851	2,762	3,557	4,415	5,554	6,862	8,203	9,581	10,981	12,380

Looking at the breakdown of schemes below there are mixed performances with some ahead of plan and others behind. The forecast has been revised upwards by £119k and is now expected to be £11,552k, £828k less than plan which will still be mitigated by balance sheet flexibilities. Individual schemes that have improved since month eight include; Outpatient Productivity £21k improvement (FY forecast £19k better than plan), Infrastructure £57k improvement (FY forecast £329k worse than plan) and Non-Medical Clinical £72k improvement (FY forecast £71k worse than plan). Conversely the Procurement scheme has slipped since the month eight position by £31k (FY forecast £160k better than plan). There have been immaterial slippages or improvements on all other schemes.

Performance Indicator	**YTD Performance**			**Annual**	**Forecast**
	Actual	**Varaiance**		**Plan**	
	£'000	**£'000**		**£'000**	**£'000**
Theatres	295	35	F	520	482
Outpatient Productivity	188	1	F	259	278
Medical Productivity	189	(10)	A	441	257
Non Medical Clinical	117	29	F	261	190
Management & Corporate Services Review	661	(47)	A	987	924
Bed Plan / LOS	1,679	(50)	A	2,683	2,320
Procurement	1,464	18	F	2,003	2,163
Clinical Admin Review	68	(57)	A	250	79
Infrastructure	322	(192)	A	894	565
Income	605	(302)	A	1,325	868
Care Group & Corporate - Local	1,202	(105)	A	1,779	1,616
Grip & Control	754	23	F	978	1,811
Total	**7,544**	**(659)**	**A**	**12,380**	**11,552**

7. Capital Programme

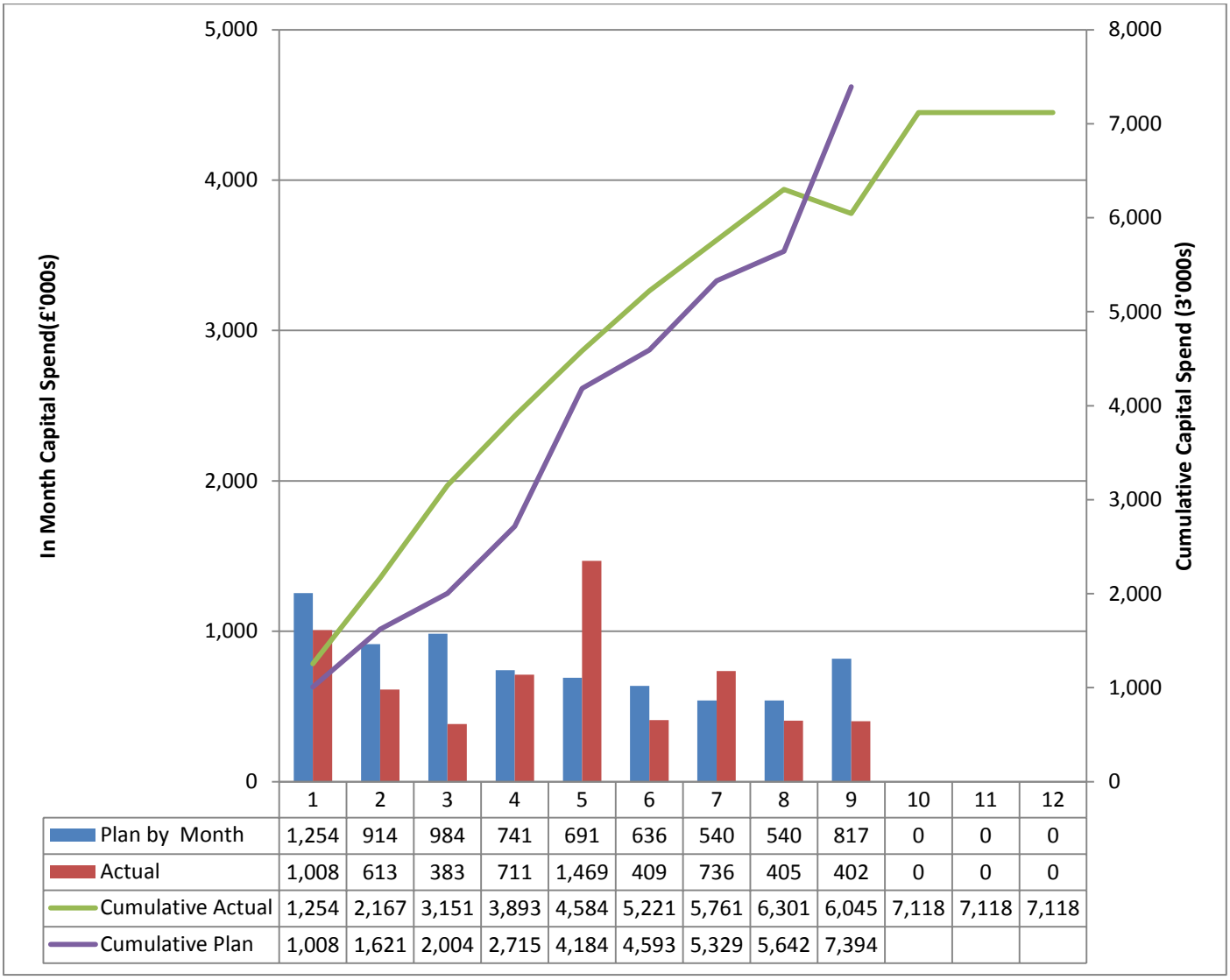
Capital expenditure YTD is £6m against a plan of £7.3m.

The capital underspends are all timing related, all critical and essential spend identified as part of capital planning is progressing.

The capital budget is currently being reviewed following the recent essential expenditure and emerging priorities not originally reflected in the plan. It is not expected to increase the capital budget for 2016/17.

Where opportunities to invest in additional schemes present themselves these will be considered based on a Clinical or Operational assessment.

All capital expenditure related to the Trust's Charity is funded directly by the Charitable Fund and therefore has no impact on cash or capital allocation for the Trust.



	1	2	3	4	5	6	7	8	9	10	11	12
Plan by Month	1,254	914	984	741	691	636	540	540	817	0	0	0
Actual	1,008	613	383	711	1,469	409	736	405	402	0	0	0
Cumulative Actual	1,254	2,167	3,151	3,893	4,584	5,221	5,761	6,301	6,045	7,118	7,118	7,118
Cumulative Plan	1,008	1,621	2,004	2,715	4,184	4,593	5,329	5,642	7,394			

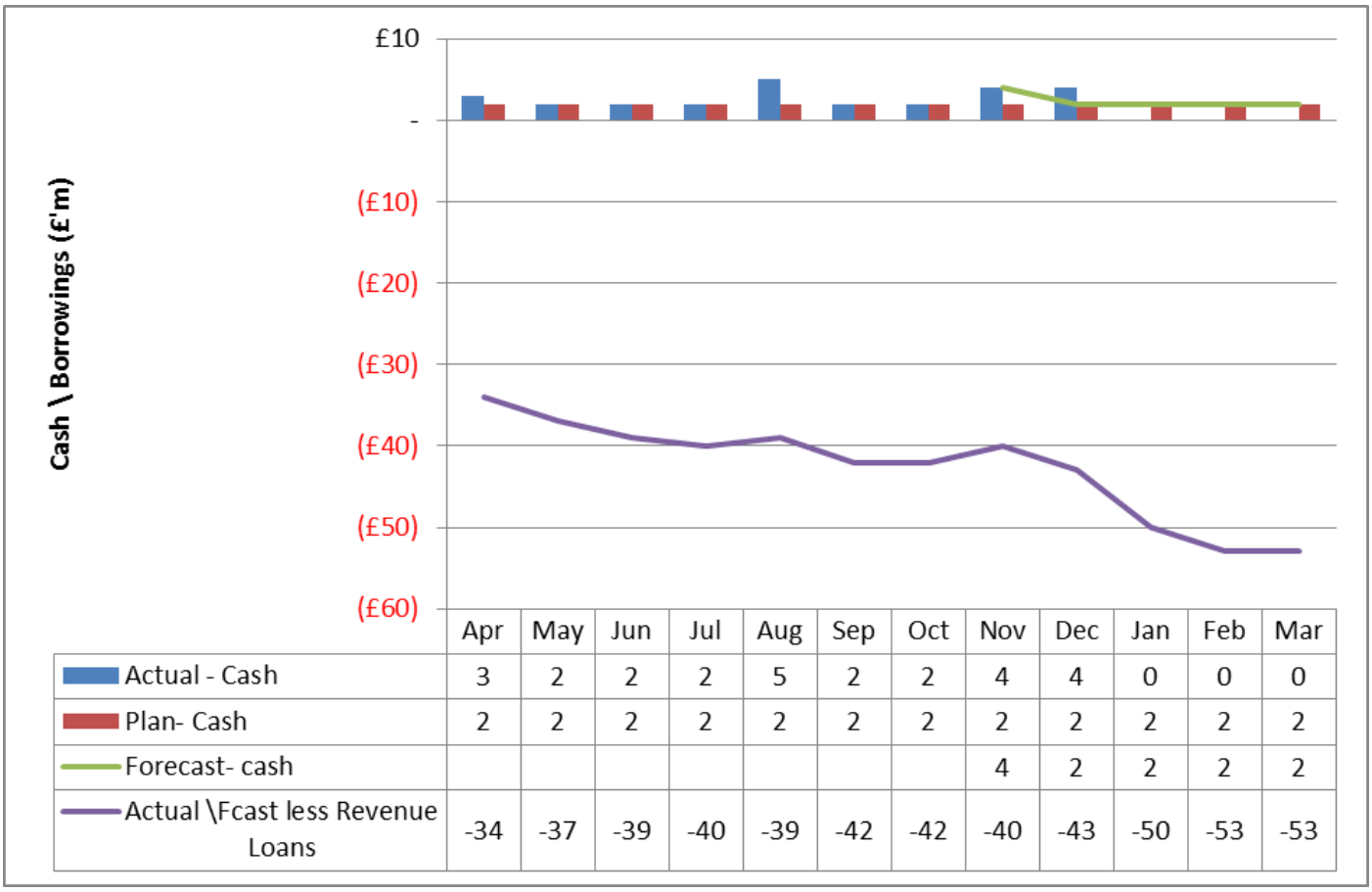
8. Cash and Investments

Cash balance at the end of December was £4.4m against a plan of £1.9m.

Cumulatively in 2016/17 the Trust has drawn remains the same as last month £10.6m against our plan of £17.0m.

No cash was drawdown in Quarter 3. Cash flow forecast indicates that there will be a drawdown in January 2017 of £3.5m therefore revenue loans in year is forecast to be £22.7m against a plan of £29.1m

Total Revenue support since December 2015 is £43.7m, forecast to increase by £3.5m for January, £3.5m for February and £3m for the month of March totalling to £53.7m at 31st March 2017.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual - Cash	3	2	2	2	5	2	2	4	4	0	0	0
Plan- Cash	2	2	2	2	2	2	2	2	2	2	2	2
Forecast- cash								4	2	2	2	2
Actual \Fcast less Revenue Loans	-34	-37	-39	-40	-39	-42	-42	-40	-43	-50	-53	-53

9. Other Financial Directorate Issues

9.1 Staffing

As reported at month seven recruitment has now taken place to strengthen the substantive staffing within the Financial Services department.

Gabriel Recalde joined the trust from RDASH at the start of January as Senior Financial Accountant and has already been integral in the production and submission of the month nine accounts.

Andy Sydney is due to join the trust on 1st March as Head of Financial Control. Andy joins the team from Rotherham FT and will take the lead on all Financial Services matters.

9.2 Financial forecast 2016/17

Following a decline in the run rate over the last quarter the previous forecast deficit of £16m has been revised to £17.4m. As can be seen from the table below the movement in the forecast relates to increased expenditure, as the income forecast has remained largely static in total.

	Budget £'000	Forecast M6 £'000	Forecast M9 £'000
Income	375,048	373,006	373,189
Expenditure	(385,337)	(374,666)	(377,110)
Capital Charges	(14,396)	(14,345)	(13,477)
Deficit	**(24,684)**	**(16,005)**	**(17,398)**

The revised expenditure forecast is based on the running rate of spend adjusted for known changes in the next four months. Care Groups have been asked to indicate where spend patterns will change and this has been validated by the finance team, with further follow up at accountability meetings.

Within this position the Trust has allowed for a number of cost pressures including; winter pressure costs, T&O recovery plan costs, additional utility costs over and above run rate (seasonal variation) and further Strategy & Improvement consultancy costs. A small contingency of £150k is kept back to cover the final three months.

Using a risk based approach to the potential upsides and down sides of the revised forecast the net impact is neutral.

Additional STF funding will be made available to further negate this deficit (£7.8m on top of the £11m already included in the forecast) although all of this is non-recurrent and only available for the next two years.

9.3 SBS Oracle System Update

The project status is currently AMBER.

OVERALL
Project Management
Accounting to Reporting
Order to Cash
Procure to Pay
Interfaces
IT
Training
Comms and Change

The project is currently focussed on designing the right solution for Doncaster and Bassetlaw but due to key project team availability this stage is behind.

Against the original plan, the project is 2 weeks behind but still on track to go-live on the 3rd April.

The key issues are the design of a suitable Trust Funds management process and the design of the HOLT locum doctor's process (development of a new interface and payment timelines).

10. Conclusion

The Trust performance to month 9 is in line with the revised forecast deficit of £17.4m. Key areas of risk to this forecast are;

- Achieving the targets aligned with securing the STF funding
- Reduction in income due to the increased emergency activity being currently experienced
- Further slippage on the CIP programme
- Continued increases above forecast levels on Medical Agency and non-pay spend

11. Recommendations

To progress actions related to the areas of risk outlined above to ensure the Trust achieves its revised forecast deficit position for 2016/17.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Business Intelligence Report**		
Report to:	**Board of Directors**	Date:	**31.01.2017**
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:	**Noting**		

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. This month's report focuses on the actions being undertaken to improve RTT.

Recommendation

To note the report.

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 risks

- 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*	*4x3= 12*
2	*Failure to match capacity with demand, particularly during winter*	*4 x 4 = 16*
3	*Failure to maintain appropriate organisational corporate governance systems*	*5x 4 = 20*

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Doncaster and Bassetlaw Hospitals NHS Foundation Trust Board of Directors Meeting

Performance -December 2016 - (Month 9)

Sewa Singh	Medical Director
Moira Hardy	Interim Director of Nursing, Midwifery & Quality
David Purdue	Chief Operating Officer
Karen Barnard	Director of People and Organisational Development

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Performance - December 2016

The performance report is against operational delivery in November and December 2016
Provide the safest, most effective care possible

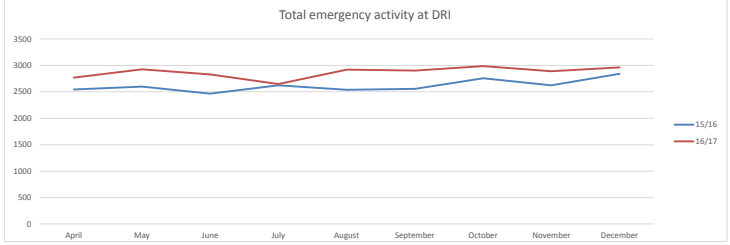
Monitor governance compliance is rated against 3 National targets, 4hr Access, Referral to Treatment, which includes diagnostic waits and Cancer Targets. The targets are all monitored quarterly, both 4hr access and cancer are averaged over the quarter but referral to treatment is monitored each month 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

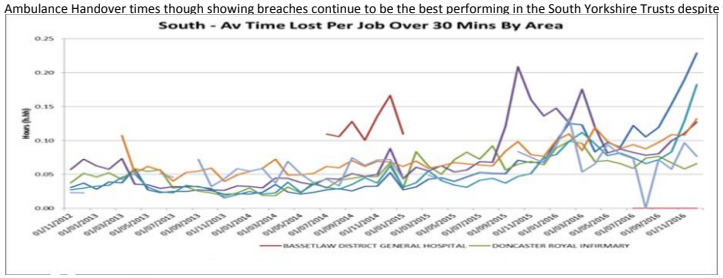
The target is based on the number of patients who are treated within 4hrs of arrival into the emergency department and set at95 and reported Quarterly as an average figure. This target is for all urgent care provided by the Trust for any patient who walks in. We have 2 type 1 facilities, ED at BDGH and DRI and 1 type 3 facility at MMH. The Trust does not count any GP admissions areas within its target.

December Performance
Trust 86.6%
Quarter 3 90.1%
Year to date 92.2%

DBHFT continues to perform in the top quartile despite the pressures faced in December.
DBHFT reduced elective capacity from the 23rd of December to meet the requirements of having 85% bed occupancy over the Christmas period. This level of bed occupancy was achieved on both main sites up til the 29th of December.
Medical staffing continues to cause major issues with lack of agency staff for key shifts. Meetings have taken place with Holt to improve the process for filling shifts in line with the other Trusts in South Yorkshire.
DRI achieved 82.04%, if MMH were included Doncaster achieved 84.55%. 1474 patients failed to be treated within 4hrs. 765 patients were delayed due to internal ED waits, 505 were delayed due to bed waits. 159 patients required to wait in the department due to their condition.
12.9% of patients were transferred to the urgent care centre.
Bassetlaw achieved 91.47%, 273 patients failed to be treated within 4hrs. 239 patients were delayed due to internal ED waits,23 due to bed waits and 41 patients were required to wait in the department due to their condition.
Emergency activity continues to be above contact with an increased attendance by ambulance. 2016 contained the highest daily total number of arrivals by emergency ambulance (120) and four of the five highest (120, 118, 116 and 115 arrivals per day).



Ambulance Handover times though showing breaches continue to be the best performing in the South Yorkshire Trusts despite theincrease in Ambulance attendances.



Referral to Treatment

The target is now measured against incomplete pathways only at 92%. Fines for RTT have been lifted for 2016/17.
The methodology used in September shows a more accurate position against patients whose treatments were stopped in Septemberrather than the snap shot at the 10th working day. This methodology has been agreed with the CCG and will be used going forwards.

December 90.1%

8 specialities were non-compliant in month, the drill down in the main report identifies the actions being undertaken to addressthe key issues in the specialites

Diagnostic performance 99.3%

All diagnostic tests were compliant in month. Audiology performance is now achieving.

Cancer Performance

All targets were achieved in month against key performance indicators
New guidance for 28 day diagnosis is being worked up for each cancer pathway.
A pilot for 2 week wait booking is being launched with dedicated patient planners working in the corporate cancer team booking all 2 week wait appointments.

David Purdue Chief Operating Officer January 2017

At a Glance -December 2016 (Month 9)

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	Nov-16	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		85.8%	
		62 day wait for first treatment from consultant screening service referral	85.0%	M		83.3%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		99.2%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		94.3%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		100.0%	
6-7		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	Dec-16	86.6%	
8-11		Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	Nov-16	90.1%	
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		99.31%	
6-7	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	Dec-16	07:15	
		A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		11:47	
		A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		04:51	
		A&E: Time to treatment decision (median) HH:MM	01:00	N		01:07	
		A&E unplanned re-attendance rate %	5.0%	N		0.4%	
		A&E: Left without being seen %	5.0%	N		4.1%	
		Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		N	Nov-16	667	
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes				103	
		Ambulance Handovers Breaches -Number waited over 60 Minutes				8	
12-14	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	N	Oct-16	47.8%	
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	N		60.9%	
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	90.0%	N		100.0%	
		Proportion of applicable patients receiving a joint health and social care plan on discharge (Trust)	90.0%	N		94.4%	
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N		78.4%	
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N		97.2%	
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	N		77.8%	
15	Theatres & Outpatients	Cancelled Operations	0.8%	N	Dec-16	1.8%	
		Cancelled Operations-28 Day Standard	0	N		6	
		Out Patients: DNA Rate		L		9.9%	
		Out Patients: Hospital Cancellation Rate		L		5.9%	
				L			
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		L	Oct-16	6.0%	

Page		Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
20	Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	Dec-16	68.8%	66.6%	77.7%	
		Best Practice Criteria					
		36 hours to surgery Performance		73.3%	69.4%	88.8%	
		72 hours to geriatrician assessment Performance		95.5%	94.0%	100.0%	
		% of patients who underwent an MDT assessment		97.7%	97.0%	100.0%	
		% of patients who underwent a falls assessment		95.2%	97.2%	88.8%	
		% of patients receiving a bone protection medication assessment		97.7%	97.0%	100.0%	
		Mortality-Deaths within 30 days of procedure		4.54%	5.60%	0.00%	

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
22	Safe	Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	Dec-16	2	
		Infection Control MRSA	0	L		0	
19		HSMR (rolling 12 Months)	100	N	Oct-16	93.62	
		Never Events	0	L	Dec-16	1	
		VTE	95.0%	N	Nov-16	95.1%	
22		Pressure Ulcers	12 Per Month 144 full Year	L	Dec-16	4	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		0	
		Catheter UTI	Snap shot audit			0.62%	

Page		Indicator	Current Month	Month Actual	Data Quality RAG Rating
23	Complaints & Claims	Complaints received (12 Month Rolling)		552	
		Concerns Received (12 Month Rolling)		850	
		Complaints Performance		32.0%	
		Clinical Negligence Scheme for Trusts (CNST)		Awaiting Data	
		Liabilities to Third Parties Scheme (LTPS)		Awaiting Data	
		Claims per 1000 occupied bed days		Awaiting Data	

Page		Indicator	Current Month	Month Actual	YTD (Cummulative)	Data Quality RAG Rating
26	Workforce	Sickness	Dec-16	4.5%	4.5%	
28		Appraisals			64.8%	
27		SET Training			65.9%	

Monitor Compliance Framework: Cancer - November 2016 (Month 8)

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

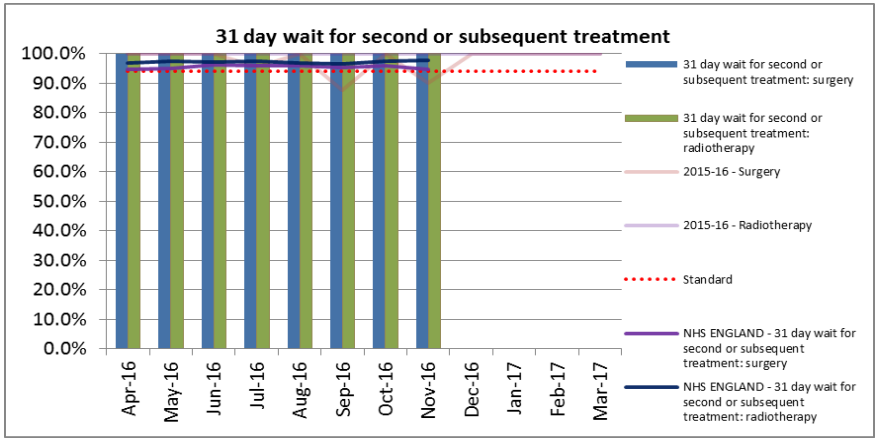
2 week wait and classic 62 day targets achieved in month, pathway reviews are being undertaken in head and neck and lower GI.

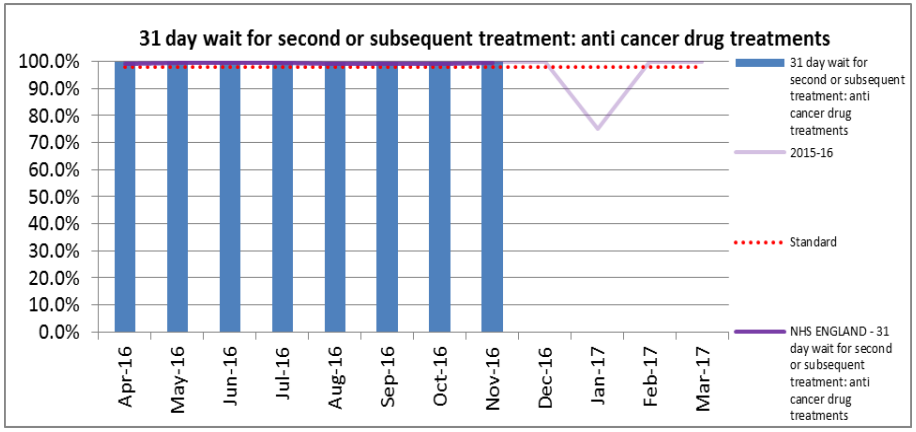
Actions being taken to address any issues

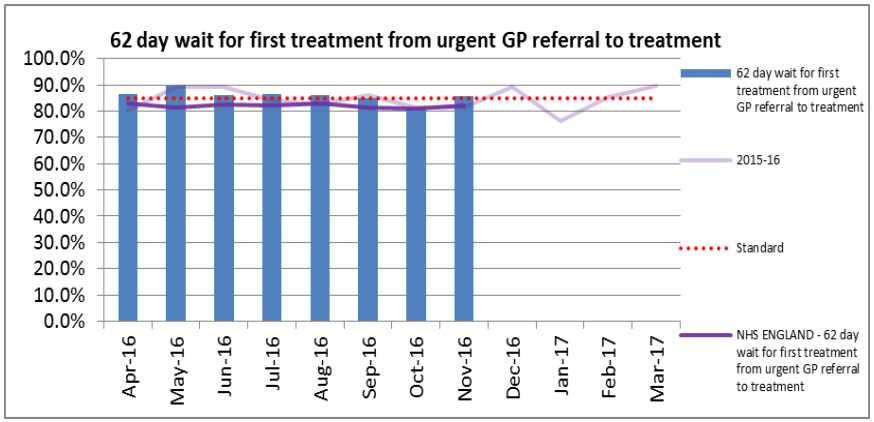
The Trust reports weekly at the PTL all 62 day target performance
Electronic system flags delays in individul pathways to the relevant consultant, MDT coordinator and performance manager are in place flagging at day 28. 30 and 50
Individual breach reports are discussed with the MDTs to ensure learning is in place
Urology pathways follow Gold Standard Framework, internal processes for MRI and OPD booking reviewed and identified clinics and slots now in place
Electronic transfer protocols now agreed with STH for transfer in Lung and Urology
Improved access to diagnostics and cancer patients flagged through the diagnostic system.
Changes to access from the NICE guidance has led to redesigned referral proformas and guidance to GPs
Process mapping carried out on two week wait administration pathways to optimise the system.
Patients being contacted when they delay their appointment outside of 14 days

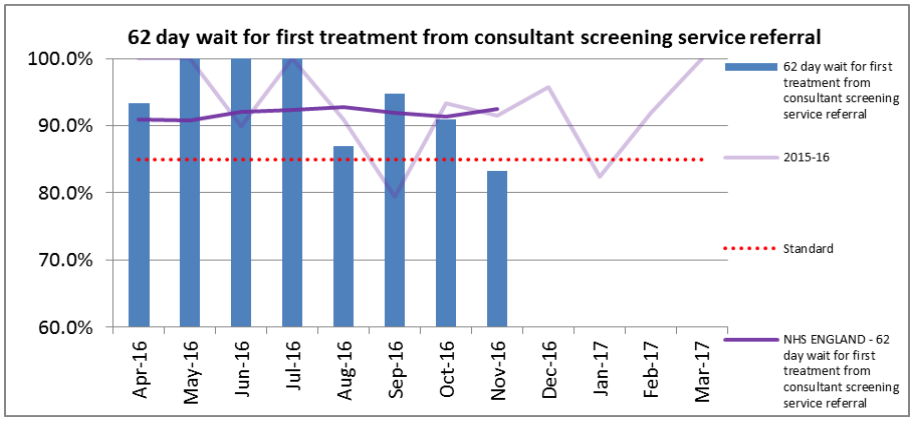
Indicator		Standard	Nov-15	QTR 2 2016-17	Sep-16	Oct-16	Nov-16
31 day wait for second or subsequent treatment: surgery		94.0%	90.0%	95.0%	100.0%	100.0%	100.0%
31 day wait for second or subsequent treatment: anti cancer drug treatments		98.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day wait for second or 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	Tumor Type	85.0%					
	Breast		100.0%	100.0%	100.0%	100.0%	100.0%
	Gynaecological		62.5%	89.7%	100.0%	83.3%	88.9%
	Haematological		100.0%	81.8%	83.3%	100.0%	66.7%
	Head & Neck		0.0%	55.0%	16.7%	50.0%	50.0%
	Lower Gastrointestinal		80.0%	77.6%	80.0%	66.7%	50.0%
	Lung		80.0%	76.9%	70.0%	71.4%	57.1%
	Other		0.0%	100.0%		80.0%	
	Sarcoma		66.7%	66.7%	100.0%	100.0%	100.0%
	Skin		100.0%	97.9%	92.9%	96.4%	93.5%
	Upper Gastrointestinal		84.6%	85.3%	87.5%	85.7%	92.3%
	Urological		57.9%	77.1%	81.1%	57.9%	90.0%
	All Cancers		81.5%	86.6%	84.7%	81.0%	85.8%
62 day wait for first treatment from consultant screening service referral	Tumor Type	85.0%					
	Breast		100.0%	95.0%	100.0%	100.0%	100.0%
	Gynaecological			0.0%			
	Haematological						
	Head & Neck						
	Lower Gastrointestinal		0.0%	85.7%	75.0%	50.0%	50.0%
	Lung						
	Other						
	Sarcoma						
	Skin						
	Upper Gastrointestinal						
	Urological						
	All Cancers		91.5%	92.8%	94.7%	90.9%	83.3%
31 day wait for diagnosis to first treatment- all cancers		96.0%	98.2%	99.8%	99.3%	99.1%	99.2%
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)		93.0%	95.0%	94.6%	94.4%	95.3%	94.3%
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)		93.0%	94.6%	96.5%	100.0%	93.5%	100.0%

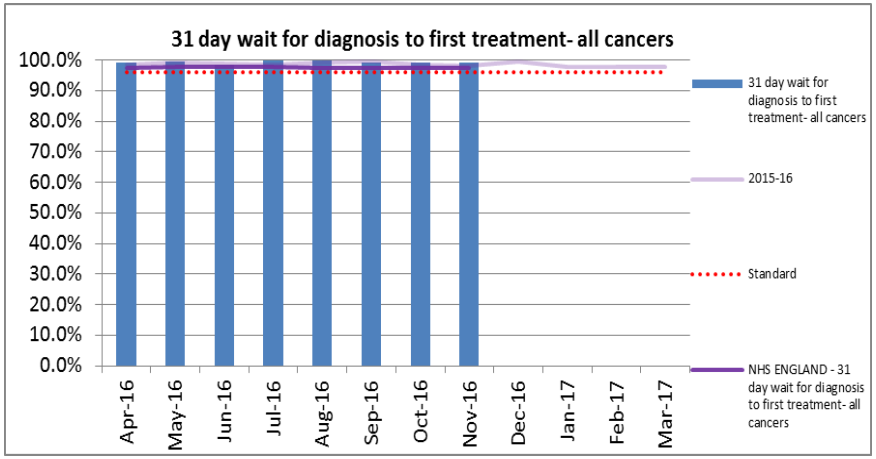
Monitor Compliance Framework: Cancer - Graphs - November 2016 (Month 8)

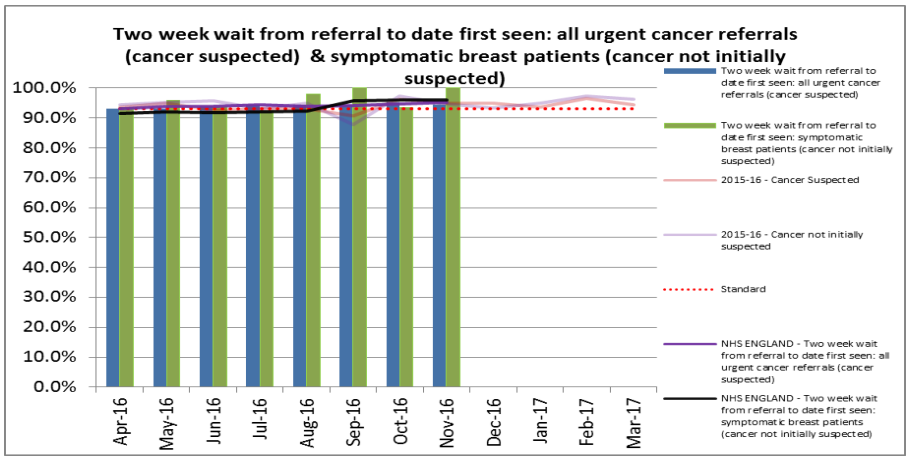












Monitor Compliance Framework: A&E - December 2016 (Month 9)

Context

Trust performance 86.6%

Reasons for Success/Failure

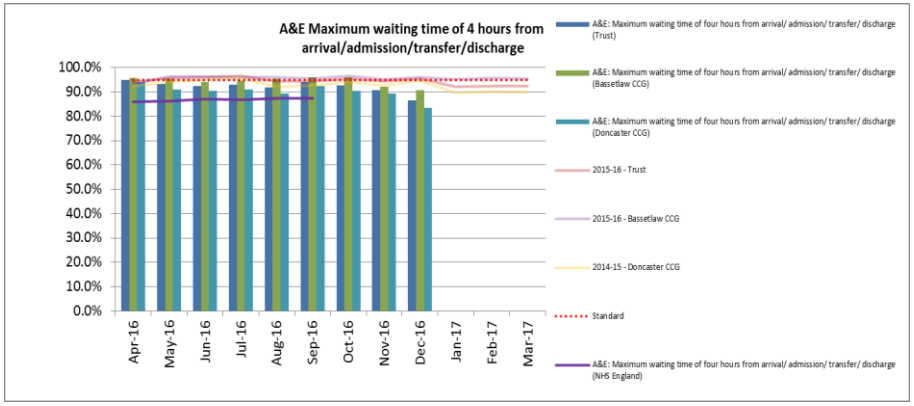
Both type 1 units failed the performance target. Continuing pressures with internal waits in both EDs due to the shortage of medical staff. This has been made worse by last minute cancellations of agency staff. Improved processes have been agreed with Holt. Bed capacity has been an issue at DRI due to emergency demand. Flu has caused some issues with closed beds.

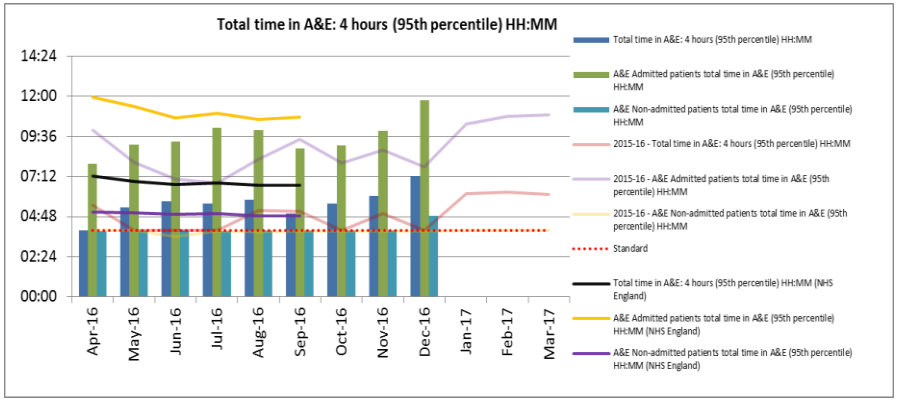
Actions being taken to address any issues

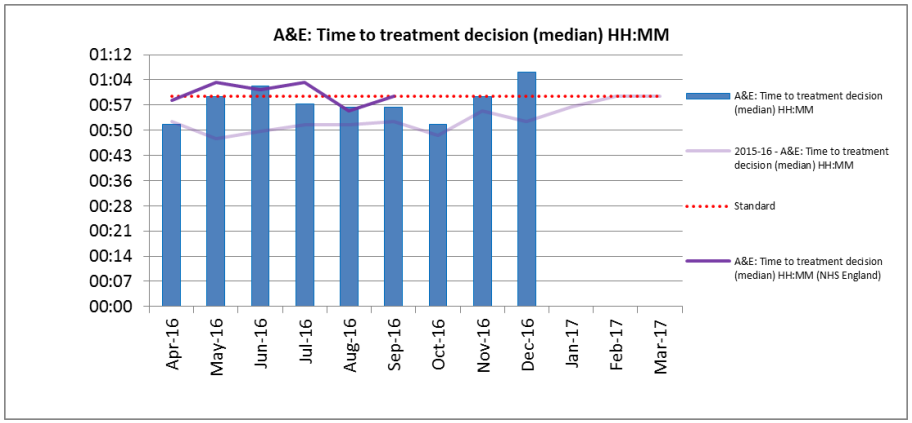
Patient flow initiatives are being piloted including red and green days
Engagement event excellent feedback. Task and Finish groups established
Internal escalation triggers reviewed and dashboard now in place to monitor ED position
Senior YAS manager seconded to ED at DRI to improve handover and partnership working
Review of FDASS model underway to increase percentage transferred to UCC
Developing leadership in managing the ED, events organised for insight training
Reviewing the workforce models to include both nursing and medical
A&E delivery board commenced across both Doncaster and Bassetlaw
Systems escalation processes being agreed

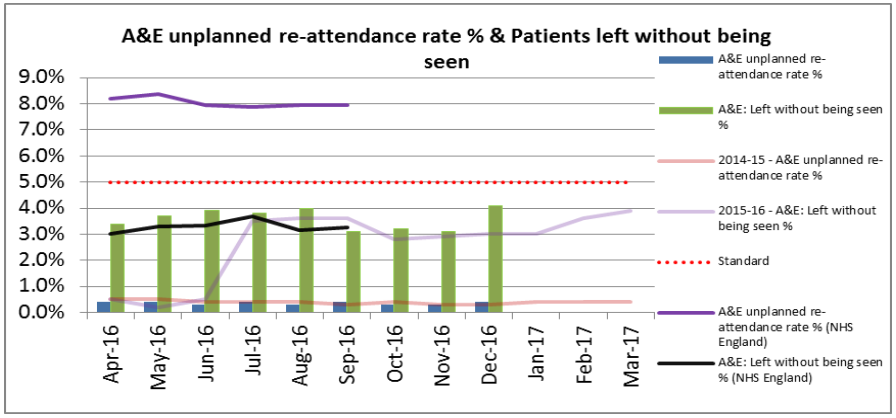
Indicator	Standard	Dec-15	Qtr 3 2016-17	Oct-16	Nov-16	Dec-16
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Trust)**	95.0%	95.5%	90.1%	92.8%	90.7%	86.6%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Bassetlaw CCG)**		96.1%	92.9%	95.9%	92.2%	90.7%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge **(Doncaster CCG)**		94.6%	87.7%	90.4%	89.2%	83.4%
Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	04:00	06:19	05:34	06:02	07:15
A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	07:48	10:24	09:03	09:57	11:47
A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	03:56	04:00	03:58	03:59	04:51
A&E: Time to treatment decision (median) MM	01:00	00:53	00:59	00:52	01:00	01:07
A&E unplanned re-attendance rate %	5.0%	0.3%	0.6%	0.3%	0.3%	0.4%
A&E: Left without being seen %	5.0%	3.0%	3.5%	3.2%	3.1%	4.1%
Indicator	**Standard**	**Nov-15**	**Qtr 2 2016-17**	**Sep-16**	**Oct-16**	**Nov-16**
Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		515	2175	741	730	667
Ambulance Handovers Breaches -Number waited over 30 & under 60 Minutes		50	180	59	62	103
Ambulance Handovers Breaches -Number waited over 60 Minutes		9	47	28	5	8

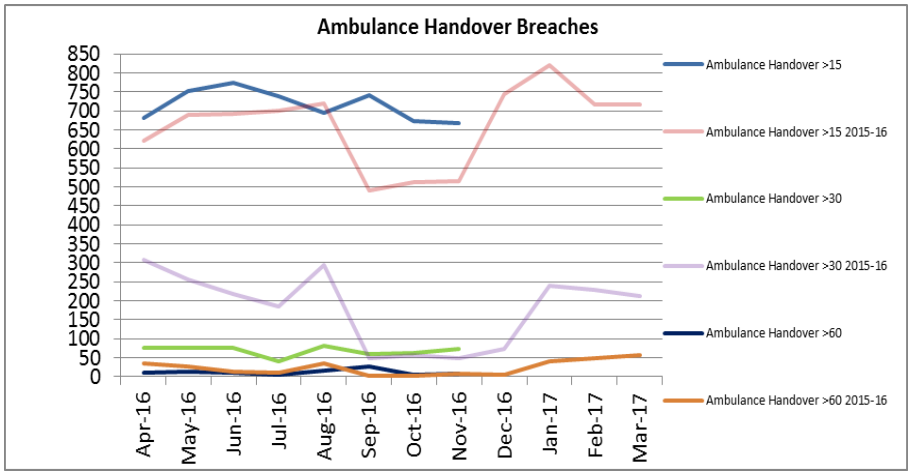
Monitor Compliance Framework: A&E - Graphs - December 2016 (Month 9)

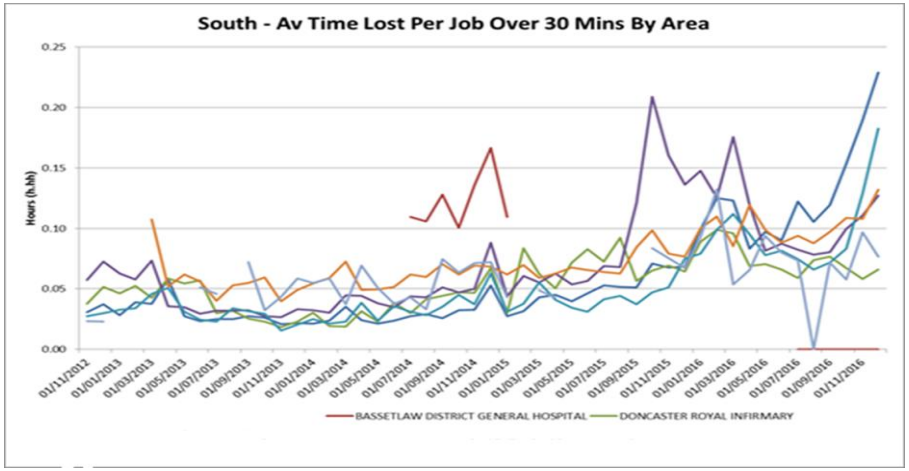












Monitor Compliance Framework: 18 Weeks & Diagnostics -December 2016 (Month 9)

Context

The Trust have changed the way the incomplete pathways snapshot is monitored.
- Late Entered Referrals are included
- All amendments made to pathways since the end of September will have been reflected in the data. Previously only those flagged on the DQ system with earlier stops would have been removed.
- The removal of any late entered clock stops prior to the end of September. Previously only those in the month or flagged on the DQ system would have been removed.
- Correction on weeks waiting calculation for incomplete pathways as the calculation previously reported one day extra on each pathway,
- Inclusion of ASIs.

Reasons for Failure (if applicable)

RTT Position – December 2016

The following is to provide an update in relation to December RTT final position.

Incomplete pathways for December 2016 ended at **90.1%.**
In accordance with NHSI STF criteria for funding the Trust has lost December income of £123K

8 specialties failed to meet 92% in December:
- General Surgery
- Urology
- General Medicine
- Dermatology
- Ophthalmology
- Rheumatology
- Trauma and Orthopaedics
- ENT

Diagnostic performance for December: **99.31%**

Actions being taken to address any issues

Weekly PTL meetings take place with Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT. In response to the current RTT position Recovery Plans are being confirmed with each Care Group. Specialty specific actions are listed in the 18 Wk & Diag Drilldown tab.

Actions
- Secure additional capacity both internally and externally through out sourcing
- Turnaround sessions planned with each Care Group commencing 18/01/17
- To focus on specific specialties to meet a Trust RTT of 92%
- To ensure chronological booking of patients to support RTT delivery
- Collaboration with CCG on referral management and support in reducing demand
- Workforce Business Case/Requests by specialty
- To provide a situation report of Care Group Review Lists and identify risks and issues
- Increase Pre-Assessment capacity to support recovery plans
- Interim service line management in place
- Dedicated Pathway Co-ordinators in Care Groups to manage specialty level pathways to improve planning and performance
- Validation process between Care Group and DQ Team agreed with weekly monitoring in place on completion

- Identify best practice PTL management to enhance Trust reporting and information
- Exploration of external support; Concsultant Resources, PTL management; cleanliness, validation, knowledge and skills
- Clean PTL being provided FOC and completed by w/e 03/02/17
- Enhance Business Intelligence to support performance conversations at Accountability meetings - new Care Group Dashboard with planned care metrics

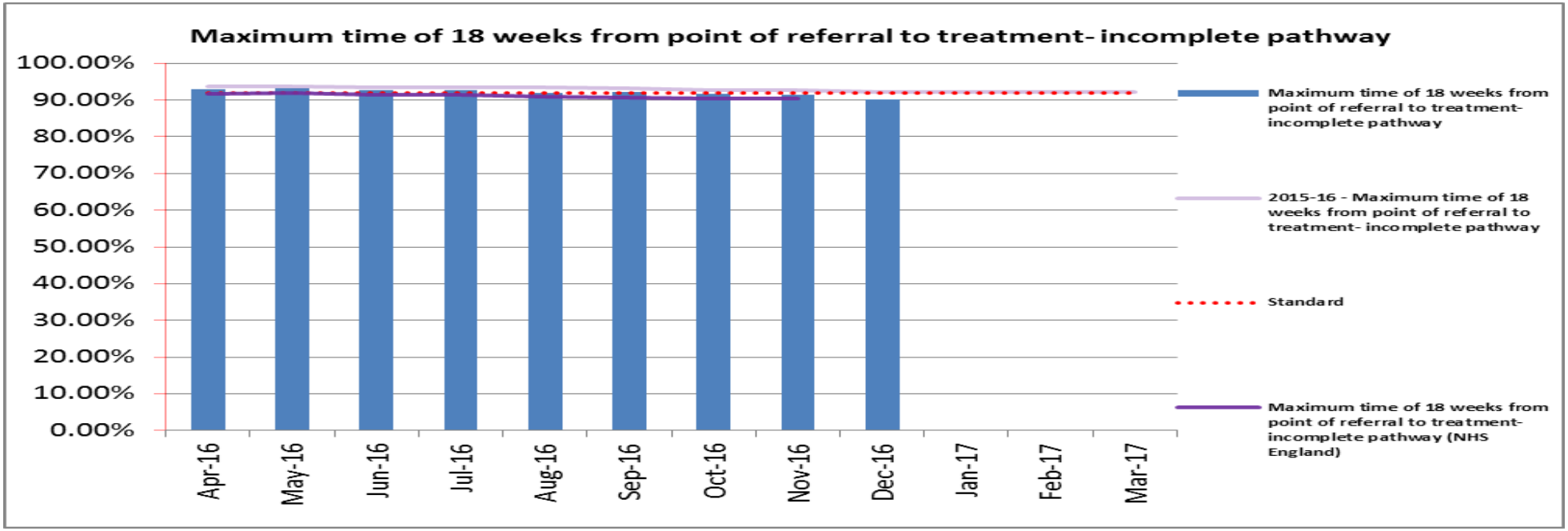
Risks
- Potential risk to further slippage in RTT due to validating below 18 weeks as part of the DQ Action Plan
- Validation and Cleanliness of PTL position
- Error rate in pathway entry (+25%)
- Costs associated with approval to increase workforce, additional sessions and outsourcing
- Securing additional capacity
- Performance management in the approval of Consultant annual leave, planned absence and other - impacting on specialty capacity

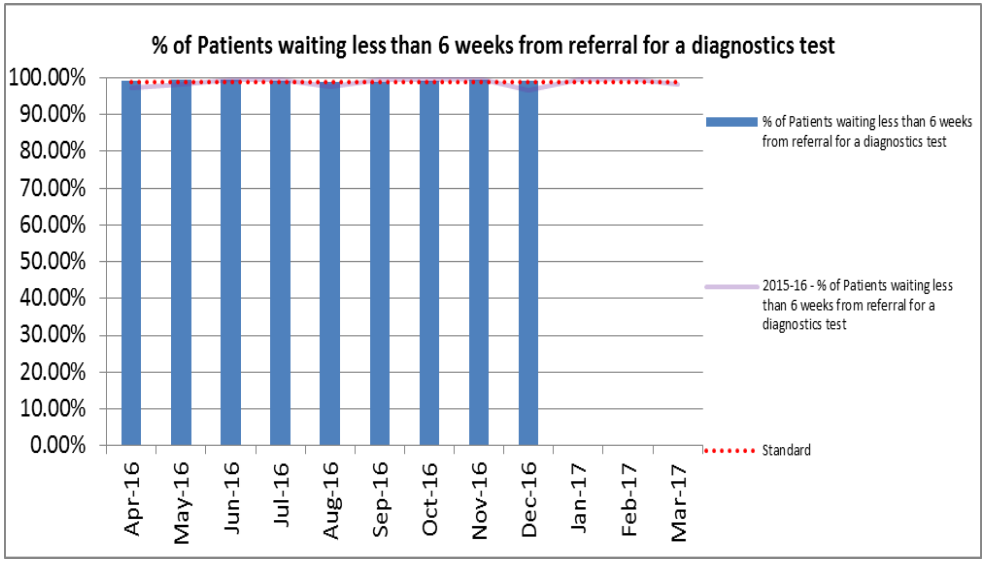
Summary

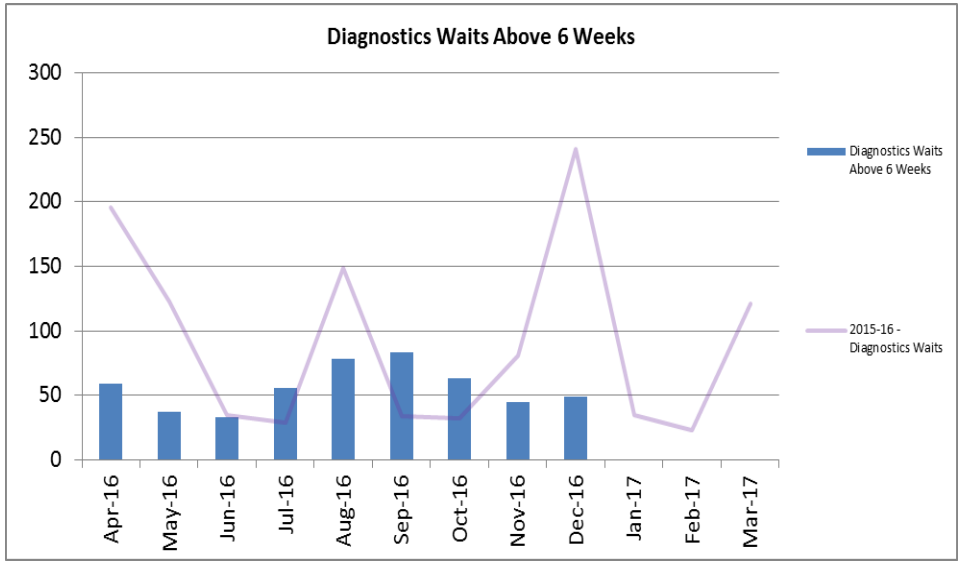
January position is expected to remain at 90%. Based on capacity and plans in place a worst case February postioin is 90.5% and 91% in March. However, the Trust position will improve and move above 92% in March 2017if the planned increased capacity is secured across key specialty areas; Dermatology, Ophthalmology and Urology. Care Groups are actively attempting to secure capacity supported by the COO and DCOO.

Indicator	Standard	Dec-15	Qtr. 3 2016-17	Oct-16	Nov-16	Dec-16	Expected date to meet standard
Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	92.10%	90.10%	91.70%	91.30%	90.10%	Jan-17
Indicator	**Standard**	**Dec-15**		**Oct-16**	**Nov-16**	**Dec-16**	**Expected date to meet standard**
% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	96.50%		99.19%	99.44%	99.34%	Standard Met
Diagnostics Waits		241		63	45	49	

Monitor Compliance Framework: 18 Weeks & Diagnostics -December (Month 9)







Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)

Alert Reason

These Indicators have alerted due to the failure to meet the National Target in relation to RTT. **December position** 90.1%.

Indicator	Target	Month Actual
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)	92.0%	90.1%

Methodology

Progress against Delivery Plans including Capacity and Demand Management is initially managed through Planned Care Delivery Group and Care Groups are held to account in capability and delivery at their Accountability Meeting. Delivery plans are monitored on a weekly basis and each month the group dedicates time for improvement and development across the planned care pathway.
Recent development includes introduction of a booking SOP and steps to enhance the current business intelligence information to support operational teams in RTT.

Reason for Failure

RTT Position – December 2016
Incomplete pathways for December 2016 ended at 90.1%.
In accordance with NHSI STF criteria for funding theTrust has therefore lost December income of £123K

8 specialties failed to meet 92% in December:
- General Surgery
- Urology
- General Medicine
- Dermatology
- Ophthalmology
- Rheumatology
- Trauma and Orthopaedics
- ENT

Key issues
- Workforce to meet demand
- Utilisation of clinic capacity: outpatient booking
- Productivity of lists due to withheld slots for training (not required), late starts and cancellations
- Cancellations due to bed availability and implmentation of Directive from NHSE to reduce Elective IP activity Dec/Jan 2017
- Growing PTL due to time involved to validate patients has doubled (CaMIS)
- Failing to book in chronological order
- Pre-Assessment availability
- Service Manager performance and capability
- Lack of pathway administration support: validation, tracking, utilisation

Actions being taken to address the issue

Below are Key Actions specific to Care Groups and Enabling Services turaround plans: Delivery Plans monitored through the weekly PCDG meetings.

Surgical Care Group

Ophthalmology
- PTL clearance times confirmed and options being confirmed
- Out sourcing of Ophthalmology and CBA for decision (Rotherham and ParkHill)
- Interim Service Manager in post to mitigate capability concerns
- Remove inappropriate training slots on theatre lists
- Escalate all cancellations to the CD for analysis and performance management
- Introduction of a time limited Ophthalmology theatre recovery group chaired by the CD with Theatre Project Lead iin support

Trajectory: RTT position to improve Feb and March and +92% from April 2017 - *earlier recovery possible if out sourcing is achievable

ENT
- Introduction of evening pre-assessment clinics
- Ensuring theatre lists are fully booked
- Agreement for additional weekend lists by 2 consultants
- To work in collaboration with outpatient booking team to increase utilisation of clinics

Trajectory: Improvement of RTT position is dependent on improvement of bookings and additional lists completed - to be closely monitored with nominated leads

GI
- 2 additional LGI clinics from mid February
- Business case in February for x 2 Middle Grades to meet confirmed shortfall to meet demand (existing SpR - in post in 4-6weeks if approved)
- To work in collaboration with WL booking team at BDGH site re under booking of theatre lists and booking in chronological order

Trajectory: +92% from April 2017 dependent on successful recruitment and in-house waiting list booking

Specialties Care Group

Urology
- Review existing capacity to support pathway management and validation across key specialty areas prior to new management structure in place
- Approval for the new Care Group management structure led by the GM (January 17)
- CD with Consultant Leads to agree number of consultants off at same time
- Additional Lists secured for February to address +18 week patients
- Confirm PTL trajectory based on additional lists and <18wk waiters

Trajectory: Dependent on securing /realigning validation support and additional sessions to accommodate need

Vascular
- Business Manager to attend Vascular Consultant meeting to discuss increase of planned Laser sessions
- To undertake a pathway review to determine where delays occur

Trajectory: Maintenance and slight increase of position. Further increase dependent on agreement of Laser sessions.

Dermatology
- Locum secured and in post from w/c 16/01. Cover retirement of Consultant
- Consultant returned to full time capacity after long term sickness w/c 23/01
- Outsourcing to ParkHill to address +500 patients >17 weeks. Immediate, time limited capacity to address the waiting list
- Primary Care Pathway agreed with DCCG. 2 week audit w/c 23/01 prior to EOI in primary care and implementation. Aim to reduce referrals and increase primary care management
- BCCG pathway meeting w/c 30/01 to discuss implementation of TeleDerm in primary care
- Capacity in place to contact patients >18weeks and analyse need of the service. To date resultant in 35% of those contacted no longer require an appointment
- Review List of 950 patients. Business Manager /Clinical Lead to undertake a risk assessment of the list based on waiting time and clinical information. Position to be reported the DCOO
- Collaboration with 2ww booking team to increase capacity to accommodate 2ww. Escalation process now in place with the Service Manager

Trajectory : Based on workforce back to full compliment and additional capacity through out sourcing, RTT position expected to increase each month.

Haematology
- Planning of patients and reducing first OP appointment to support clinical decision making process within 18 weeks

Trajectory: Maintain position with gradual increase back to +92%

MSK/Frailty Care Group

T&O
- Continue to capitalise on additional out sourcing opportunities
- Weekly joint theatre planning meetings to review productivity and performance to address lasted starts, under population of lists
- Capacity and Demand plan in development supported by Kingsgate
- Bass and Donc waiting list booking service review

Trajectory: Increase on current position and back to 90% from March. Deep Dive session planned in early February.

Rheumatology
- Additional sessions booked up to 31/03/17.
- Consultant JD to be signed off for advertisement
- Osteo and DEXA Scan position statement with recommendations to be signed off by COO and DCOO w/c 30/01/17.

Trajectory: +92% January 2017

Enabling Services

Out patient Booking Service
- Assess capability of booking staff to fulfil role (OPC)
- To review capacity to support CG recovery plans at a specialty level
- To ensure chronological booking
- Review of Waiting List Booking Service across all 3 sites to improve performance - specific issues with BDGH service

Pre-Assessment Service
- To review capacity up to 31/03/2017 to ensure it meets the needs of CG Recovery Plans

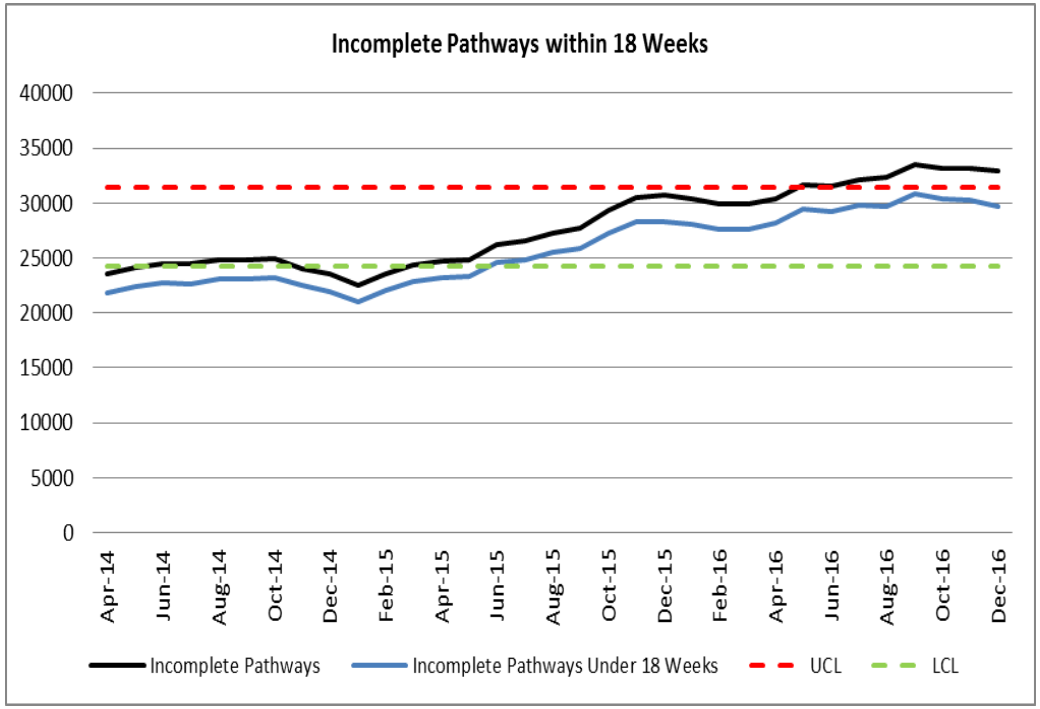
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)

Alert Reason

These Indicators have alerted due to the failure to meet the National Target in relation to RTT. **December posit**

Indicator	Target	Month Actual	Trend (Oct -Dec)
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)	**92.0%**	**90.1%**	↓

2016/17	October	November	December	January Predicted	Trend (Oct -Dec)
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)	**91.7%**	**91.3%**	**90.1%**	**90.5%**	↓
Total Patients Waiting	33127	33155	32974	28092	↘
Total Patients Waiting under 18 Weeks	30370	30255	29722	25871	↓
2015/16	**October**	**November**	**December**	**January**	**Trend (Oct -Dec)**
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)	**92.7%**	**92.6%**	**92.1%**	**92.3%**	↓
Total Patients Waiting	29365	30498	30726	30393	↑
Total Patients Waiting under 18 Weeks	27216	28245	28311	28052	↑
2014/15	**October**	**November**	**December**	**January**	**Trend (Oct -Dec)**
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral (Trust)	**92.9%**	**93.6%**	**93.1%**	**93.0%**	↘
Total Patients Waiting	24989	24012	23521	22562	↓
Total Patients Waiting under 18 Weeks	23203	22475	21898	20986	↓



Stroke -October 2016 (Month 7)

Context

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

Reasons for Failure (if applicable)

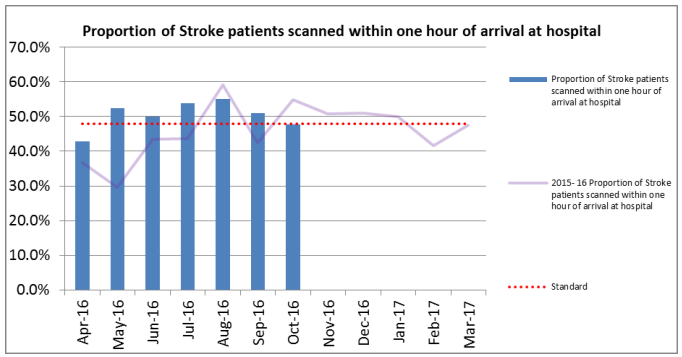
The key pathway remains direct admission to a stroke unit, this months performance levels are based on 46 discharges in the month. 28 patients were directly transferred within 4hrs. 5 patients were admitted after 10 hrs as their presenting symptoms were not suggestive of a stroke. 5 pathways were delayed through transfer from Bassetlaw

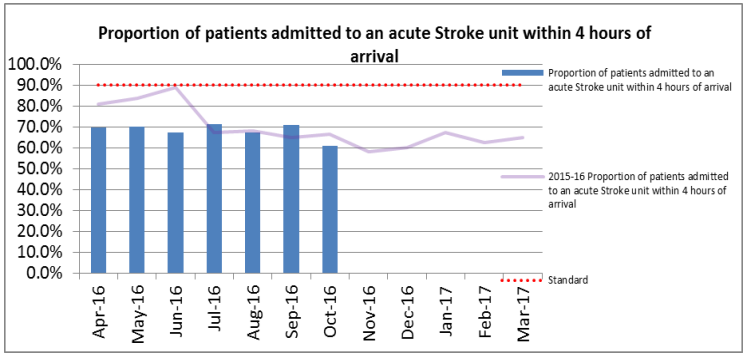
Actions being taken to address any issues

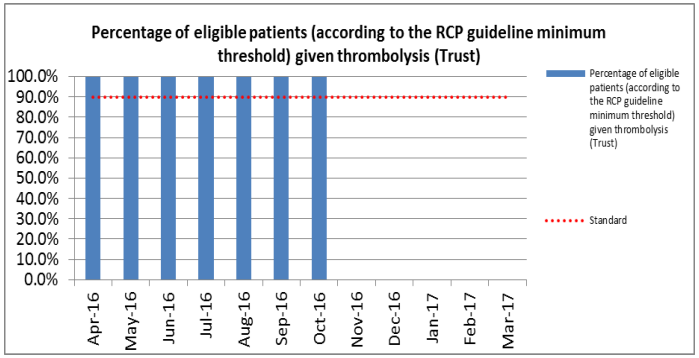
The stroke pathway process has been reviewed to improve direct access for CT
A new assessment area in ED for stroke assessment is being identified
The number of direct access beds for hyper acute stroke is being increased across the stroke unit
The teaching programme for ED staff continues
Pathways for the stroke service out of the hospital to MMH and early supported discharge are being reviewed to ensure adequate bed capacity

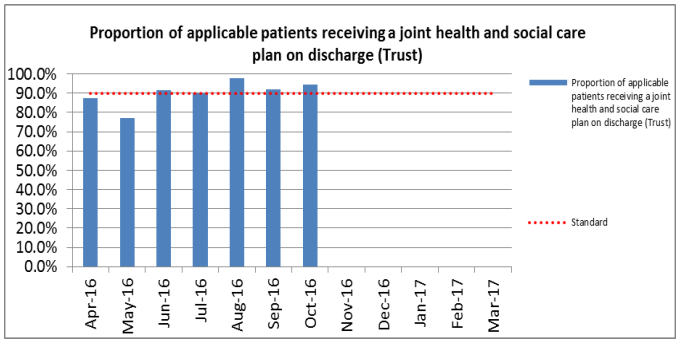
Indicator	Standard	Oct-15	Qtr 2 2015-16	Aug-16	Sep-16	Oct-16
Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	54.8%	53.4%	55.1%	51.1%	47.8%
Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	66.7%	69.9%	67.3%	71.1%	60.9%
Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	90.0%	N/A	100.0%	100.0%	100.0%	100.0%
Proportion of applicable patients receiving a joint health and social care plan on discharge (Trust)	90.0%	N/A	93.4%	97.7%	92.1%	94.4%
Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N/A	65.6%	70.5%	59.0%	78.4%
Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N/A	87.8%	95.5%	94.9%	97.2%
Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	80.6%	66.4%	80.0%	77.3%	77.8%

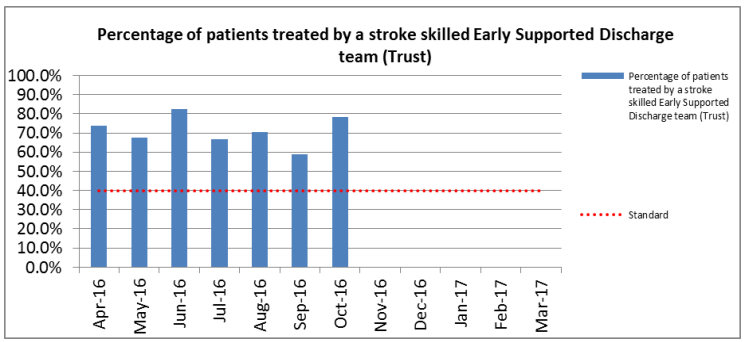
Stroke - Graphs October 2016 (Month 7)

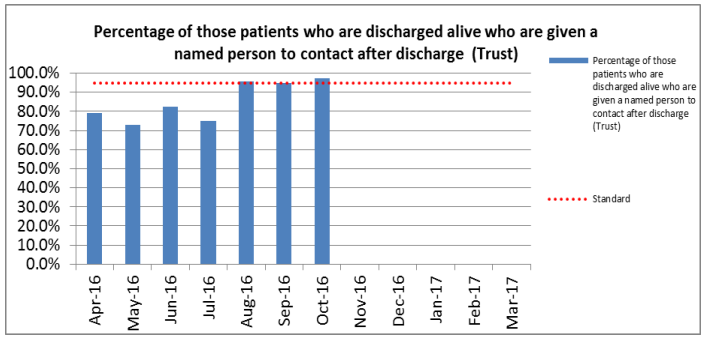


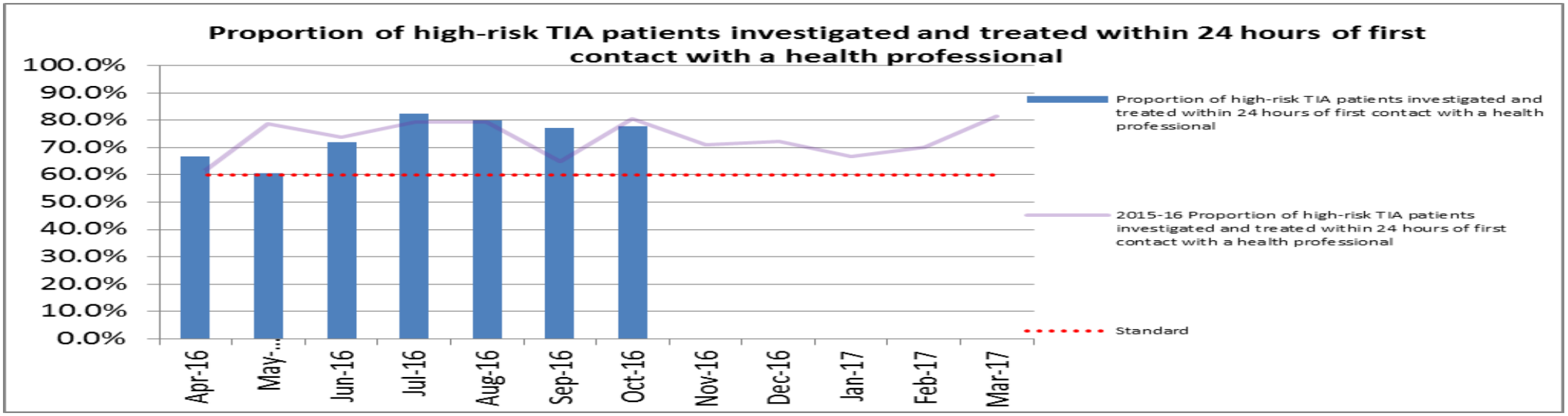




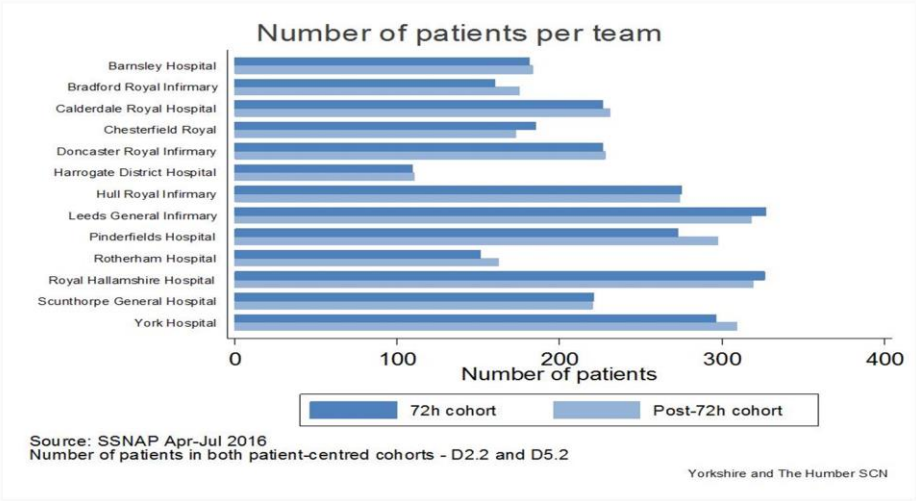


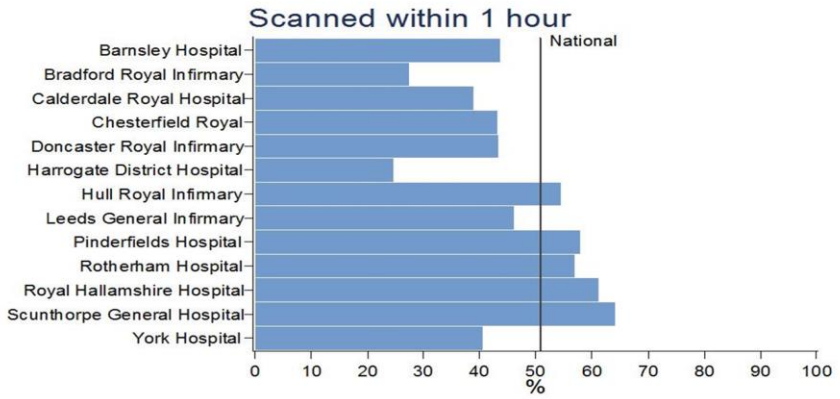


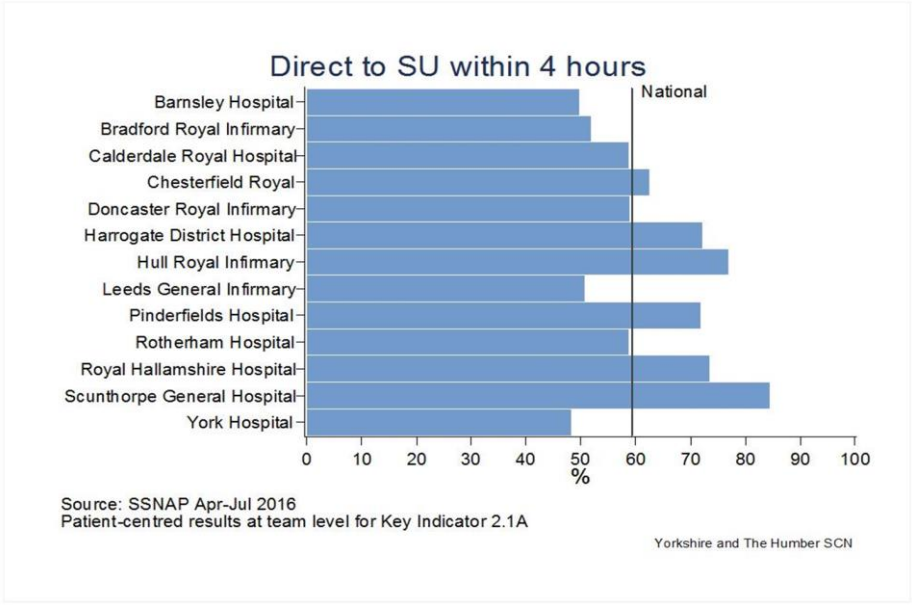


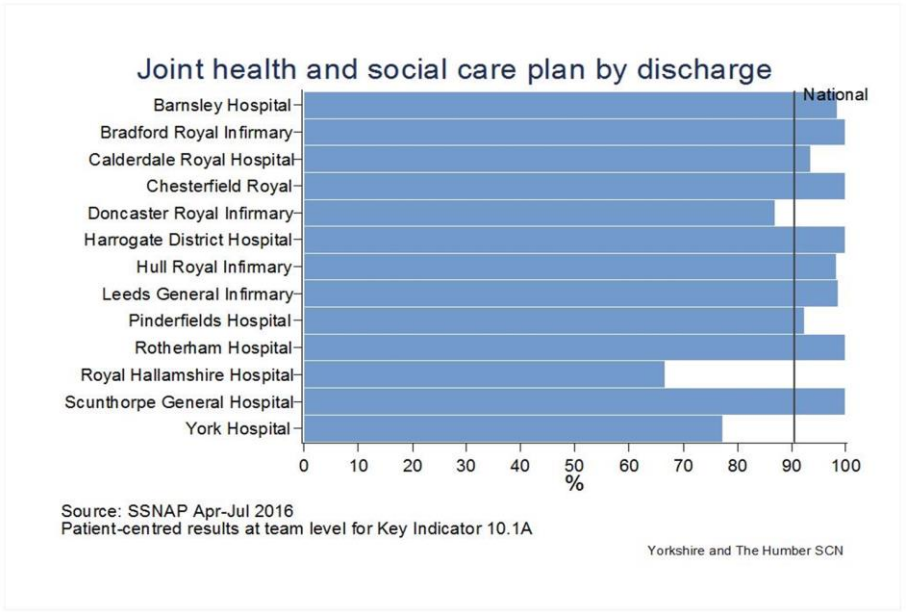


Stroke - Graphs South Yorkshire April - July 2016



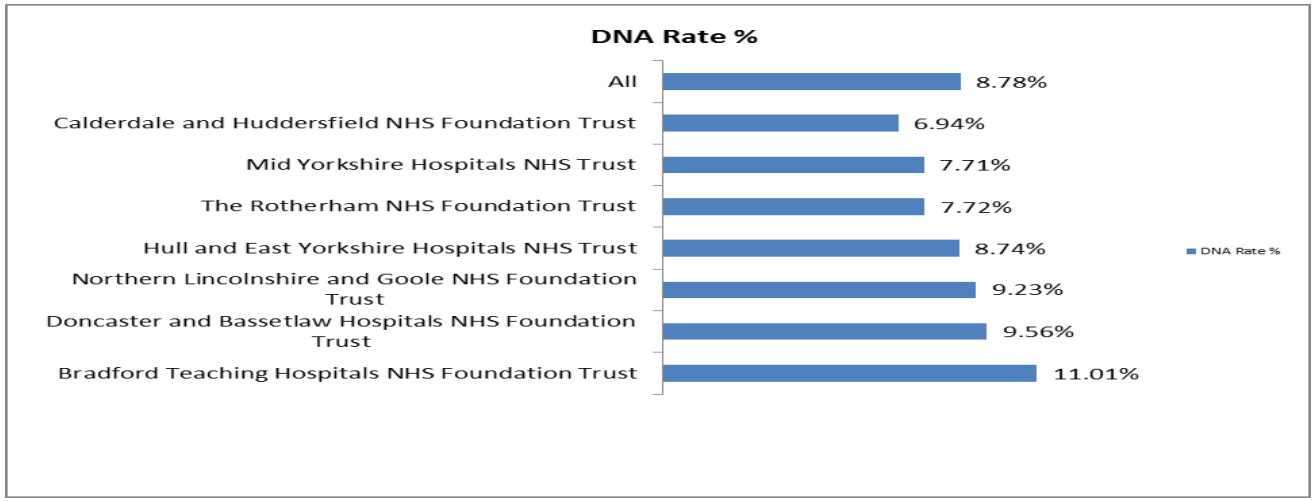






Theatre & Outpatients -December 2016 (Month 9)

DNA Rate: Benchmarking data taken from Healthcare Evaluation Data (HED) (September 2015 to August 2016)



Indicator	Standard	Dec-15	Qtr 3 2016-17	Oct-16	Nov-16	Dec-16
Cancelled Operations (Total)	0.8%	2.0%	1.6%	1.5%	1.5%	1.8%
Cancelled Operations (Theatre)		1.4%	1.1%	1.0%	1.2%	1.2%
Cancelled Operations (Non Theatre)		0.6%	0.4%	0.4%	0.3%	0.6%
Cancelled Operations-28 Day Standard	0	2	8	1	1	6
Outpatients: DNA Rate Total (Refreshed Each Month)		10.44%	9.48%	9.26%	9.31%	9.90%
Outpatients: DNA Rate First (Refreshed Each Month)		10.37%	9.68%	9.63%	9.53%	9.91%
Outpatients: DNA Rate Follow Up (Refreshed Each Month)		10.47%	9.38%	9.13%	9.21%	9.86%
Outpatients: Hospital cancellation Rate (Refreshed Each Month)		6.47%	6.05%	6.25%	5.95%	5.94%
Outpatients: Patient cancellation Rate (Refreshed Each Month)		11.48%	10.92%	10.37%	10.75%	11.76%
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 cancelltions made within 14 days of the appt.

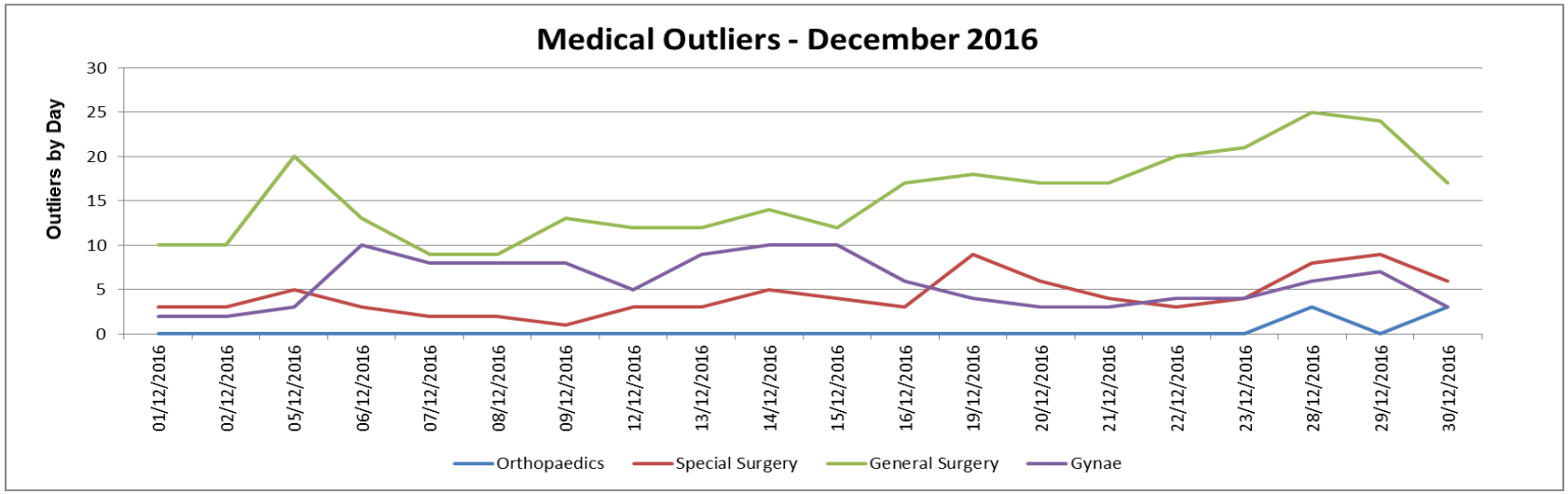
* Did not wait data is currently unavailable

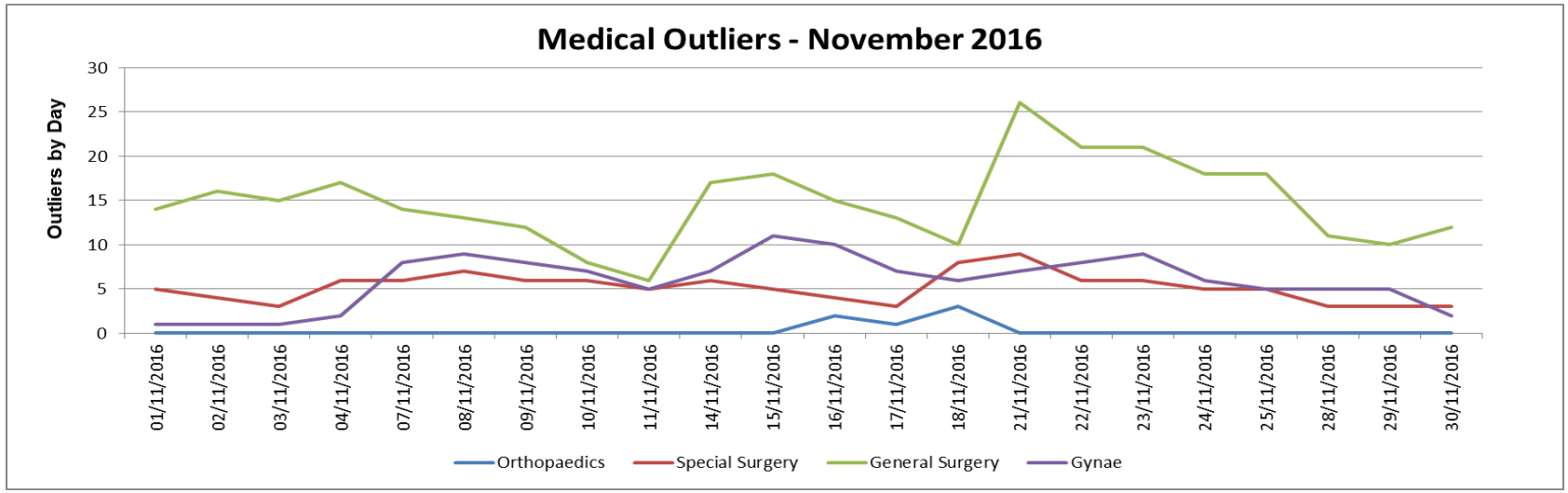
Bed Plan 2016/17

The winter plan additional beds on ward 25 will be opened in January as per plan. The escalation beds and closed beds have been in use throughout November as a result of closed beds for infection control. The deep clean plan will be reintroduced in March to allow for plannned fogging of wards. The new Paediatric out-patient Department is now open on A3 with a reduction of inpatient beds to 12.

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
DRI												
Bed requirement for medical and care of the elderly patients based on current length of stay per month, statistical process control methodology used to review special cause variation.	248	253	267	239	236	241	259	243	279	273	266	239
Bed capacity is based on the Trust achieving length of stay reductions in line with benchmarked Trusts	235	235	235	235	235	235	235		235	235	235	235
Specialty medicine bed requirement (Cardiology, stroke, Renal, Diabetes, Haematology)	72	67	66	74	64	71	90	69	64	78	68	72
Specialty beds available	90	90	90	90	90	90	90	90	90	90	90	90
Total medical patient beds required	310	320	357	313	300	312	349	312	343	353	334	311
Beds position against funded	15	5	-22	12	25	13	-24	13	-18	-28	-9	14
Surgical Bed requirements, includes new pathways for Bassetlaw patients	75	69	72	73	87	70	76	77	76	74	75	76
Surgical beds capacity	79	79	79	79	79	79	79	79	79	79	79	79
Specailty surgical bed requirements urology and vascular	32	34	35	37	31	33	35	29	31	26	27	31
Specialty bed capacity	39	39	39	39	39	39	39	39	39	39	39	39
Total surgical bed requirements	107	103	107	110	118	103	111	106	107	100	104	107
Bed position against funded	11	15	11	8	0	15	7	12	11	18	14	11
Orthopaedic Bed requirements	60	62	60	56	59	58	56	57	51	48	59	55
Total beds available taking into consideration of the new models of care	70	70	70	62	62	62	62	62	62	62	62	62
Bed position against funded	10	8	10	6	3	4	6	5	11	14	3	7
Gynaecology bed requirement including breast services	13	12	12	11	12	14	13	11	11	11	11	15
Gynaecology beds available including daycase	24	24	24	24	24	24	24	24	24	24	24	24
Beds against funded	11	12	12	13	12	10	11	13	13	13	13	9
Total adult bed requirement against funded beds	**47**	**40**	**11**	**39**	**30**	**42**	**0**	**17**	**27**	**17**	**22**	**44**
Paediatric bed requirement	16	22	17	17	14	13	13	17	20	18	15	16
Paediatric Beds Available	39	39	39	39	39	39	39	39	39	39	39	39
Bed against funded	**23**	**17**	**22**	**22**	**25**	**26**	**26**	**22**	**19**	**21**	**24**	**23**
Bassetlaw												
Medicine bed requirements	101	86	99	95	94	94	103	98	108	90	97	98
Medical beds available	104	104	104	104	104	104	104	104	104	104	104	104
Beds against funded	3	18	5	11	10	10	1	6	-4	14	7	6
Surgical Elective Requirements	7	7	8	10	11	11	10	11	10	12	11	10
Surgical beds open Monday to Saturday am	16	16	16	16	16	16	16	16	16	16	16	16
Beds agsinst funded	8	4	9	6	5	5	8	4	10	8	5	5
Orthopaedic bed requirements	18	24	23	23	25	19	21	23	22	19	21	24
Orthopaedic beds available	31	31	31	31	31	31	31	31	31	31	31	31
Beds against funded	13	7	8	8	6	12	10	8	9	12	10	7
Bed total available	126	117	130	128	130	124	134	132	140	121	129	132
Bed difference against beds	**25**	**34**	**21**	**23**	**21**	**27**	**17**	**19**	**11**	**30**	**22**	**19**
Paediatric bed requirements for inpatient care	7	9	7	7	6	8	9	10	11	9	8	8
Paediatric beds available	**14**	**14**	**14**	**14**	**14**	**12**	**12**	**12**	**6**	**6**	**6**	**6**
Beds against funded	**7**	**5**	**7**	**7**	**8**	**6**	**5**	**4**	**3**	**5**	**6**	**6**

Medical Outliers by Specialty -Decemberr 16 (Month 9)





	Daily average	Most Sleepers-out in November 2016	Least Sleepers-out in November 2016
Medicine to Ortho	0	3	0
Medicine to S12	5	9	3
Medicine to Surgery	15	26	6
Medicine to Gynae	6	11	1

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Safety & Quality - December 2016 (Month 9)

HSMR:
The Trust's rolling 12 month HSMR to the end of October 2016 remains better than expected at 93.6.

Fractured Neck of Femur:
The Trust achieved Best Practice Tariff in 70% of patients presenting with #NOF in December. Mortality has remained above th e National Benchmark. 6 month mortality review revealed no cause for concern. In depth 12 month review under way.

Serious Incidents:
The Trust remains on trajectory to deliver a significant reduction in SIs

Executive Lead:
Mr S Singh

C.Diff:
Whilst performance in month was higher again than the same month last year, Q3 data was 20% less than in the Q3 2015/16. Per formance year to date also remains better than at the same point in 2015/16

Fall resulting in significant harm:
There are no falls resulting in significant harm for the month of December. Performance for Q3 is the same as the Q3 position 2015/16, with current year to date performance remaining at 33.33% better than the same period 2015/16

Hospital Acquired Pressure Ulcers:
Performance in December was higher than the same month last year, Q3 performance is slightly better (9%) than in Q3 2015/16. Current year to date performance remains at 45% better than in the same period 2015/16

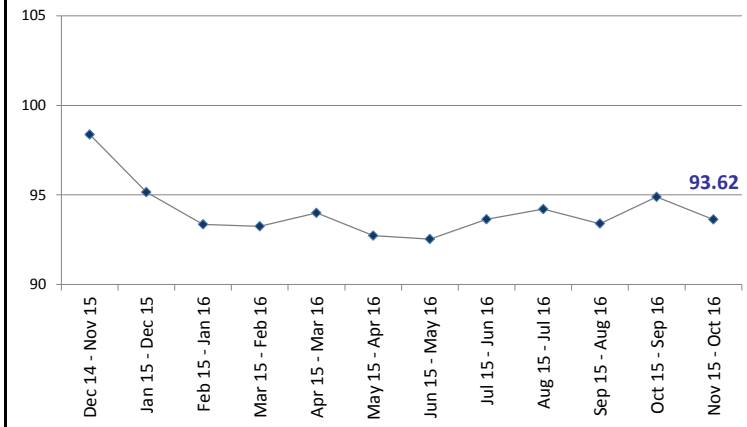
Complaints and concerns:
Work continues to improve response rates

Friends & Family Test:
Work is continuing to improve ED response rates

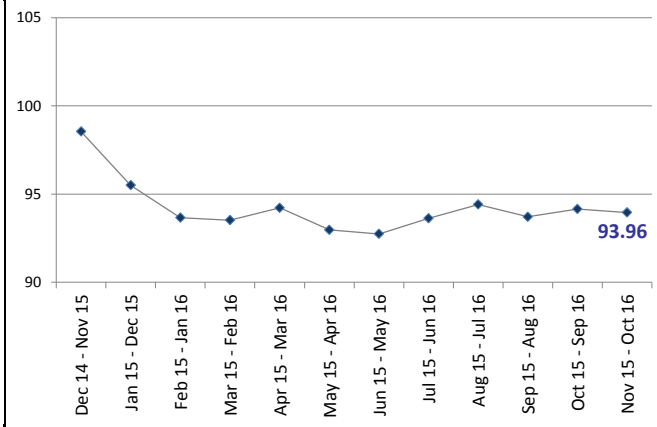
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - October 2016 (Month 7)

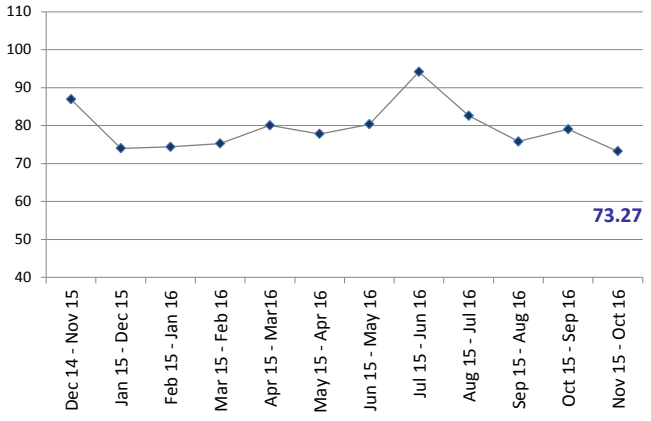
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

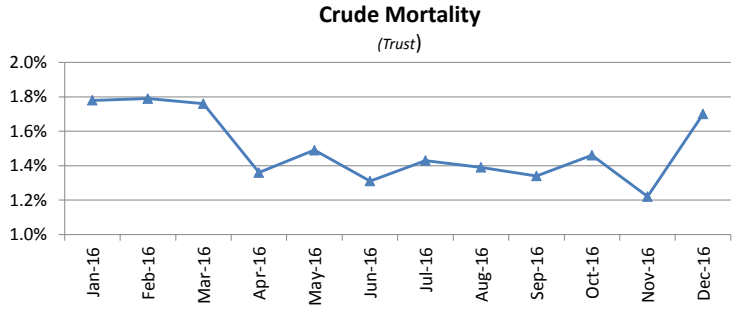


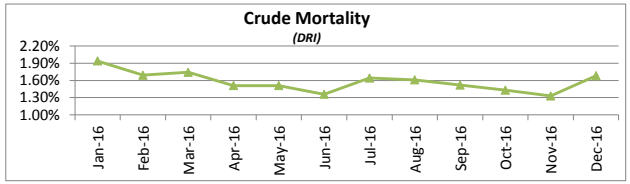
HSMR Trend (monthly)

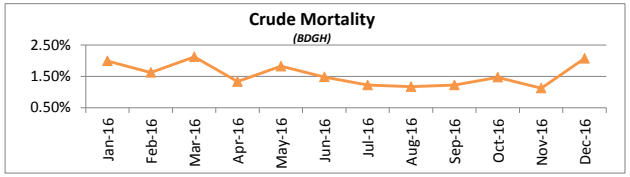
	2014	2015	2016
January	115.45	116.80	99.19
February	99.11	99.94	97.71
March	102.91	90.54	98.43
April	110.49	105.91	90.11
May	90.93	101.15	98.73
June	113.74	80.27	94.18
July	109.94	92.56	101.10
August	120.18	100.27	88.88
September	110.10	90.26	97.08
October	106.58	90.29	87.33
November	106.84	88.98	
December	115.87	82.30	

Crude Mortality (monthly) - December 2016 (Month 9)

(number of deaths/number of patient discharged)



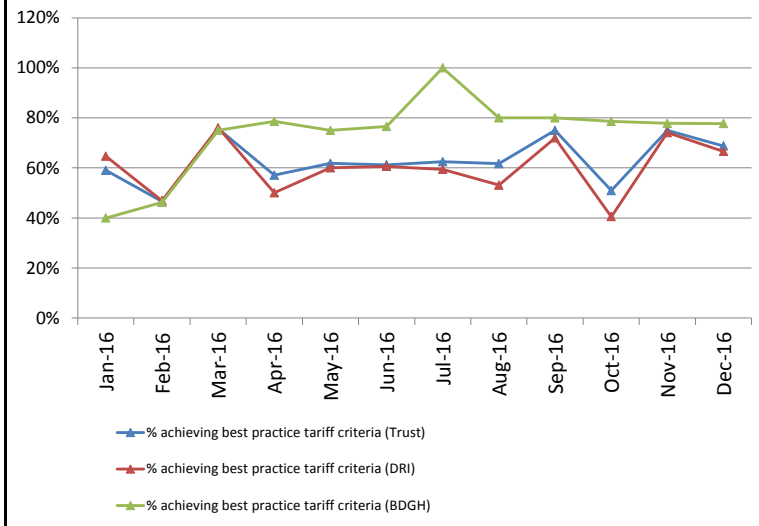




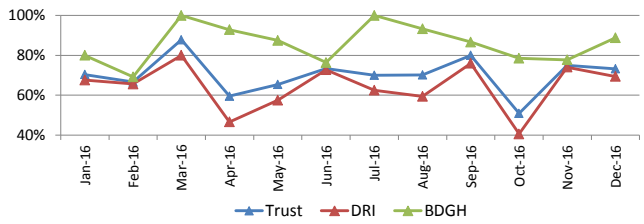
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust	**1.78%**	**1.79%**	**1.76%**	**1.38%**	**1.50%**	**1.32%**	**1.47%**	**1.37%**	1.34%	1.38%	1.22%	1.70%
Doncaster	1.94%	1.99%	1.74%	1.51%	1.52%	1.37%	1.70%	1.59%	1.53%	1.43%	1.33%	1.68%
Bassetlaw	1.69%	1.62%	2.12%	1.34%	1.82%	1.48%	1.22%	1.17%	1.22%	1.47%	1.12%	2.07%

NHFD Best Practice Pathway Performance - December 2016 (Month 9)

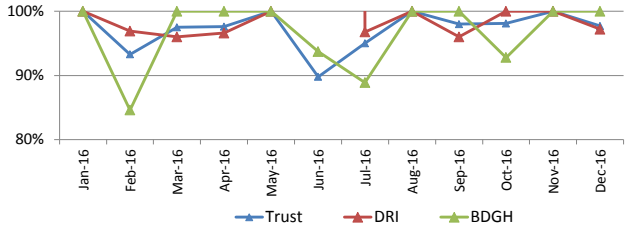
Best Practice Criteria Performance



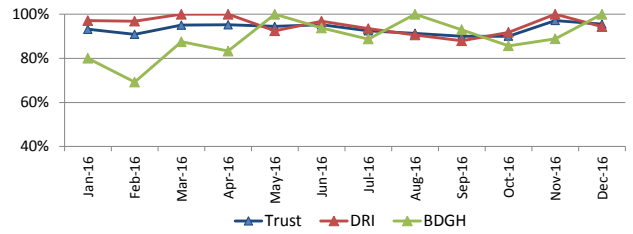
36 Hours to Surgery Performance



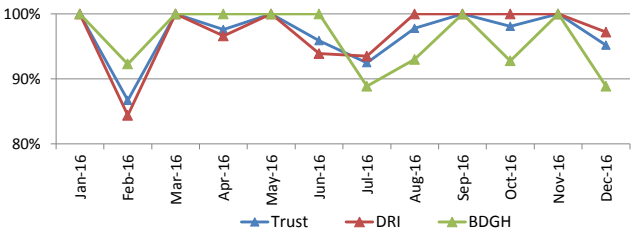
MDT Assessment Performance



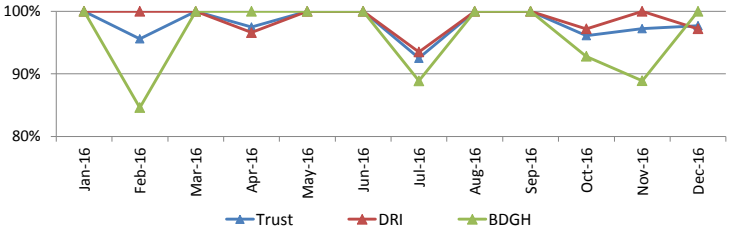
72 Hours to Geriatrician Assessment Performance



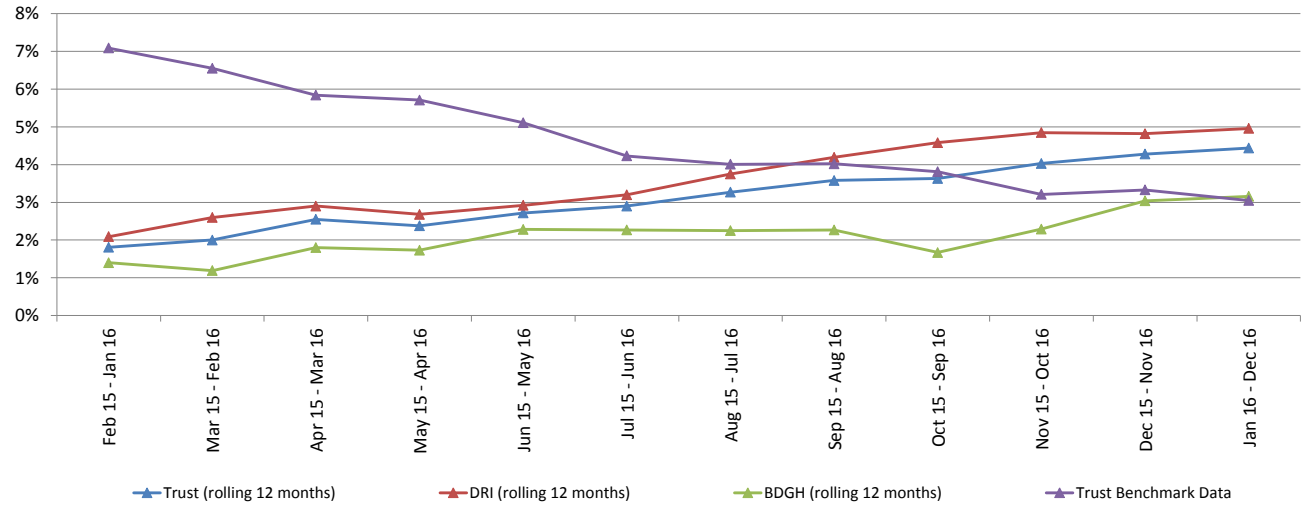
Falls Assessment Performance



Bone Protection Medication Assessment



Deaths within 30 days of procedure (Rolling 12 months)



Serious Incidents - December 2016 (Month 9)

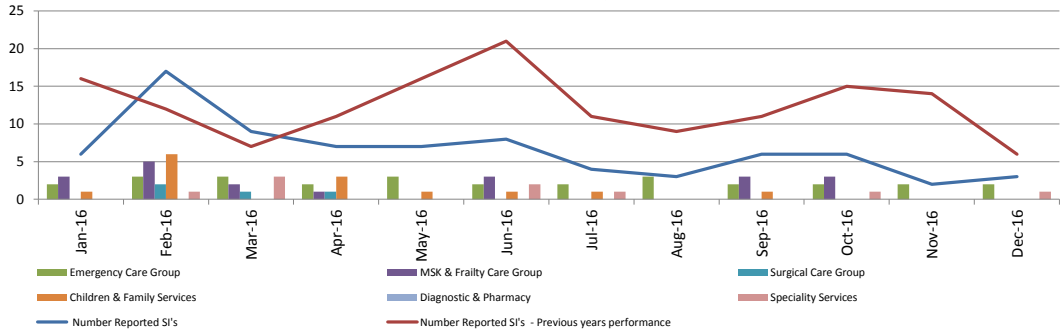
(Data accurate as at 9/01/17)

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

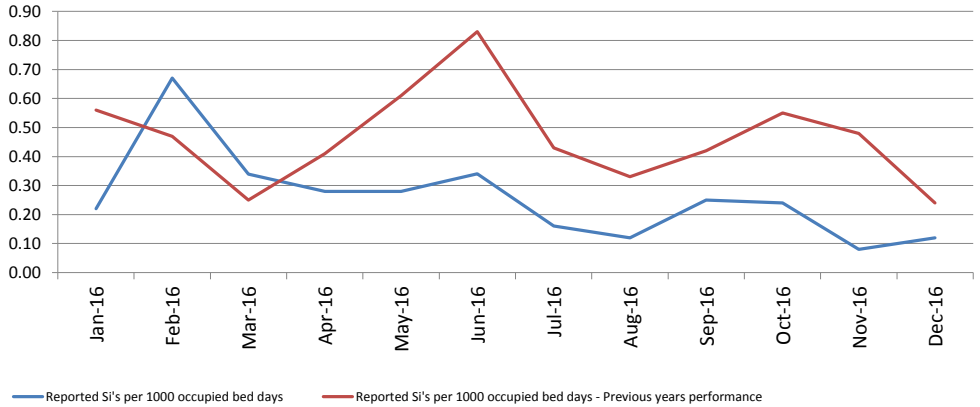
Overall Serious Incidents

Number Serious Incidents Reported

(Trust & Care Group)



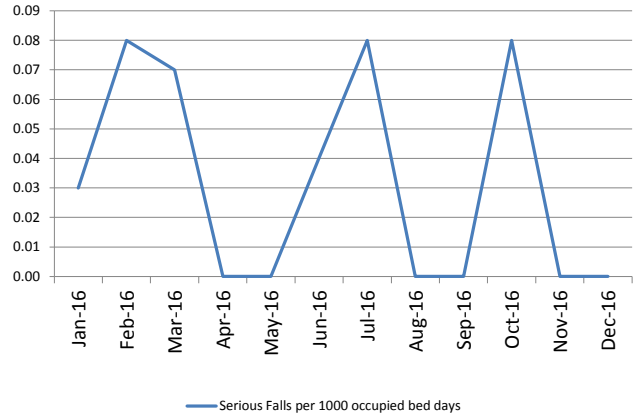
Serious Incidents per 1000 occupied bed days



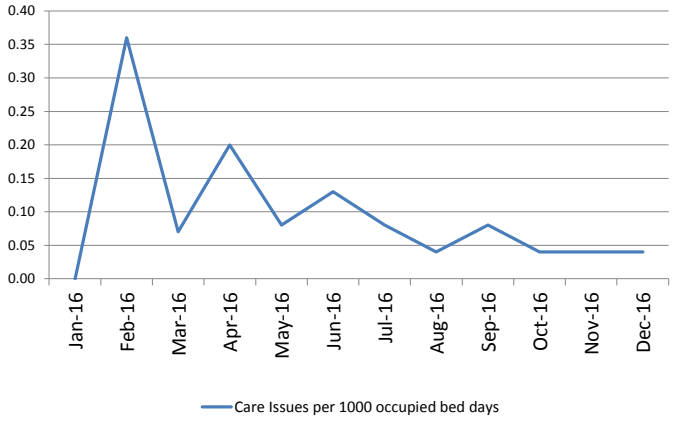
Current YTD reported SI's (Apr 16 -Dec16)	46	Number reported SI's (Apr 15 - Dec 15)	114
Current YTD delogged SI's (Apr 16 - Dec 16)	8	Number delogged SI's (Apr 15 - Dec 15)	43

Themes

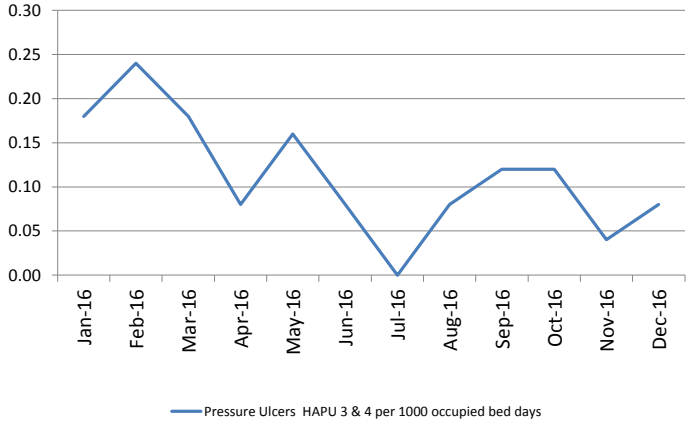
Serious Falls



Care Issues

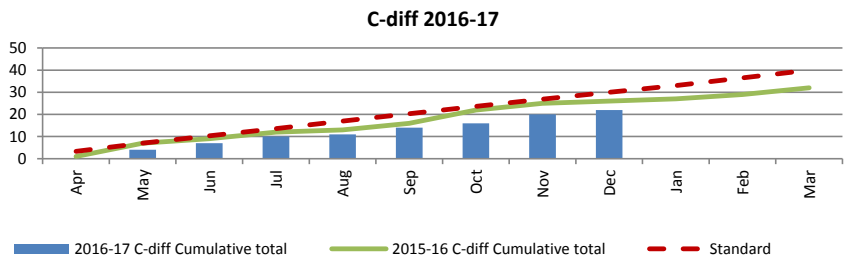


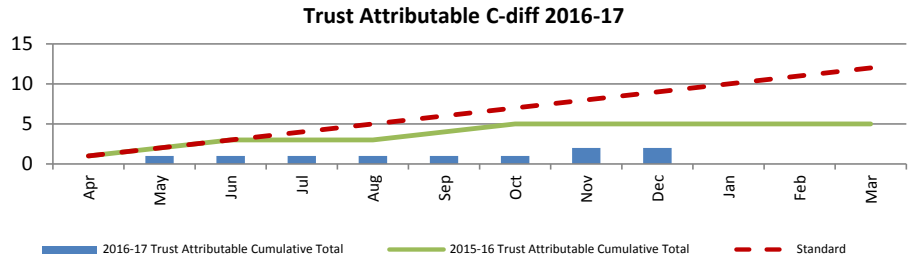
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - December 2016 (Month 9)
(Data accurate as at 16/01/2017)

	Standard	Q1	Q2	Oct	Nov	Dec	Q3	YTD
2016-17 Infection Control - C-diff	40 Full Year	7	7	2	4	2	8	22
2015-16 Infection Control - C-diff	40 Full Year	9	7	6	3	1	10	26
2016-17 Trust Attributable	12	1	0	0	1	0	1	2
2015-16 Trust Attributable	12	3	1	1	0	0	0	5

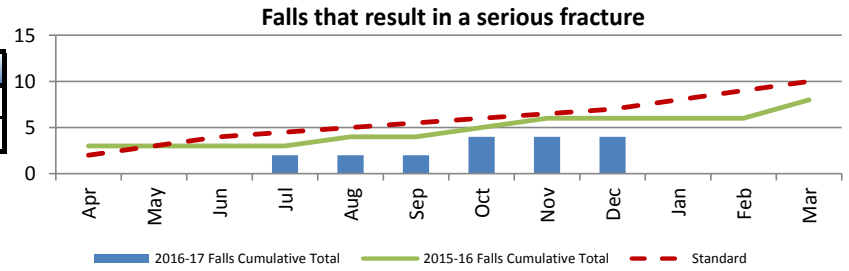




Pressure Ulcers & Falls that result in a serious fracture - December 2016 (Month 9)
(Data accurate as at 06/01/2016)

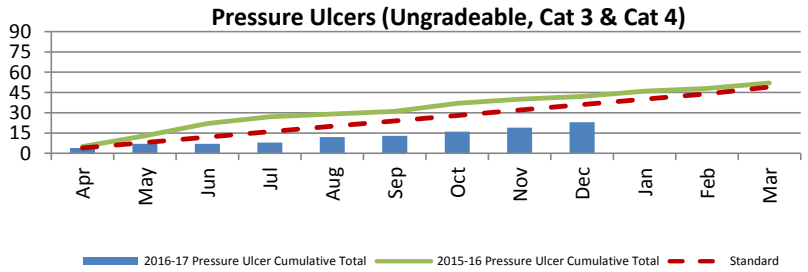
	Standard	Q1	Q2	Oct	Nov	Dec	Q3	YTD
2016-17 Serious Falls	19 Full Year	0	2	2	0	0	2	4
2015-16 Serious Falls	20 Full Year	3	1	1	1	0	2	6

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	Q2	Oct	Nov	Dec	Q3	YTD
2016-17 Pressure Ulcers	60 Full Year	7	6	3	3	4	10	23
2015-16 Pressure Ulcers	82 Full Year	22	9	6	3	2	11	42

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

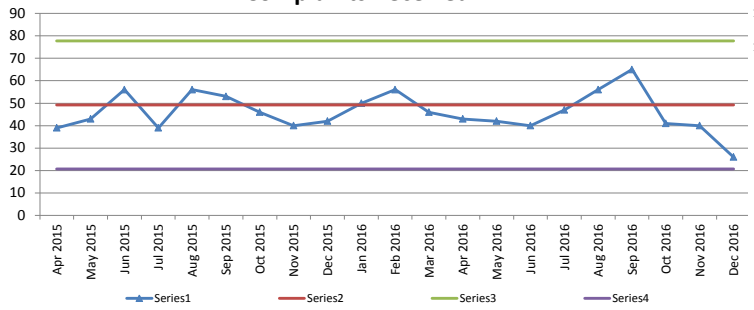


Complaints & Claims - December 2016 (Month 9)

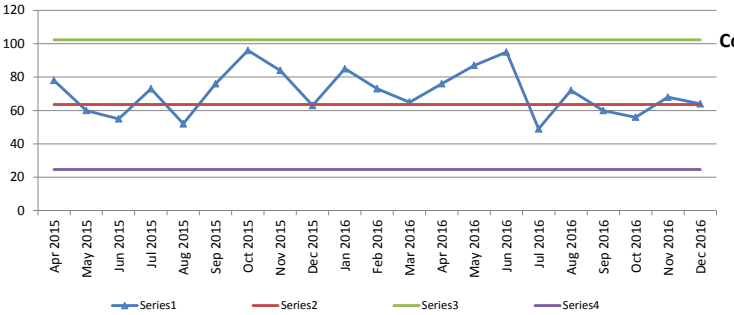
(Data accurate as at 10/01/2017)

Complaints

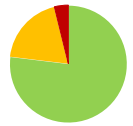
Complaints Received



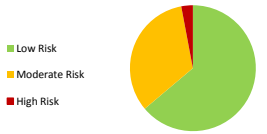
Concerns Received



December 2016 Complaints Recieved Risk Breakdown



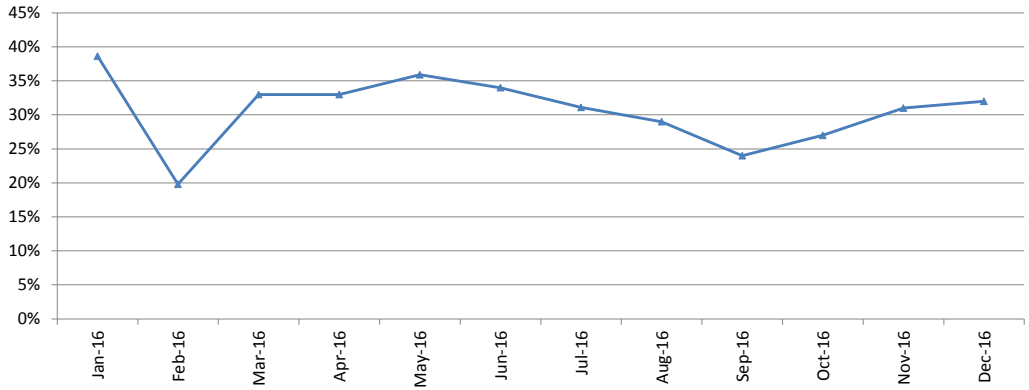
Year to Date Complaints Recieved Risk Breakdown



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
December	2	5

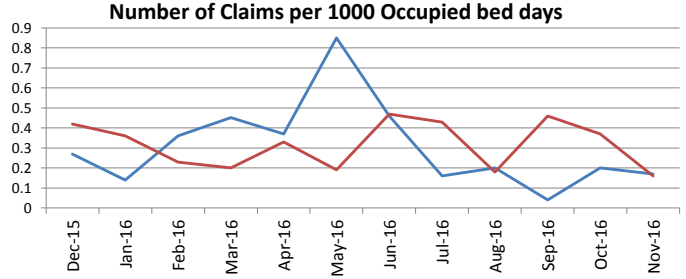
	Number referred for investigation YTD	Outcomes YTD	
2015/16	14	Fully / Partially Upheld	4
		Not Upheld	7
		No further Investigation	1
		Case Withdrawn	1
2016/17	6	Fully / Partially Upheld	0
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0

Claims

	Current Month	Month Actual	YTD
Clinical Negligence Scheme for Trusts (CNST)	Dec-16	awaiting data	31
Liabilities to Third Parties Scheme (LTPS)	Dec-16	awaiting data	9

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

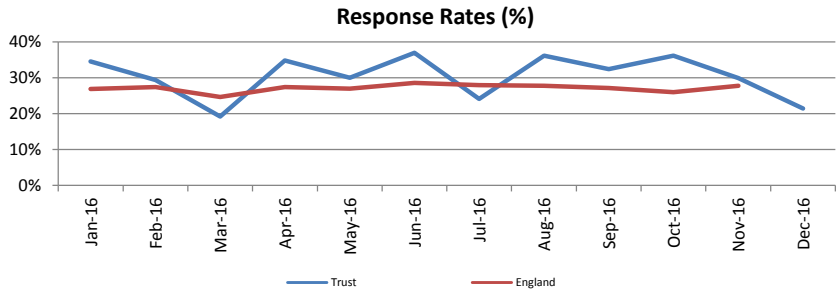


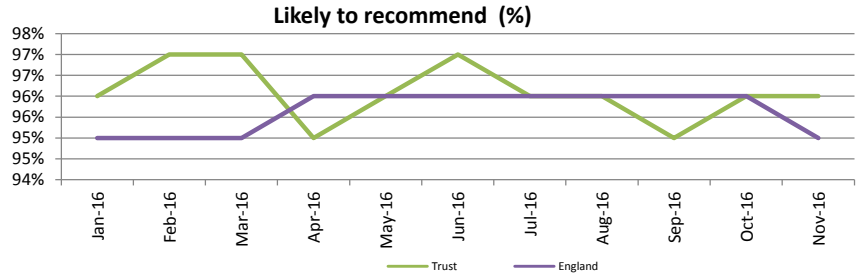
Friends & Family - December 2016 (Month 9)

(Data accurate as at 13/01/2016)

Inpatients

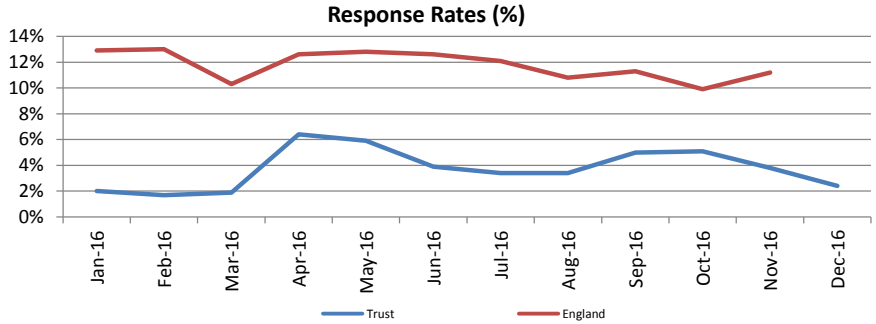
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

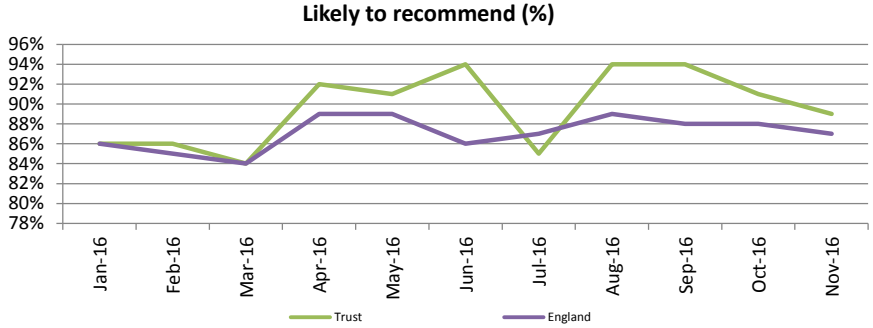




Accident & Emergency

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- December 2016 (Month 9)

Sickness absence

The sickness rate for December 2016 has reduced to 4.46% resulting in a year to date rate of 4.48%. We are now starting to see a reduction in the number of staff who are absent from work for more than 6 months (down to 28); unfortunately this month we have seen an increase in the number of staff who have been off between 1 and 6 months. Benchmarking data indicates that we are below the acute average across the region for both the month of November (the most up to date data we can access) which was our highest monthly figure since July 2016 and also year to date. Details around the action we are taking to reduce sickness levels can be found within the Quarter 3 P&OD quartlery report.

Appraisals

Appraisal compliance rates have seen a small increase to 64.75% .

SET

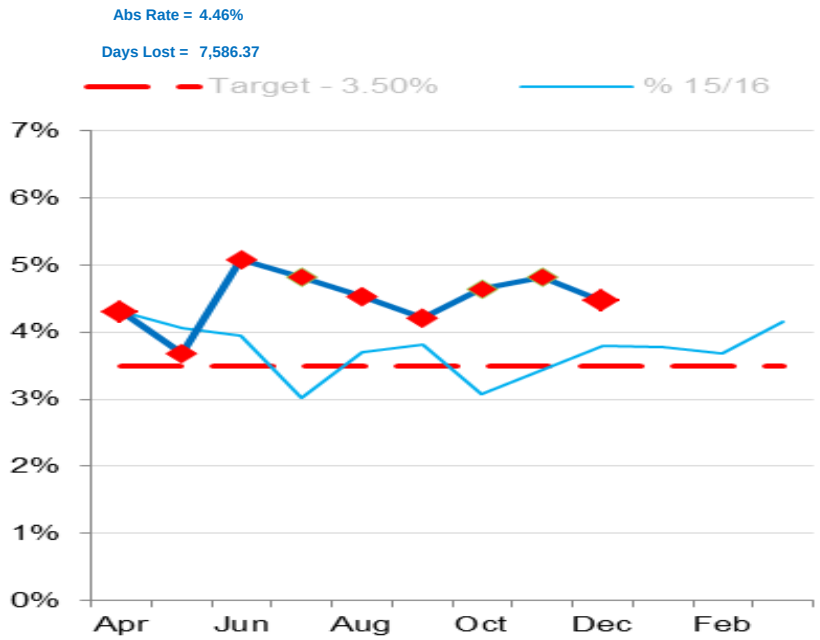
Compliance with Statutory and Essential Training continues to rise month on month with rates at the end of December being 65.93%.

Staff in post

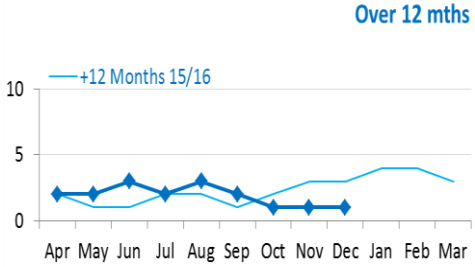
Between November and December2016 the Trust's workforce has increased slightly by 4.39wte (a headcount increase of 5).

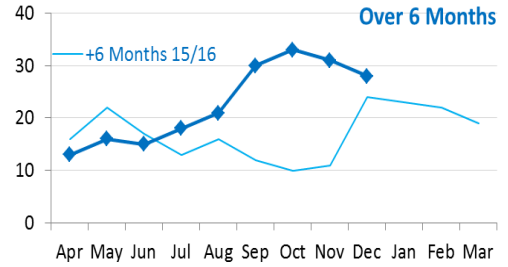
Workforce: Sickness Absence-December (Month 9)

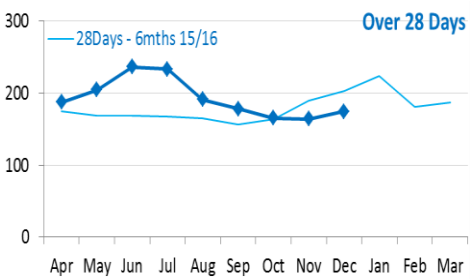
Sickness

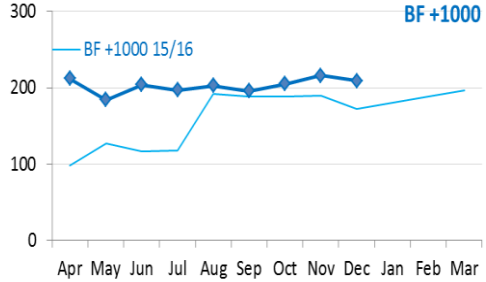


Absence Occurences





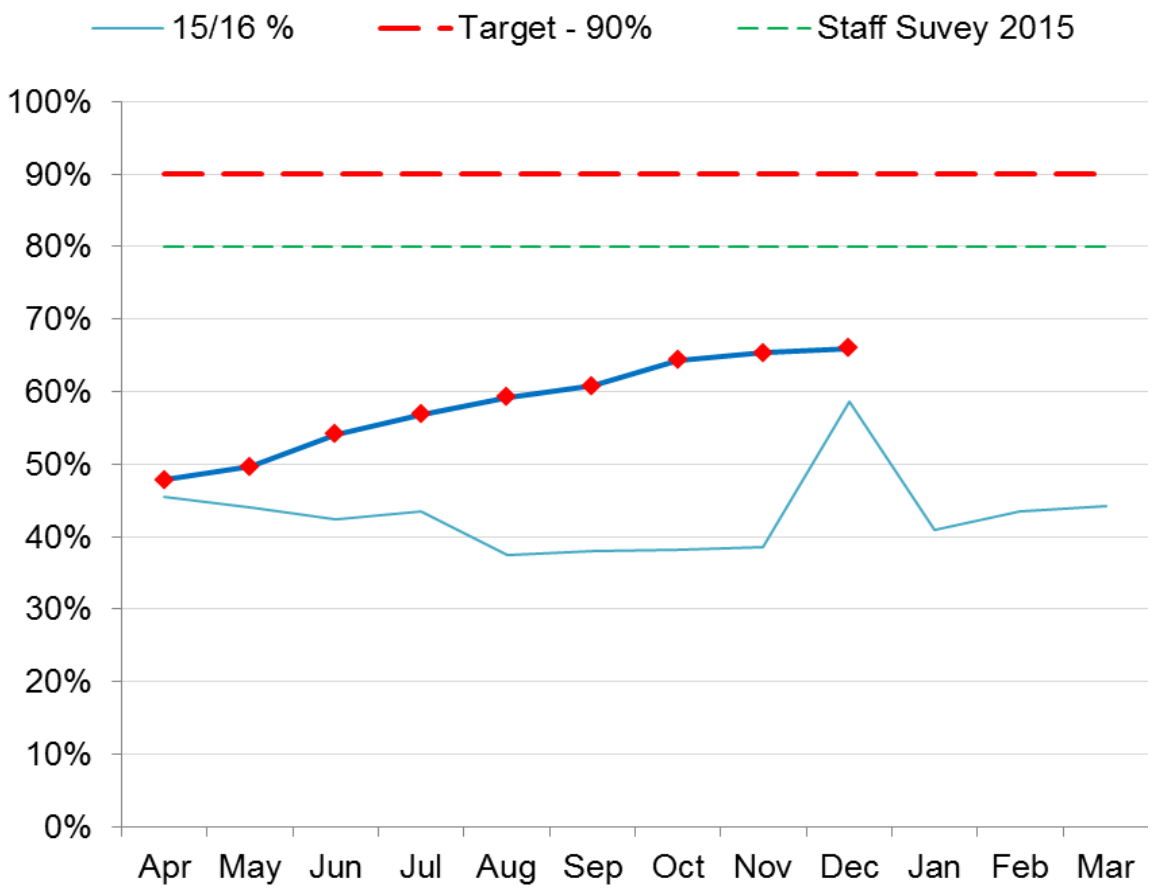




Workforce: SET Training-December (Month 9)

SET Training

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

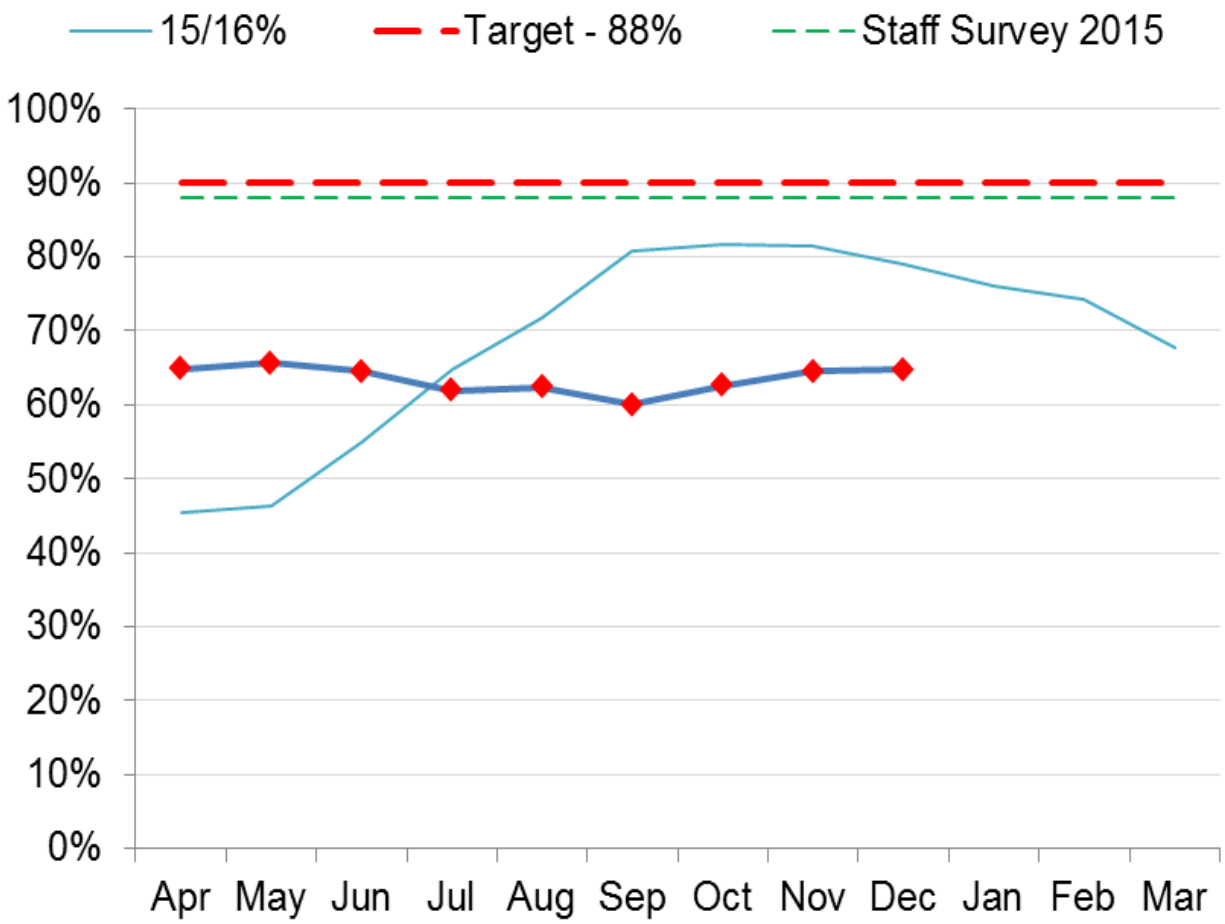


	% Compliance
Doncaster & Bassetlaw NHS FT	**65.93%**
Chief Executive Directorate	**67.00%**
Children & Family Care Group	**70.86%**
Diagnostic & Pharmacy Care Group	**72.16%**
Directorate Of Strategy & Improvement	**62.99%**
Emergency Care Group	**66.13%**
Estates & Facilities	**36.66%**
Finance & Healthcare Contracting Directorate	**80.43%**
IT Information & Telecoms Directorate	**85.36%**
MSK & Frailty Care Group	**79.55%**
Medical Director	**47.44%**
Nursing Services	**73.32%**
People & Organisational Development	**89.59%**
Performance	**38.19%**
Speciality Services Care Group	**69.98%**
Surgical Care Group	**69.23%**
Trust Funds	**100.00%**

Workforce: Appraisals-December (Month 9)

Appraisal Reviews

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



	% Completed
Doncaster & Bassetlaw NHS FT	**64.75**
Chief Executive Directorate	58.33
Children & Family Care Group	79.97
Diagnostic & Pharmacy Care Group	79.45
Directorate Of Strategy & Improvement	66.67
Emergency Care Group	53.92
Estates & Facilities	59.37
Finance & Healthcare Contracting Directorate	46.97
IT Information & Telecoms Directorate	33.88
MSK & Frailty Care Group	83.97
Medical Director	50.00
Nursing Services	50.00
People & Organisational Development	95.83
Performance	27.74
Speciality Services Care Group	52.30
Surgical Care Group	64.47
Trust Funds	0.00

Workforce: Staff in post-November (Month 8)

Staff in Post

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Apr-16**		**May-16**		**Jun-16**		**Jul-16**		**Aug-16**		**Sep-16**		**Oct-16**		**Nov-16**		**Dec-16**	
Add Prof Scientific and Technic	165.68	181.00	165.68	181.00	164.62	180.00	163.62	179.00	167.82	183.00	172.05	187.00	170.53	185.00	171.53	186.00	170.53	185.00
Additional Clinical Services	1,088.18	1,327.00	1,080.20	1,317.00	1,091.62	1,330.00	1,091.49	1,326.00	1,080.90	1,315.00	1,086.61	1,321.00	1,085.59	1,317.00	1,086.57	1,318.00	1,092.13	1,324.00
Administrative and Clerical	1,074.68	1,332.00	1,078.05	1,334.00	1,063.02	1,318.00	1,063.75	1,315.00	1,058.57	1,310.00	1,060.39	1,316.00	1,061.98	1,312.00	1,063.44	1,314.00	1,074.13	1,323.00
Allied Health Professionals	337.66	388.00	333.35	383.00	331.17	381.00	329.67	380.00	333.57	383.00	335.11	386.00	334.39	385.00	331.03	382.00	324.90	373.00
Estates and Ancillary	607.44	879.00	606.17	878.00	602.26	870.00	600.64	867.00	586.24	847.00	582.06	838.00	578.09	832.00	576.02	829.00	579.96	835.00
Healthcare Scientists	129.09	142.00	127.09	140.00	128.09	141.00	126.70	140.00	125.70	139.00	125.70	139.00	126.70	140.00	126.70	140.00	128.22	142.00
Medical and Dental	478.08	547.00	476.36	547.00	479.22	550.00	481.25	557.00	480.23	565.00	496.68	581.00	497.41	584.00	495.36	588.00	495.19	593.00
Nursing and Midwifery Registered	1,646.03	1,912.00	1,639.23	1,903.00	1,630.88	1,894.00	1,620.97	1,882.00	1,609.35	1,869.00	1,604.55	1,866.00	1,619.72	1,880.00	1,607.05	1,865.00	1,597.02	1,851.00
Students	3.80	4.00	2.80	3.00	1.80	2.00	1.80	2.00	0.80	1.00	6.80	8.00	15.44	17.00	15.44	17.00	15.44	17.00
Grand Total	**5,530.62**	**6,712.00**	**5,508.93**	**6,686.00**	**5,492.68**	**6,666.00**	**5,479.89**	**6,648.00**	**5,443.20**	**6,612.00**	**5,469.94**	**6,642.00**	**5,489.83**	**6,652.00**	**5,473.13**	**6,639.00**	**5,477.52**	**6,644.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Nursing Workforce Information**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Moira Hardy, Interim Director of Nursing, Midwifery & Quality**		
For:	**Information**		

Purpose of Paper: 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 January 2017 UNIFY return which relates to December 2016 actual and planned hours:

- Workforce information and variances between planned and actual hours worked
- Care Hours Per Patient Day (CHPPD) implementation as set out in Lord Carter's report; Operational productivity and performance in English acute hospitals: Unwarranted variations
- Update Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), including How to ensure the right people, with the right skills, are in the right place at the right time (2013) and Safe staffing for nursing in adult inpatient wards in acute hospitals (2014) relating to Hard Truths
- Update of Trust position regarding safe nurse staffing and efficiency (Agency Capping) from TDA, Monitor, NHSE, CQC and NICE
- Information in relation to Safe, Sustainable and Productive Staffing Improvement resource for adult inpatient ward
- Information in relation to the launch of AHPs into action
- Key issues and actions

Recommendation

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.

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

We always put the patient first

- *By delivering safe and effective care by providing staff who can be responsive and well led*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity

- *By listening to staff and patients when developing and evaluating quality and safety of care.*
- *Monitoring that care is delivered with compassion*

Committed to quality and continuously improving patient experience

- *By developing and monitoring safe staffing levels and the quality of care provision*

Always caring and compassionate

- *By providing staff with the right skills and ensuring that they are in the right place at the right time*
- *We monitor care is delivered with compassion*

Responsible and accountable for our actions – taking pride in our work • *By assuring ourselves that the quality of care meets the CQC standard. Having escalation processes in place when staffing, safety and quality vary from optimum levels* **E**ncouraging and valuing our diverse staff and rewarding ability and innovation *By setting up systems and processes that avoid duplication and reward good 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 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.

Board Assurance Framework		
3	Failure to deliver financial plan.	4 x 4 = 16
13	Inability to recruit the right staff and ensure that staff have the right skills to meet operational needs.	4 x 3 = 12

1. INTRODUCTION

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

This report also provides the Board of Directors with the Trust position in relation to the agency and frameworks caps from TDA, Monitor, NHSE, CQC and NICE.

The paper also informs the Board of Directors of the draft improvement resource for acute adult inpatient services; *Safe, sustainable and productive staffing. An improvement resource for adult inpatient wards in acute hospitals*

2. BACKGROUND

This paper provides the DBHFT Board of Directors with the relevant information to consider staffing levels and skill mixes across the Trust. It provides the planned and actual workforce information, along with the Care Hours per Patient Day (CHPPD) for December 2016, which has been submitted to the UNIFY system, with additional information relating to the December Quality Metrics dashboard for each ward, focusing on those areas that require improvement.

3. WORKFORCE INFORMATION

The workforce data submitted to UNIFY provides the actual hours worked in December 2016 by registered nurses and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked decreased by 2% in December to 97% from the November position of 99%. This decrease in the overall planned versus actual hours worked, is attributed to vacancies and significant sickness absence which could not be fully covered by temporary staffing.

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

The actual staffing levels for December were collected manually, mostly contemporaneously, and validated by the Matrons and Heads of Nursing (HoNs) retrospectively. The Matrons based the planned levels on the agreed planned staffing levels in the 2016/2017 funded establishments. The planned hours are adjusted each month to account for the number of days in the month. The fill rate includes shifts used to support escalation and closed beds.

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

The data for December 2016 (Appendix 1) demonstrates that the actual available hours compared to planned hours were;

- within 5% for 22 Wards (55%), 1 less than November
- between 5% – 10% for 11 Wards (26%) the same as November
- surpluses over 10% for 3 Wards (7%) the same as November
- deficits over 10% for 6 Wards (12%) 1 more than in November.

The 3 Wards where there were surpluses in excess of 10% of the planned hours; Ward 24, A4 and Rehab 2, had higher than planned staffing levels due to;

- provision of enhanced care and opening of escalation beds on Ward 24 and Ward A4
- Provision of enhanced care on Rehab 2 at MMH

The 6 wards where there were deficits in excess of 10% of the planned hours were; The Respiratory Unit, M2 and A2, Labour Ward, Ward B6 and ITU at Bassetlaw Hospital. The lower than planned staffing levels were due to;

- Acuity and dependency of patients on Ward B6 and Intensive Care at Bassetlaw Hospital allowed staff to be safely moved to support other clinical areas.
- Significant sickness absence despite utilising NHSP midwives, specialist midwives and on call Community Midwives along with vacancies has resulted in the lower than planned staffing levels across A2 and Labour Ward. In addition, acuity and dependency of patients on M2 allowed staff to be safety moved to support other clinical areas.
- Vacancies that were unable to be filled by NHS P shifts and opening escalation beds on the Respiratory Unit

An analysis of quarterly hospital-level staffing data (Q4 2014 – Q3 2016), planned versus actual hours worked, was published in January 2017.

A review of the data for DBHFT shows;

Quarterly hospital-level staffing data (Q4 2014 – Q3 2016),		**Median - All Trusts**	**Median - DBHFT**
Registered staff	Day Shift	93%	91%
	Night Shift	97%	97%
Non-Registered staff	Day Shift	100%	101%
	Night shift	107%	111%

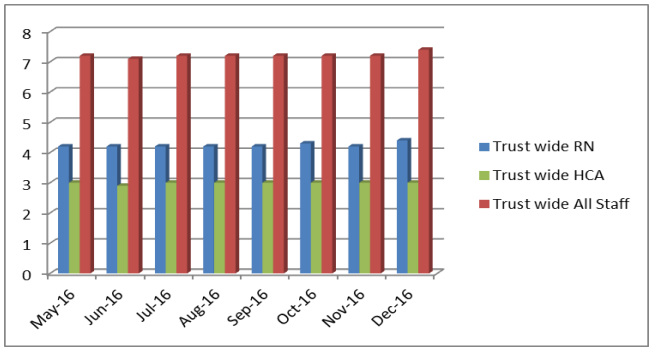
The data illustrates the need to continue to progress with our recruitment campaign for registered professionals and further explore the opportunity to recruit nursing staff from overseas initially through the recruitment undertaken by Health Education England, Yorkshire & the Humber programme.

3b. Care Hours Per Patient Day (CHPPD)

From 01 May 2016, CHPPD has become the principle measure of nursing and healthcare support worker deployment. Utilising actual versus planned staffing data submitted to UNIFY in December 2016 and applying the CHPPD calculation the care hours for December 2016 are;

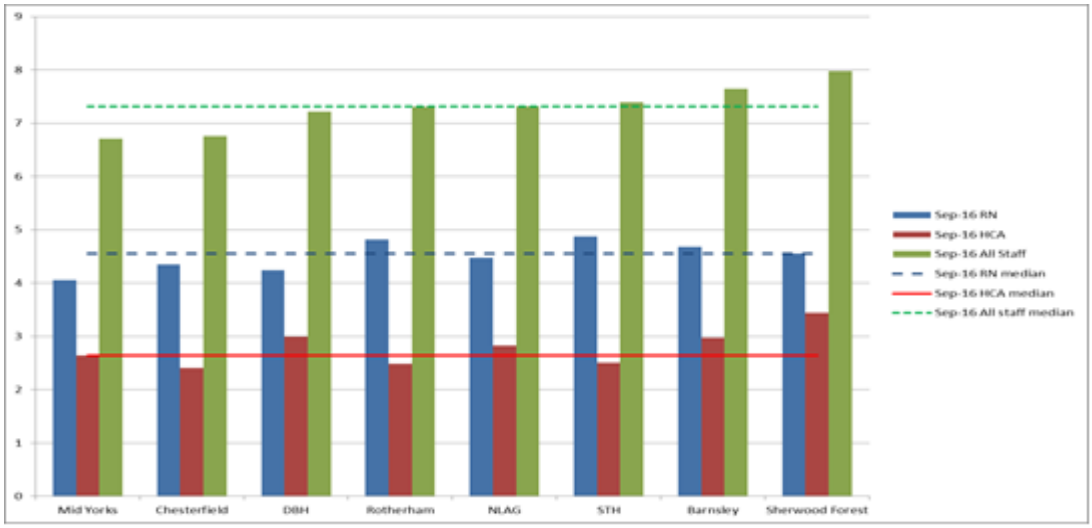
Care Hours Per Patient Day (CHPPD) – December 2016			
Site Name	**Registered midwives/ nurses**	**Care Staff**	**Overall**
BASSETLAW HOSPITAL	5.2	3.6	8.8
DONCASTER ROYAL INFIRMARY	4.4	3.0	7.4
MONTAGU HOSPITAL	2.2	2.6	4.8
TRUST	**4.4**	**3.0**	**7.4**

The CHPPD care hour's data from May 2016 – December 2016 remain relatively consistent with a slight increase for registered professionals trust wide to 4.4 for December.



The model hospital portal has been made available in January 2017, although it is only possible to compare at a trust wide level at present. Dashboards to allow comparison at ward level are still under development.

The data is available via the portal for the month of September 2016 only at present and a peer group of local organisations has been chosen to benchmark against.



Of the peer group chosen DBHFT has the third lowest total CHPPD value compared to peers, being the second lowest CHPPD for registered professionals and the third highest CHPPD for Healthcare Support Staff.
This is probably a reflection of our registered professionals' vacancy rate and that we utilise healthcare support staff to backfill these vacancies. In addition the non-medical workforce review may have also contributed to this position.

As more data becomes available via the model hospital portal, more detailed comparisons, which will be able to be tracked over time, will make the data more meaningful.

3c. Safe Staffing and Efficiency

A cap of agency expenditure for registered general and specialist nursing staff, midwives and health visitors has been in place since November 2015. The annual ceiling for DBHFT has been set at the lowest level of 3% which is a reflection of the relatively low level of bank and agency usage when compared to the national picture. The December figure has reduced to 0.79% compared to the November figure of 1.11%, and continues to be well below the 3% agency cap.

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

3d. Nurse Manager Clinical Time

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

The Clinical and Supervisory Time in December 2016 was:

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

All HoN's and the majority of Matrons have undertaken their clinical time in order to support ward areas clinically, with the exception of surgery, where one Matron had a period of annual leave and sick leave. The majority of senior sisters/charge nurses have been unable to completely maintain their 2 days a week supernumerary time as they have been working clinically due to staffing pressures.

3e. Quality and Safety Profile

The Quality Metrics (appendix 1) for adult wards include 15 indicators that cover each of the five CQC Key Assessment Criteria (safe, effective, caring, responsive and well led). These were agreed by the HoNs in April 2015, and remain the same for 2016/17, but with an adjusted baseline based on outturn in 2015/16 and revised trajectories for CDI, PU, falls with harm and multiple falls.

The quality data for December is improved with no wards being assessed as red for quality.

Following discussion at both Clinical Governance and Quality Committee and Clinical Governance Oversight Committee, the quality metrics data will be presented at both committees to allow the opportunity for more detailed discussion.

3f. Safe, Sustainable and Productive Staffing Improvement resource

This improvement resource is to support nurse staffing in adult inpatient wards in acute hospitals and is aligned to commitment 9 of Leading Change, Adding Value: a framework for nursing, midwifery and care staff (2016). It is based on the National Quality Board's expectations that to ensure safe, effective, caring, responsive and well-led care on a sustainable basis, trusts will employ the right staff with the right skills in the right place and at the right time.

The resource outlines a systematic approach for identifying the organisational, managerial and ward factors that support safe staffing and makes recommendations for monitoring and taking action if not enough staff are available on the ward to meet patients' needs, building on NICE guidelines on safe and sustainable staffing for nursing in adult inpatients in acute wards.

The resource concludes with ten recommendations in determining nurse staffing requirements in adult inpatient settings and can be found at;

https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-adult-inpatient-acute-care/

The trust implemented NICE guidance in 2013 and previous NQB guidance in both 2013 and July 2016 in relation to nurse staffing in adult inpatient settings upon which these recommendations are based and therefore have systems and processes in place to partially or fully meet the recommendations. However, following the consultation and publication of the final improvement resource, and as part of our review of the Ward Quality Assurance Tool and our annual review of the Quality Metrics, we will ensure that any additional metrics identified in the recommendations are included in our systems and processes so that we continue to meet best practice.

4. AHPs INTO ACTION. USING AHP's TO TRANSFORM HEALTH, CAE AND WELLBEING

'AHPs into Action' was launched on 17th January 2017 and defines how AHPs can support STPs implement the triple aim set out in the Five Year Forward View; driving improvements in health and wellbeing, restoring and maintaining financial balance and delivering core quality standards and in summary describes the:

- impact of the effective and efficient use of AHPs for people and populations
- commitment to the way services are delivered
- priorities to meet the challenges of changing care needs.

Split into two parts; Part 1 of AHPs into Action describes AHPs transformative potential within the health, care and wider system. It gives case examples of where AHPs have achieved significant impact in addressing the challenges posed in addressing the triple aim set out in the Five Year Forward View

Part 2 of the document provides a blueprint for action, with 16 challenge questions posed in a framework, based on the commitments and priorities identified by AHPs, to guide thinking when developing a plan of delivery. This framework will help to identify best practice currently being delivered and any gaps requiring action and can be found at;
https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

Whilst SYB STP may take a similar approach, we are not clear that this will be progressed on an STP basis or of any timescales for such work and therefore the Head of Therapies will set out a local approach and a plan as to how we can take forward some of the opportunities at a PLACE level and how to reflect the carter metrics to evidence the AHP contribution.

5. PLANNED ACTIONS AND KEY RISKS

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

- The Trust has put measures in place to reduce use of non-framework agencies and to minimise the breaching of the price cap
- Monitoring and use of escalation processes are in place to tightly control use of registered and non-registered agency usage
- Analysis of the November 2016 AUKUH data collection and ward nurse staffing requirements in specific inpatient areas, which will be available to the Board of Directors in February 2017.
- Continue to progress the Non-Medical workforce utilisation programme as part of DBH Strategy and Improvement programme utilising enabling tools e.g. Calderdale Framework, including;

  - Challenging and reviewing skill mix to make better use of Non-registered staff exploring the development of extended roles
  - Reviewing the non-ward staff roles and responsibilities
- Provide further detailed comparison CHPPD data as this becomes available nationally
- Review the Safe, Sustainable and Productive Staffing Improvement resource following final publication
- Provide a local approach and plan to take forward opportunities from AHPs into action

6. RECOMMENDATION

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

APPENDIX 1: HARD TRUTHS January 2017 Paper

Quality/Safety Profiles December 2016 Data

				anned v Actu	Safe	Effective	Caring	Responsive	Well led	Total Quality Dashboard	Profile		WQAT annual assessment 2015/6	WQAT annual assessment 2016/17
Care Group	Matron	Ward	No of Funded Beds	Variance	Total	Total	Total	Total	Total	RAG rating	Workforce	Quality Dashboard	Rating	Rating
Surgical	NS	B6	16	75%	0.0	0.0	1.5	0.0	0.5	2.0			Jan-16	
	NS	20	27	95%	1.0	0.0	1.5	0.0	1.0	3.5			Dec-15	Nov-16
	NS	21	27	96%	2.5	0.0	0.0	0.0	1.0	3.5			Jan-16	
	LM	S12	20	99%	1.0	0.0	2.0	0.0	1.0	4.0			Apr-16	
	RF	SAW	21	99%	1.0	0.0	3.0	0.0	1.5	5.5			Feb-16	
	LC	ITU DRI	20	93%	1.0	0.0	0.5	0.0	1.0	2.5			Nov-15	
	LC	ITU BDGH	6	88%	1.0	0.0	3.0	0.0	1.0	5.0			Jan-16	Jan-17
				93%										
MSK and Frailty	SS	A4	24	110%	1.0	0.0	0.0	0.5	0.5	2.0			Mar-16	
	SS	B5	30.7	92%	0.0	0.0	0.0	0.5	0.5	1.0			Feb-16	
	AH	St Leger	35	104%	1.5	0.0	2.0	0.5	0.5	4.5			Mar-16	
	AH	1&3	23	102%	0.0	0.0	0.0	0.0	0.5	0.5			Nov-15	
	SS	Mallard	16	106%	0.5	0.0	1.0	0.0	0.0	1.5			Nov-15	
	SS	Gresley	32	104%	1.0	1.0	0.0	0.0	0.5	2.5			Feb-16	
	SS	Stirling	16	103%	1.5	0.0	2.0	0.0	0.0	3.5			Oct-15	
	KM	Adwick (rehab2)	29	98%	1.0	0.0	2.0	0.0	1.0	4.0			Feb-16	
	KM	Wentworth (rehab1)	29	116%	0.0	0.0	1.0	0.5	1.0	2.5			Feb-16	
				103%										
Specialty Service	JP	18	12	96%	1.0	0.0	1.5	0.5	1.0	4.0			Nov-15	
	JP	18 CCU	12	92%	1.0	0.0	0.0	0.5	1.5	3.0			Oct-15	Nov-16
	AW	32	18	91%	0.5	0.0	2.0	0.5	1.5	4.5			Nov-15	Nov-16
	AW	16	24	93%	0.0	0.0	1.5	0.0	1.5	3.0			Nov-15	
	RM	17	24	105%	1.0	0.0	1.0	0.5	1.5	4.0			Feb-16	Jan-17
	JP	CCU/C2	18	106%	1.0	0.0	0.0	1.0	1.5	3.5			Nov-15	Dec-16
	RM	S10	20	99%	0.0	0.0	3.0	0.5	1.0	4.5			Nov-15	Jan-17
	RM	S11	19	100%	1.0	0.0	2.0	1.0	1.5	5.5			Dec-15	
				98%										
Emergency	MH	ATC	21	98%	2.5	0.5	0.0	0.5	1.0	4.5			Dec-15	
	SS	AMU	40	99%	2.5	0.0	1.0	1.0	1.5	6.0			Feb-16	
	MH	A5	16	102%	1.0	0.0	3.0	0.0	1.5	5.5			Jan-16	
	MH	C1	24	102%	1.0	0.0	0.5	0.0	1.0	2.5			Dec-15	
	SC	24	24	115%	1.0	0.0	2.0	0.0	1.0	4.0			Nov-15	
	SC	25	16	98%	1.0	1.0	0.0	1.0	1.5	4.5			Nov-15	
	SC	Respiratory unit	56	90%	2.5	0.0	1.0	0.0	1.5	5.0			Nov-15	
				99%										
Children and Families	AB	SCBU	8	100%	0.0	0.0		0.5	1.0	1.5			n/a	
	AB	NNU	18	99%	0.0	0.0		1.0	0.5	1.5			n/a	
	AB	CHW	18	94%	0.0	1.0		0.0	0.0	1.0			n/a	
	AB	A3	14	99%	1.0	0.0		0.0	1.0	2.0			n/a	
	AB	COU/CSU	21	95%	0.5	0.0		0.0	1.0	1.5			n/a	
	SS	G5	24	96%	0.0	0.0	2.0	0.5	1.0	3.5			Apr-16	
	SS	M1	26	94%	0.5	1.0	0.5	1.0	1.0	4.0			Nov-15	Nov-16
	SS	M2	18	81%	1.0	1.0	0.0	0.5	0.5	3.0			Nov-15	Nov-16
	SS	CDS	14	95%	0.0	0.0	1.5	0.5	1.0	3.0			Oct-15	Jan-17
	SS	A2	18	90%	0.0	1.0	0.0	0.5	1.0	2.5			May-16	
	SS	A2L	6	79%	1.0	0.0	1.5	1.0	1.0	4.5			May-16	
				92%										
		Trust Position		97%										

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	**Quarter 3 People & Organisational Development update**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Karen Barnard, Director of People & OD**		
For:	**Noting**		

Purpose of Paper: Executive Summary containing key messages and issues

This paper seeks to update the Board of Directors on the progress made in Q3 to deliver the current P&OD Strategy in 2016/17; the annual workforce related KPIs, corporate objectives and P&OD led projects.

Headline data

Sickness absence (and health and wellbeing) – Over the 3 months of quarter 3 we have seen variance in sickness absence rates with a spike in November resulting in the cumulative figure at the end of quarter 3 being 4.48% as compared with 4.49% at the end of September 2016. The greatest proportion of sickness absence is long term (i.e. over 28 days) and therefore cases are being closely monitored with action plans developed for cases in excess of 5 months absence. An action plan has been developed which comprises a focus on health and wellbeing with particular emphasis on MSK and mental wellbeing and use of the Sickness Absence policy together with support from P&OD to line managers. A health and wellbeing group reporting to the WEC is being established with its first meeting due to be held in February. A more detailed update is included within the report.

Staff Engagement

As a result of financial and operational pressures in the NHS and in light of the financial misreporting and difficult actions required in the turnaround programme we anticipate that the staff survey results for 2016 will show a general decline and require a new approach to staff engagement in 2017/ 2018. Working with Staff side and elected Governors work is commencing on a Staff Engagement Action plan which will be amended if necessary once the national reports are received. The report also details the various internal and external communications undertaken during the quarter.

Education and training

SET compliance – we continue to see improvements in the data recorded in ESR which indicates compliance rates of 65.93%. Work is on-going across the Working Together Trusts to standardise SET training in terms of content, mode of delivery and frequency. A report is due to be received shortly which will be considered by the Executive Team and WEC.

Appraisal rates – data held within ESR indicates a compliance rate of 64.75% across the Trust; there is quite a variance between Care Groups.

The Knowledge & Library Service at the Trust have achieved a compliance score of 100% in the national quality assurance annual assessments for NHS Libraries in 2016. The assessors were particularly impressed by the range of services for patients, carers and the public as part of the partnership with Doncaster Libraries and recognised the improvements made, and new developments introduced in relation to knowledge

management activities.

Freedom to Speak Up Guardian report

The FTSU Guardian role was introduced in the Trust in October 2016 – this report contains an update of their work since then. The Well Led Governance review undertaken by Deloitte's found that staff are aware of the guardians and would be confident in raising concerns. In addition to this role being in place Alan Armstrong has the NED lead for whistleblowing.

Recommendation

Members of the Board are asked to note this quarterly update.

Delivering the Values – We Care

We always put the patient first

- *By focusing on improving staff presence, well-being, engagement and skill level*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity

- *By having clear and transparent processes and policies and by living our values*

Committed to quality and continuously improving patient experience

- *By ensuring we are continuously improving against our KPIs and objectives*

Always caring and compassionate

- *By recruiting, retaining and engaging the right staff who demonstrate our values*

Responsible and accountable for our actions – taking pride in our work

- *By having clear objectives and actions to improve our performance and quality*

Encouraging and valuing our diverse staff and rewarding ability and innovation

By ensuring the right people with the right skills are involved in delivering our progress

Related Strategic Objectives

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

Analysis of risks

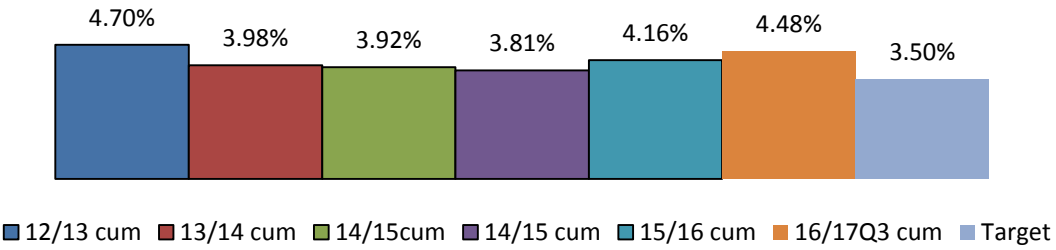
There are three Trust wide risks on the Corporate Risk Register and the Board Assurance Framework that will be directly improved or mitigated by the delivery of the P&OD Strategy though successful delivery will help to support the delivery or mitigation of most corporate risks.

Board Assurance Framework

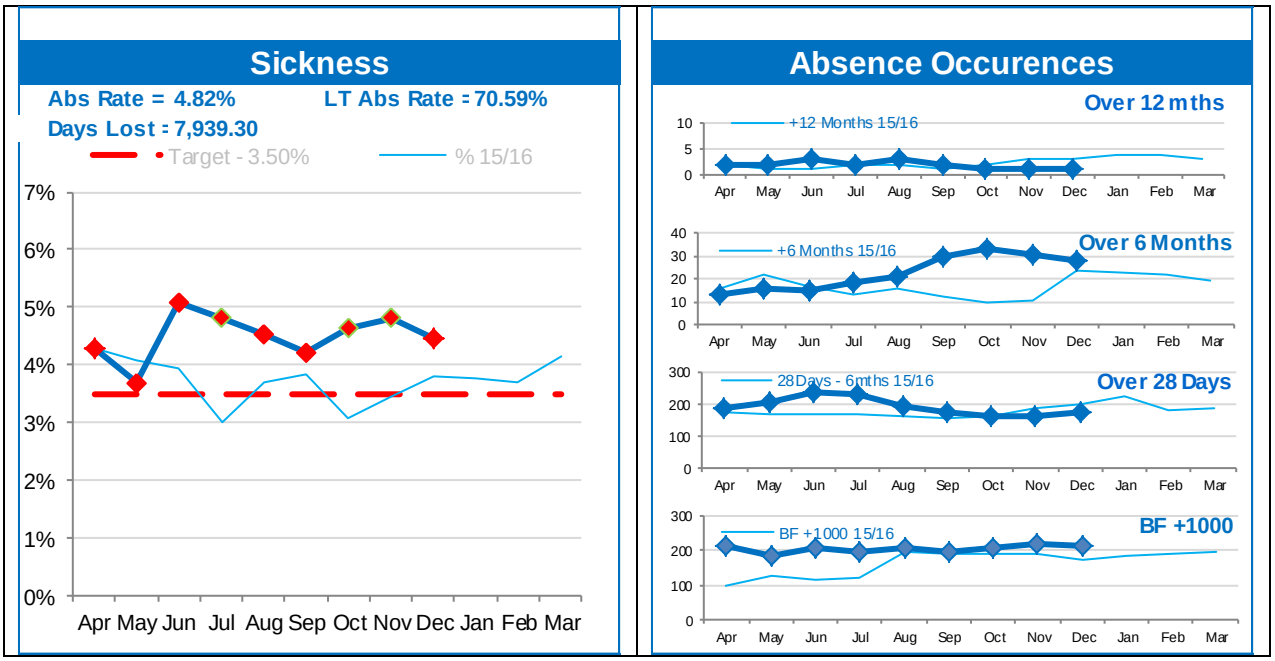
7	Risk of failing to address the effects of the medical agency cap, leading to gaps in medical rotas	*4x4=16*
8	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	*3x4=12*
13	Inability to recruit right staff and ensure staff have the right skills to meet operational needs	*4x3=12*

1. Absence and Wellbeing

Corporate Objectives 16/17	Q3 16/17
Comprehensively implement and maintain processes and procedures to reduce and then maintain staff sickness to <3.5% measured as an annual position. Hold corporate directorate and care groups to account by escalating performance issues or failure to use corporate tools and processes designed to manage sickness.	Q4 annual
People and Organisational Development Strategy KPIs	
Staff sickness <3.5%	Q4 annual
Flu immunisation >81% - 63.6% outcome in December 2015. A national CQUIN has been introduced for 16/17 which sets a target of 75% of front line clinical staff being vaccinated – this was achieved within 6 weeks of commencing the programme; the Trust being the first acute Trust to achieve the target.	Q3



We have not yet met the cumulative target of 3.5%; we saw a downward trajectory to 3.81% in 14/15 and during 15/16 we generally saw monthly absence well below 4% (and below Trust target in 4 separate months); however there was a spike to 4.45% in March 2016 which is continuing during 2016/17. Following a spike in the number of staff off sick for more than 6 months in October there has been a gradual reduction with the number currently at 28. The HR Business Partners and Care Group/Directorate leadership teams have been focused on the return to work of these members of staff wherever possible.



The Trust's sickness absence percentage rates have been increasing in recent months and the team in P&OD have been taking a number of actions to address the increasing trend and support management teams to reduce the volume of sickness absence across departments and teams.

The Business Partners have been arranging regular sickness absence clinics / review meetings with key members of management teams and have been producing individual plans for all members of staff who have been absent for a period of 6 months or more. This work has also focused on those members of staff who have been absent

for 4 or 5 months ensuring on-going management of their absence is undertaken. This work has been reviewed and monitored by both the Director and Deputy Director of P&OD through case review meetings which have included support from members of the Occupational Health and Wellbeing team. This on-going work has seen a reduction in the numbers of staff who have long term periods of absence. In addition the Business Partners continue to provide OD interventions to support teams.

The Business Partners have also been working closely with management teams to ensure that return to work interviews are taking place and that those members of staff who reach defined trigger points are managed formally under the Trusts Sickness Absence Policy. The purchase of an automated system is being explored which would provide real time data to managers and P&OD and would flag triggers for action by managers.

A more detailed analysis and breakdown of the Trusts sickness absence data is also in progress, trying to identify trends for sickness absence amongst staff groups, Care Groups / Directorates, different bands of staff, broken down by long term and short term classifications. In addition there has been a focus on the reasons for absence to enable the Trust to respond by trying to improve access and uptake to support around MSK and mental health issues.

A review has been undertaken in relation to the guidance document that supports the Trusts Sickness Absence Policy and amendments have been made. The revised guidance has been shared with Staff Side colleagues for information and will be ratified at the next Workforce & Education Committee.

The Trust has seen a successful flu vaccination programme take place in Q3. DBH was the first Trust in the country to achieve the 75% vaccination target in just 6 weeks. We anticipate this will help towards keeping staff in work throughout the winter flu season and help reduce the amount of flu cases seen amongst staff within the organisation.

The onsite physiotherapy service has continued to offer direct access to staff suffering with MSK related problems. Communication work has begun with GP practices to remind them of the service that is available to our staff rather than staff waiting to be seen in community service which often have long waiting time. We have seen an increase in referral rates to the service compared to last year. April to Dec has seen 543 referrals and our annual target is to achieve 686, which we are on plan to achieve. This will be 100 more referrals than last year.

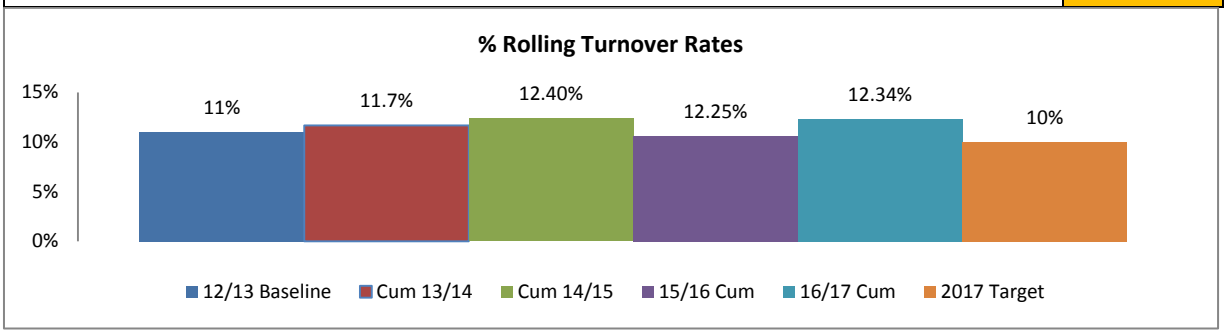
Stress Management Courses have commenced delivery with 4 courses planned to be delivered in quarter 4. This will see over 80 people having accessed support in dealing with stress. We have trained over 35 managers in 'Creating a mentally healthy workplace' with 2 more courses being ran in quarter 4 to take our total to over 60. Promotion of a range of mindfulness opportunities has commenced and more are planned for quarter 4 along with the promotion of sleep counselling through our HELP Employee Assistance Programme.

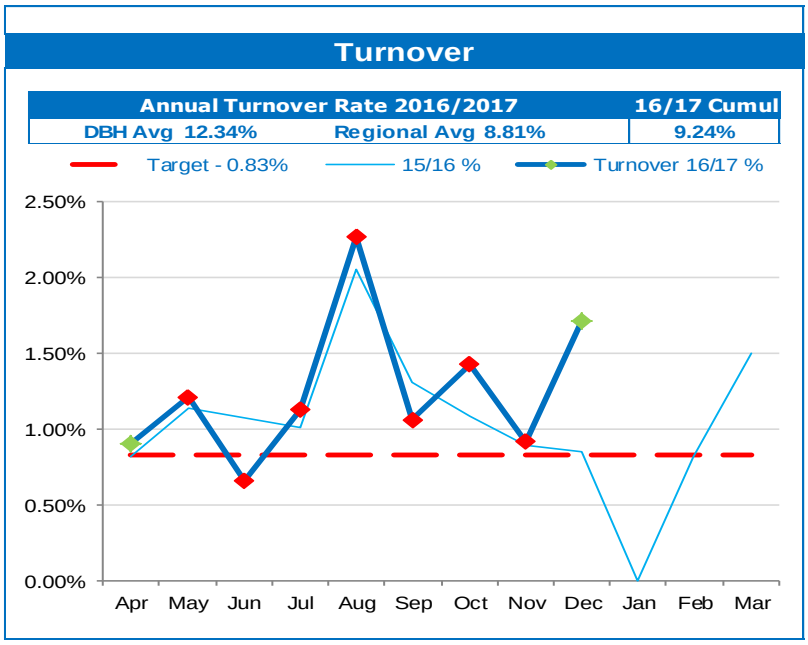
A range of physical activity initiatives have maintained delivery and new initiatives developed including the onsite programme of exercise classes and promotion of national campaigns, including Race to Rio and Around the world in 80 days. More of these are planned for quarter 4. An established netball team and choir have formed and are keeping staff active and healthy. Quarter 4 plans to see a range of initiatives developed to increase the amount of walking done around the hospital sites by staff.

In addition to the above we are on target to achieve the required numbers of health champions within the organisation by the end of Q4, this will hopefully have a very positive impact on the organisation in terms of raising the health and wellbeing profile and promoting good health. All of these programmes of work are supporting the delivery of the Health and Wellbeing CQUIN. The Trust's Communications team are actively involved in supporting and publicising these programmes. A health and wellbeing group is being established as a sub group of the WEC to ensure we continue to have focus on the delivery of the forthcoming CQUIN targets.

2. Turnover, deployment and staffing levels

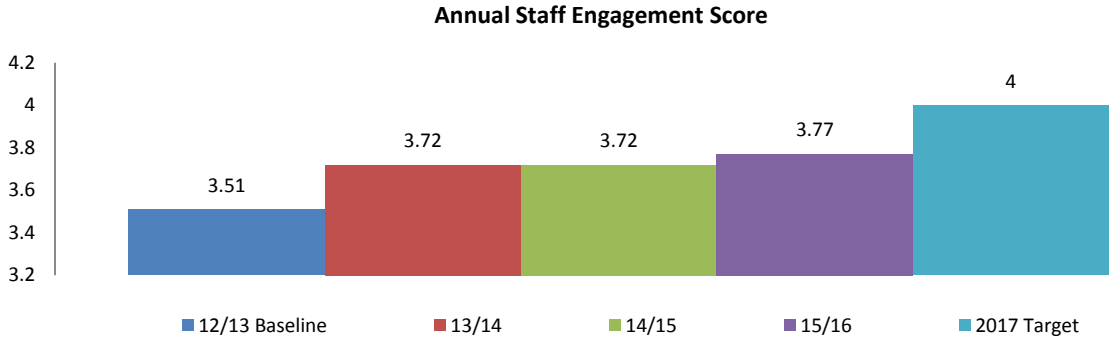
Corporate Objectives	Q3 16/17
N/A	
People and Organisational Development Strategy KIPs	
Voluntary turnover <10% annually	Q4 annual
Additional P&OD led projects	
E-roster roll out	ongoing
Introduction of new medical agency provider	Q3
NHS Professionals Phase2	On hold





3. Staff Survey and Engagement

Corporate Objectives	Q1
Implement the key actions arising from the Staff Survey 15/16 and quarterly Staff FFTs. Ensure each care group and corporate directorate has developed a local action plan by the end of Q1 to take forward local issues identified in the staff survey	Q1 & Q3
People and Organisational Development Strategy KPIs	**Q1**
Engagement scores at 4.00 by 2017	2017
Staff survey response rates at 55% in the annual staff survey by 2017 Our response rate for annual staff survey increased to 44% in 2015 against an average of 38%	2017
Additional P&OD led projects	
Internet/Intranet Procurement and Implementation	Q4
Quarterly Staff Friends and Family Test (FFT).	**Q1,2,3,4**



NHS organisations are mandated to complete an annual full staff survey and a quarterly Staff Friends and Family Test (FFT). We were one of a minority of Trusts carrying out a full census in 2015 with a response rate of 44%; it represented a response from almost half of the organisation. The 2016 annual staff survey took place at the end of 2016 with results due in March 2017. All Care Groups and Directorates have developed local action plans and progress against them is reviewed through the leadership team meetings. Much of the local work has focused on improving appraisal and SET rates, developing managers to manage attendance issues and other management development. Corporately work is continuing in relation to health and wellbeing as described above and a review is underway with regard to the leadership and management development programme we provide to managers and supervisors. A paper will be brought to Board Brief in February to consider how we move forward with staff engagement and staff experience during 2017.

Communications and engagement update

Internal communications and engagement

- 12 issues of DBH Buzz have been issued with the average of 3.25k views per issue and an average read time of four minutes 27 seconds. We saw a drop in views/ readership from mid-December to January. The 1 November edition had the highest readership at 3,854 views, the edition included details on how all staff can access their flu vaccination, following the successful programme of vaccinating frontline staff first.
- 82 Ask The Boss questions were submitted, the majority of which focused on car parking. All questions requiring a response have been answered except for 22 which are more complex and require further investigation.
- The closed Facebook group now has 1051 members (450 at last report). The group contains mainly frontline staff enabling more staff to access corporate messages, including the Buzz.

Media, social media and stakeholder relations

- 32 proactive press releases have been issued and four column pieces. This contributed to 95 pieces of coverage in local, regional and national media. 74% of coverage was positive in tone, 16% negative and 10% neutral. A range of stories contributed to the positive coverage including Trust teams and services being shortlisted for awards, being the first Trust to achieve 75% uptake for the flu vaccine, charitable donations, support for breast cancer awareness month and the launch of the new Fred and Ann Green Eye Centre. The

majority of negative coverage focuses around Bassetlaw, and is presented in local opinion pieces specifically surrounding changes to car parking, x-ray and children's services.

- There have been three editions of DBH in the News which is shared with a small distribution list and the closed staff Facebook group. They have been read a total of 473 times.
- 2,838 people like us on Facebook (2,347 at last report) and content during the three months reached 311,362 people (56k in October, 75k in November and 180k in December). During this time posts were engaged with 26,317 times with people liking, sharing or clicking on the posts. The increases in likes, engagement, and reach correlate with the 12 Days of Christmas campaign focusing on celebrating and thanking staff.
- 2,509 followers on Twitter (2,295 at last report) made 139,900 impressions, with 565 retweets, 641 likes for content.
- 164,210 unique user sessions to our website with 340,928 page views.

Events and campaigns

- A comprehensive communications plan and campaign was successfully delivered to support the staff flu campaign, helping to reach 75% uptake before any other Trust in the country. The approach featured in the NHS Employers weekly engagement bulletin as good practice.
- The second Turnaround Workshop was held in Doncaster and Bassetlaw. Though the event saw less attendance than the first event (80), the overall feedback was good with 52 cost saving ideas shared.
- A campaign with local football club Doncaster Rovers, supporting Breast Cancer Awareness month (October) helped to raise awareness of screening in the community as the team wore promotion t-shirts in the month, included an article on the importance of breast screening in their match programme and also attended the screening clinic to meet staff and show their support. This generated a lot of coverage with local health organisations helping to spread the message wider.
- Staff were encouraged to complete their staff surveys through an awareness raising campaign which included myth busting videos, a blog from Karen Barnard, incentives and also the offer of additional support to complete the survey through drop in sessions for frontline staff. As a result it is hopeful that the completion rate will have increased on last year.
- A winter health campaign made up of small stories surrounding a range of winter health conditions/ issues have been distributed through social media channels with illustrations providing more engaging content. The illustrations, along with the key messages, were also printed and provided across sites for staff and visitors to use for colouring in and taking away. These were interspersed with more traditional Choose Well messages to ensure messages were accessible for all audiences. The campaign has also been complimented with coverage in the local media about keeping the hospital healthy over winter.
- The 12 Days of Christmas campaign featured in the Buzz and also over social media was made up of photos of a range of staff groups to highlight their work. Involving staff across the Trust generated a 'feel good factor' and a video including all groups, with the accompanying song performed by the DBH choir was viewed nearly 9,000 times on Facebook.

Focus for next quarter

A campaign to mark the launch of Teaching Hospital status will be developed in support an official launch event. For cervical screening week we are working with local, large employers to provide materials to their female employees and also gain some insights about the barriers to screening. There will also be a campaign to support the upcoming Governor elections in order to promote the how to become a Governor and get involved in the elections.

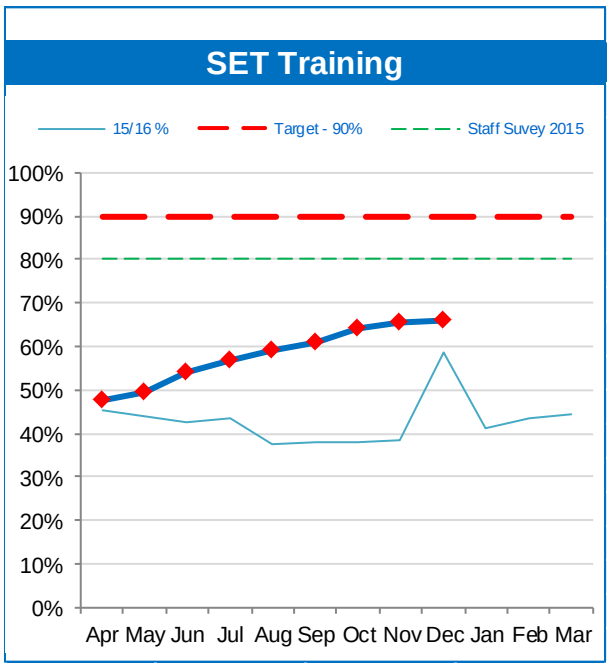
Work will also begin on the planning for the production of the annual report and for the Trust's transition from Turnaround into Transformation.

4. Training, education and development

Corporate Objectives	Q1
Deliver the Statutory and Essential to role (SET) training project to ensure that at least 90% of staff accesses the full programme appropriate to their role, including safeguarding training, by Q3	Q3
Develop the Education and Training programme within resources, with the aim of being comparable in quality with teaching hospital standards by the end of the project period. Clearly define the source and allocation of funds to ensure full transparency for external and internal stakeholders.	Q4
People and Organisational Development Strategy KPIs and deliverables	
SET training completed for >85% of staff by 2017 (subsequently amended)	2017
Appraisal completion >90% by 2017 (updated to be 90% by Q4 2015/16)	2017

Statutory and Essential Training (SET)

We are currently at 65.93% with compliance rates steadily improving, although in the 2015 NHS Staff Survey 91% of staff said they had mandatory training in the last 12 months.



Overall compliance continues to improve across the range of topics and clinical and corporate directorates (see appendix 1). Numbers of staff have been added to the data presented following a request from the last CGOC report. Specific areas of concern (where we have seen a reduction in compliance outside the required percentage achievement) highlighted in red have a clear action and are summarised below.

Area of concern	Action plan
Adult and Paediatric resuscitation	The resuscitation team (responsible for delivery of training) has had reduced capacity due to a vacancy. Additionally it has been recognised that the existing staffing infrastructure does not meet the resuscitation council guidelines of numbers of resuscitation officers to the ratio of staffing numbers. A business case is about to be submitted for consideration of increasing this central resource.
Fire	The Deputy Director of Education is meeting with the Deputy Director of Estates to support action planning.
Estates and Facilities	A plan has been developed with the Deputy Director of Estates to support some bespoke education sessions for the estates and facilities staff (specifically around access to and support with eLearning).

OLMS continues to be a challenging electronic solution for the recording of education data due to its inability to capture individual level compliance requirements i.e. staff roles being allocated to the same position number and therefore the same SET requirement standard to achieve e.g. a physiotherapist who works in care of the elderly could be on the same position number as a physiotherapist who works in Women's and Children's. The latter requires paediatric resuscitation education whereas the former does not but the system allocates the requirements to both so the data reports only 50% compliance. The data presented in appendix 1 reflects all levels and frequency of compliance for all staff groups. Other organisation using OLMS only report awareness level training due to these issues. A request has been submitted to the ESR central team to allow us locally to report awareness level data alongside the more complex data so we will have a clearer understanding
Following the last CGOC and WEC it was agreed that the percentage of compliance for all the topics should reflect the frequency of requirement e.g. those topics that only need to be updated on a 3 yearly programme would only be expected to achieve 30% in year 1 (2016/17), 60% in year 2 (2017/18) and 90% in year 3 (2018/19). Risk assessments have been undertaken to help identify and prioritise which areas should be educated in year one when the frequency is more than a year.

Recommendations from the HRD MAST Working Together Group around the levels of training for different staff groups continue to be reviewed for use at DBTH. It is anticipated that recommendations from the working group will be finalised for April 2017 onwards. A paper will be submitted to the Workforce and Education Committee outlining the differences with current practice and recommendations for DBTH.

The technical issues within the DBTH IT systems continue to result in some eLearning modules not being automatically recorded onto OLMS resulting in compliance dropping. With the appointment of the new Chief Information Officer there is a commitment to standardise operating platforms on all the computers across the organisation by January 2017. This should result in an improvement of recording within the eLearning system going forward.

The corporate induction day has been reviewed and launched in January 2017. It now includes most of the SET topics and any not covered are booked at this point of contact with the new starter. This should result in all new starters being compliant within the first 3 months of employment. Again, the data reported will not include this improvement as it is up to December 2016.

Teaching Hospital Status

As members of the Board will be aware the Trust has now achieved Teaching Hospital status with the launch scheduled for 27 January 2017. A development plan is now being developed to ensure we continue to drive improvements going forward into 2017/18. This development plan will be monitored through the Workforce and Education committee with regular updates being received by the Board of Directors.

Knowledge & Library Service

The Knowledge & Library Service at the Trust have achieved a compliance score of 100% in the national quality assurance annual assessments for NHS Libraries in 2016.

Each year as part of the quality assurance process overseen by Health Education England, NHS Libraries are assessed against the national standards as detailed in the NHS Library Quality Assurance Framework (LQAF). Meeting compliance with this quality assurance framework is also a pre-requisite of the Learning and Development Agreement's that Trusts have with Health Education England. The service was one of only five services out of 65 Knowledge & Library Services across the North of England, and one of only three in Yorkshire and the Humber, to achieve this excellent score.

This is a fantastic achievement for the service and the result compares well against the mean average compliance scores for Yorkshire and the Humber which were:

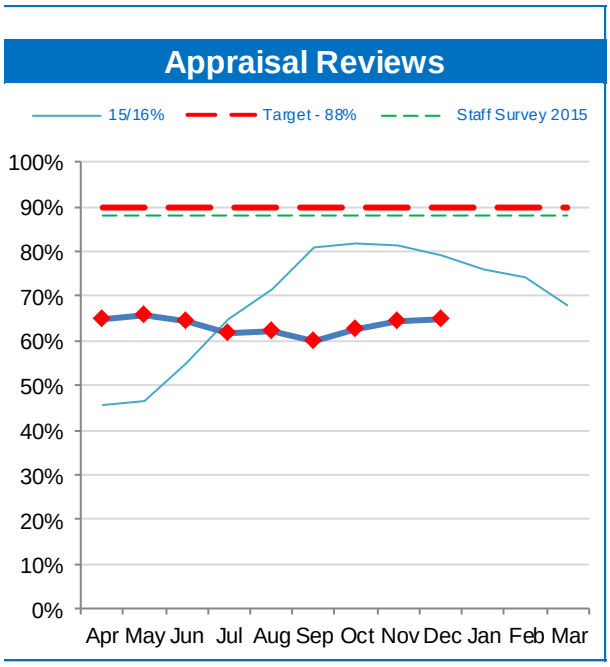
2016 Mean Yorkshire and the Humber % compliance rates		**RAG tolerances**	
all YH LKS	94%	**Red**	Less than 80%
acute LKS*	93%	**Amber**	80% to 89%
mental health & learning disability LKS*	96%	**Green**	90% and above

* includes those with community staff

The assessors were particularly impressed by the range of services for patients, carers and the public as part of the partnership with Doncaster Libraries and recognised the improvements made, and new developments introduced in relation to knowledge management activities. As these are two of the main *Knowledge for Healthcare* priorities for HEE in 2017, the service is well positioned to meet and maintain targets in these areas. A great deal of work also went into highlighting the work done by the service in supporting the health and wellbeing activities of the Trust, supporting staff and students in their CPD, e-learning and research activities and we also highlighted the various achievements of our outreach and e-resource service provision in supporting the objectives of the Trust and the educational needs of staff.

This was all achieved by a tremendous team effort and the hard work and enthusiasm of all the knowledge and library staff – well done and congratulations to them all.

Appraisal compliance



Whilst the staff survey census last year indicated that 88% of staff had received an appraisal we are struggling to maintain that level of compliance such that we hover around 60% - currently 64.75%. However there are some quite considerable differences across Care Groups and directorates.

5. Casework

Case Type	2013/14	2014/15	2015/16	2016/17 to date	
Grievance (17/19/16/14)	2	9	1	1	Grievance Upheld
	12	7	5	4	Grievance Not Upheld
	3	3	4	1	Part/Informal
			2	1	Withdrawn
			4	7	Resolved
Conduct/Discipline (176/160/79/42)	66	73	30	13	No Action/Informal Action
	87	72	36	18	Formal Action not Dismissal
	23	15	8	9	Dismissal
			5	2	Resigned
Capability (26/67/190/212)	4	11	27	48	No Action/Informal Action
	18	33	135	134	Formal Action not Dismissal
	4	23	19	23	Dismissal
			9	7	Resigned
Harassment & Bullying (4/4/5/0)	4	3	5	0	No Action/Informal Action
	0	1	0	0	Formal Action not Dismissal
	3	0	0	0	Dismissal
Appeals # (21/9/7/5)	1	1	0	0	Appeal Successful
	20	9	5	2	Appeal Unsuccessful
			2	3	Withdrawn
Employment Tribunals # (4/0/6/2)	0	0	0	1	ET Successful for claimant
	4	0	1	1	ET Unsuccessful for claimant
	0	3	5	0	ET Withdrawn
Whistleblowing (0/1/2/2)	0	1	2	2	
Suspensions *&** (6/6)	6 paid	5paid 1 unpaid	6 paid	9 paid	Calculated as a cumulative total year to date – i.e., there are currently (17.01.17) just 4 ongoing suspensions.
Alternatives to Suspensions (8/7)	8 paid	7 paid	3 paid	3 paid	2014/15 includes 1 individual who was initially suspended on full pay for two weeks and this was then commuted to alt. to suspension.
Capability - failure of sickness targets	5	2	161	184	
Ill Health Capability	3	23	25	23	
Capability - Performance	1	1	4	5	

No. of Appeals/ET cases concluded in period (case included only if also concluded in same period)

* These will be included in the above figures; ** With and without pay;

6. Freedom to Speak Up (FTSU) Guardian Report October – December 2016

This is the first update since the FTSU Guardian team was established in October 2016.

The Guardian Team comprises of; Lynn Goy (named lead guardian for DBHFT), Lorraine Robinson, Roy Underwood, George Webb and Utpal Barua.

October 2016

The current Whistleblowing Policy was re-named to 'Raising Concerns', including the Guardian logo of 'We Care, We Listen, We Act', and updated to include a revised Model Process Flow Pathway for raising concerns.

The communications team and information technology teams worked collaboratively with the Guardian project team, to produce a guardian icon for staff, with direct access, to the Raising Concerns Policy and Model Pathway on the Trust intranet website. A secure, confidential website address and telephone system is established, only accessible through the Guardian Team to retrieve sent messages.

Additional communication methods for staff unable to access a computer terminal included, information disseminated via the Trusts internal communication networks through; the Buzz magazine, Staff Brief and Foundations for Health. Further information was shown on patient information television screens throughout the Trust.

December 2017

National Guardian Regional Engagement Managers were established through the National Guardian Office. An introductory meeting occurred with the manager for Yorkshire and Humber, Russell Parkinson and Lynn Goy. Russell is to support Yorkshire & Humber (Y & H) guardians through the establishment of a Y & H guardian network, and as a direct access to the national guardian office based in London.

Lynn and Roy attended the first regional guardian network meeting hosted by the RDASH guardian. Quarterly meetings will be held across the Y & H region.

January 2017

The Role of the Guardian is now delivered in the monthly Trust Induction Programmes and Preceptorship programmes.

Summary of concerns raised

Five concerns have been raised with the FTSU guardians covering the themes of behaviours, attitudes, quality and safety; 2 of these concerns have been closed with the others being ongoing.

P&OD Strategy KPI tracker 2012 – 2017

The DBH P&OD Strategy was launched in 13/14 to support the delivery of the Trust's Strategic Direction. This stated our aims under four key P&OD themes, supporting the Trust's Strategic Themes and planned by 2017 to deliver a range of positive changes across the Trust, with and for staff, which would improve the quality and consistency of care given to our patients.

The strategy agreed a set of Key Performance Indicators (KPIs), base lined in 12/13 for delivery by 2017; below is an overview of progress towards these KPIs and this report highlights progress towards delivery of objectives delegated to the Director of P&OD - fully delivered (black) and partially delivered (amber).

The review of the Trust Strategic Direction has been delayed slightly to take account of any modification on direction as a result of our financial turnaround and the development of the STP. Given that the P&OD Strategy has a further year to run to 2017, its refresh needs to link to any modifications to Trust Strategic Direction and link to the STP workforce plan.

KPI	2017 Target	12/13	15/16	Cum. 16/17	Descriptor
Vacancies	5%*	9-12%	7.19%	NK	
Absence	3.5%**	4.7%	4.16%	4.48% Q3	Cumulative YTD taken directly from eWin workforce data source
Turnover	<10%	11%		12.34%	Rolling annual % **includes voluntary turnover** taken directly from eWin data source
Engagement	4.00	3.51	3.77	Annual only	
Flu immunisation	>81%	80%	64.7% - including 61% nursing	Annual only but currently 77.56%	% of clinical, front line staff immunized, our denominator group as determined by NHS England is around 4700, results are a % of that figure. Other staff cannot count towards results
Staff Survey response rates	>55%***	57%	44% (2015)	Annual only	2% increase of staff responding – based on full annual on line survey since 2013.
Appraisal	>90%	20%	86% (2015)	64.75%	
Training	>85%	20%	81% (2015)	65.93%	

*4.5% raised to 5% by Board of Directors following nurse staffing paper June 2014

**absence target is 3.5% not 3% as stated in the printed copy of P&OD Strategy

***reduced from 70% by Board of Directors following March 2015 Board paper on staff survey after reviewing performance of top decile Trusts.

Appendix 1: SET compliance data taken from OLMS for recorded training up to 31st December 2016

	Adult Resuscitation - Annually			Equality and Diversity - 3 Yearly			Fire - Annually			Fraud - 3 Yearly			Infection Prevention and Control			Manual Handling		
Org L2	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**
272 Chief Executive Directorate	5	3	**60.00%** ↑	24	17	**70.83%** ↑	24	17	**70.83%** ↑	24	17	**70.83%**	23	17	**73.91%** ↑	24	17	**70.83%** ↑
272 Children & Family Care Group	384	218	**56.77%** ↑	697	530	**76.04%** ↑	697	495	**71.02%** ↓	697	564	**80.92%** ↑	685	529	**77.23%** ↑	693	461	**66.52%** ↑
272 Diagnostic & Pharmacy Care Group	285	104	**36.49%** ↑	660	552	**83.64%** ↑	660	512	**77.58%** ↑	660	572	**86.67%** ↑	655	372	**56.79%** ↑	660	485	**73.48%** ↑
272 Directorate Of Strategy & Improvement				12	8	**66.67%** ↑	12	9	**75.00%** ↑	12	9	**75.00%** ↑	12	10	**83.33%** ↑	12	8	**66.67%** ↑
272 Emergency Care Group	680	319	**46.91%** ↑	814	632	**77.64%** ↑	814	524	**64.37%** ↓	814	640	**78.62%** ↑	808	631	**78.09%** ↑	802	475	**59.23%** ↑
272 Estates & Facilities				795	271	**34.09%** ↑	795	274	**34.47%** ↓	795	296	**37.23%** ↑	792	247	**31.19%** ↑	490	290	**59.18%** ↑
272 Finance & Healthcare Contracting Directorate				67	54	**80.60%**	67	51	**76.12%** ↓	67	64	**95.52%** ↑	65	61	**93.85%** ↑	65	59	**90.77%** ↑
272 IT Information & Telecoms Directorate*				121	108	**89.26%**	121	108	**89.26%**	121	112	**92.56%**	120	99	**82.50%**	120	107	**89.17%**
272 MSK & Frailty Care Group	676	449	**66.42%** ↓	899	767	**85.32%** ↑	899	703	**78.20%** ↓	899	780	**86.76%** ↑	852	734	**86.15%** ↑	812	569	**70.07%** ↑
272 Medical Director	2	0	**0.00%** -	8	3	**37.50%**	8	3	**37.50%** ↑	8	6	**75.00%** -	8	2	**25.00%** ↓	8	2	**25.00%** -
272 Nursing Services	21	10	**47.62%** ↑	62	45	**72.58%** ↑	62	39	**62.90%** ↑	62	54	**87.10%** ↑	61	37	**60.66%** ↑	62	48	**77.42%** ↑
272 People & Organisational Development	32	24	**75.00%** ↑	96	92	**95.83%** ↑	96	90	**93.75%**	96	91	**94.79%**	96	89	**92.71%** ↑	96	85	**88.54%** ↑
272 Performance				274	95	**34.67%** ↑	274	107	**39.05%** ↑	274	144	**52.55%** ↑	273	95	**34.80%** ↑	216	114	**52.78%** ↑
272 Speciality Services Care Group	536	316	**58.96%** ↓	682	512	**75.07%** ↑	682	459	**67.30%** ↑	682	535	**78.45%** ↑	680	532	**78.24%** ↑	677	419	**61.89%** ↑
272 Surgical Care Group	946	543	**57.40%** ↑	1107	900	**81.30%** ↑	1107	764	**69.02%** ↓	1107	940	**84.91%** ↑	1071	874	**81.61%** ↑	1102	751	**68.15%** ↑
272 Trust Funds				1	1	**100%**	1	1	**100%**	1	1	**100%**	1	1	**100%**	1	1	**100%**
Overall	3567	1986	**55.68%**	6319	4587	**72.59%**	6319	4156	**65.77%**	6319	4825	**76.36%**	6202	4330	**69.82%**	5840	3891	**66.63%**

	Paediatric Resuscitation - Annually			Conflict Resolution - 3 Yearly			Health and Safety - Annual			Information Governance - Annual			Safeguarding Adults - 3 Yearly			Safeguarding Children - 3 Yearly		
Org L2	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**	**R**	**A**	**C**
272 Chief Executive Directorate	4	0	**0.00%**	24	18	**75.00%** ↑	24	18	**75.00%** ↑	24	17	**70.83%** ↑	24	17	**70.83%** ↑	24	17	**70.83%**
272 Children & Family Care Group	220	169	**76.82%** ↑	697	531	**76.18%** ↑	697	562	**80.63%** ↑	697	517	**74.18%** ↑	655	503	**76.79%** ↑	697	377	**54.09%** ↑
272 Diagnostic & Pharmacy Care Group	279	88	**31.54%** ↑	660	556	**84.24%** ↑	660	553	**83.79%** ↑	660	547	**82.88%** ↑	553	386	**69.80%** ↑	556	299	**53.78%** ↑
272 Directorate Of Strategy & Improvement				12	8	**66.67%** ↑	12	10	**83.33%** ↑	12	9	**75.00%** ↑	12	9	**75.00%** ↑	12	9	**75.00%** ↑
272 Emergency Care Group	250	56	**22.40%** ↓	814	628	**77.15%** ↑	814	648	**79.61%** ↑	814	610	**74.94%** ↑	745	415	**55.70%** ↑	751	373	**49.67%** ↑
272 Estates & Facilities				795	275	**34.59%** ↑	795	275	**34.59%** ↓	795	248	**31.19%** ↑	790	283	**35.82%** ↑	790	284	**35.95%** ↑
272 Finance & Healthcare Contracting Directorate				67	57	**85.07%**	67	52	**77.61%** ↓	67	51	**76.12%** ↓	64	60	**93.75%** ↑	64	59	**92.19%** ↑
272 IT Information & Telecoms Directorate*				121	104	**85.95%**	121	100	**82.64%**	121	102	**84.30%**	119	104	**87.39%**	119	107	**89.92%**
272 MSK & Frailty Care Group	285	156	**54.74%** ↑	899	778	**86.54%** ↑	899	782	**86.99%** ↑	899	756	**84.09%** ↑	822	687	**83.58%** ↑	837	611	**73.00%** ↑
272 Medical Director	1	0	**0.00%**	8	4	**50.00%** -	8	2	**25.00%**	8	2	**25.00%**	8	3	**37.50%** ↑	8	3	**37.50%**
272 Nursing Services	6	0	**0.00%**	62	49	**79.03%** ↑	62	46	**74.19%** ↑	62	47	**75.81%** ↑	54	45	**83.33%** ↑	57	44	**77.19%** ↑
272 People & Organisational Development	14	8	**57.14%** ↓	96	91	**94.79%** ↑	96	91	**94.79%** ↑	96	90	**93.75%** ↑	83	76	**91.57%** ↑	79	74	**93.67%** ↑
272 Performance				274	87	**31.75%** ↑	274	107	**39.05%** ↑	274	84	**30.66%** ↑	273	113	**41.39%** ↑	267	113	**42.32%** ↑
272 Speciality Services Care Group	152	73	**48.03%** ↓	682	506	**74.19%** ↑	682	527	**77.27%** ↑	682	505	**74.05%** ↑	635	422	**66.46%** ↑	640	427	**66.72%** ↑
272 Surgical Care Group	655	123	**18.78%** ↑	1107	878	**79.31%** ↑	1107	916	**82.75%** ↑	1107	889	**80.31%** ↑	1048	736	**70.23%** ↑	1183	633	**53.51%** ↑
272 Trust Funds				1	1	**100%**	1	1	**100%**	1	1	**100%**	1	1	**100%**	1	1	**100%**
Overall	1866	673	**36.07%**	6319	4571	**72.34%**	6319	4690	**74.22%**	6319	4475	**70.82%**	5886	3860	**65.58%**	6085	3431	**56.38%**

* New Directorate set up in ESR – split from 272 Finance & Healthcare Contracting Directorate

R = Required A = Achieved C = Compliance

Trust - Key Performance Indicators (KPI) - Dec 2016 (Q3)

Q3 2016 / 2017

KPI		Absence			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q3 Trust / Target		%	4.48%	3.50%	%	1.71	A - 10.00% M - 0.83%	%	99.25%	100.00%	3.77 / 3.79	44.00 / 55.00	%	64.75	90.00	%	65.93%	90.00%
Months		Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec	Score	Response	Oct	Nov	Dec	Oct	Nov	Dec
Trust	%	4.64%	4.82%	4.46%	1.43	0.92	1.71	98.54%	96.91%	99.25%			62.64	64.51	64.75	64.33%	65.37%	65.93%
Care Group	C&F	5.68%	5.93%	4.97%	1.22	0.94	2.86	98.65%	97.71%	99.54%	3.68	47.00	80.82	80.95	79.97	67.54%	69.28%	70.86%
	D&P	4.47%	4.00%	4.23%	1.30	0.58	0.86	99.41%	99.44%	100.00%	3.59	40.00	74.15	78.92	79.45	69.50%	71.09%	72.16%
	Em	4.71%	4.85%	4.42%	1.18	0.82	1.06	98.45%	98.00%	99.33%	3.79	42.00	50.26	51.38	53.92	65.71%	65.90%	66.13%
	M&F	3.84%	4.57%	3.05%	1.47	1.16	1.48	98.61%	99.03%	100.00%	3.84	50.00	82.82	83.65	83.97	76.91%	77.65%	79.55%
	Sp	5.45%	4.44%	4.30%	0.44	0.29	0.29	98.85%	98.59%	99.72%	3.95	49.00	51.31	52.70	52.30	67.93%	68.88%	69.98%
	Su	4.61%	4.57%	4.10%	1.61	1.79	0.95	98.51%	92.89%	99.31%	3.79	41.00	59.35	65.19	64.47	66.81%	68.45%	69.23%
Corp Dir	CEO	7.64%	4.16%	3.08%	0.00	3.39	3.51	100.00%	87.50%	85.71%	4.24	77.00	65.22	60.87	58.33	65.85%	65.26%	67.00%
	E&F	6.45%	7.27%	8.44%	0.73	0.37	0.61				3.65	24.00	58.04	57.97	59.37	36.98%	37.80%	36.66%
	Fi	2.99%	5.79%	6.06%	4.08	1.35	1.34	100.00%	100.00%	100.00%	3.66	67.00	47.06	46.27	46.97	85.23%	82.89%	80.43%
	IT/Info/Tel	4.06%	5.60%	5.57%	0.83	0.00	1.64	100.00%	100.00%	100.00%			30.83	33.61	33.88	86.43%	86.19%	85.36%
	MD	0.00%	1.69%	0.00%	0.00	0.00	12.50	100.00%	100.00%	100.00%			50.00	50.00	50.00	34.83%	35.96%	47.44%
	NS	3.36%	2.89%	2.75%	3.23	0.00	0.00	100.00%	100.00%	100.00%	3.99	75.00	46.67	50.00	50.00	67.85%	71.02%	73.32%
	P&OD	1.82%	1.82%	2.93%	2.96	1.01	2.00	96.15%	91.67%	100.00%	3.95	92.00	97.92	96.84	95.83	91.80%	90.88%	89.59%
	Pe	1.33%	2.70%	2.12%	1.87	0.37	0.00	100.00%	100.00%	65.38%	3.68	55.00	28.89	28.25	27.74	38.22%	37.47%	38.19%
	Strat & Im	1.13%	3.97%	0.00%	0.00	13.79	0.00	100.00%	100.00%	100.00%			66.67	66.67	66.67	69.13%	72.73%	62.99%

Q2 2016 / 2017

KPI		Absence			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q2 Trust / Target		%	4.49%	3.50%	%	1.06	A - 10.00% M - 0.83%	%	98.36%	100.00%	3.77 3.79	44.00 55.00	%	60.02	90.00	%	60.73%	90.00%
Months		July	Aug	Sept	July	Aug	Sept	July	Aug	Sept	Score	Response	July	Aug	Sept	July	Aug	Sept
Trust	%	4.82%	4.53%	4.21%	1.13	2.27	1.06	97.32%	98.36%	97.92%			61.93	62.36	60.02	56.86%	59.26%	60.73%
Care Group	C&F	5.70%	6.18%	6.23%	0.82	2.47	0.83	99.32%	99.33%	97.66%	3.68	47.00	62.75	65.74	80.54	57.59%	65.03%	63.12%
	D&P	3.17%	2.91%	3.65%	1.04	0.89	0.88	98.81%	99.70%	98.58%	3.59	40.00	77.52	79.43	70.36	62.51%	66.68%	64.43%
	Em	5.54%	4.97%	4.58%	1.23	3.58	0.84	97.48%	97.08%	97.59%	3.79	42.00	49.36	48.40	40.03	55.40%	60.09%	60.66%
	M&F	3.83%	3.76%	3.12%	1.25	1.57	1.78	99.18%	98.99%	99.22%	3.84	50.00	82.93	87.10	86.15	72.58%	74.76%	74.05%
	Sp	4.46%	4.67%	4.43%	1.17	3.25	0.74	98.79%	98.81%	99.15%	3.95	49.00	63.99	66.15	59.55	59.50%	62.45%	64.52%
	Su	4.00%	3.67%	3.76%	1.19	2.39	1.28	98.74%	97.51%	97.50%	3.79	41.00	53.37	51.61	49.42	56.70%	63.04%	61.69%
Corp Dir	CEO	5.50%	7.01%	7.69%	4.08	4.00	0.00	100.00%	100.00%	86.67%	4.24	77.00	61.90	71.43	58.33	50.59%	59.59%	63.40%
	E&F	8.35%	7.60%	6.37%	0.47	2.26	1.09		0.00		3.65	24.00	62.43	59.59	54.40	33.47%	35.15%	33.85%
	Fi	3.12%	2.97%	2.07%	1.98	1.00	1.52	100.00%	100.00%	100.00%	3.66	67.00	42.05	32.64	35.20	85.04%	85.37%	85.38%
	MD	0.00%	0.00%	0.00%	0.00	0.00	0.00	100.00%	100.00%	100.00%			62.50	62.50	50.00	27.70%	28.75%	27.78%
	NS	8.31%	9.17%	5.65%	1.65	1.65	0.00	100.00%	100.00%	100.00%	3.99	75.00	65.00	61.67	51.61	57.30%	57.46%	62.28%
	P&OD	1.21%	0.81%	2.10%	1.03	0.00	1.00	100.00%	95.83%	92.31%	3.95	92.00	92.39	94.62	97.96	89.92%	91.83%	90.55%
	Pe	6.82%	4.01%	1.81%	2.06	1.05	0.37	100.00%	96.15%	100.00%	3.68	55.00	34.80	33.45	28.16	35.47%	35.51%	37.04%
	Strat & Im	1.19%	2.49%	0.00%	5.71	12.50	0.00	100.00%	100.00%	100.00%			25.00	70.00	76.92	55.11%	53.70%	62.96%

Q1 2016 / 2017

KPI		Absence			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q1 Trust / Target		%	4.62%	3.50%	%	0.62	A - 10.00% M - 0.83%	%	99.90%	100.00%	3.77 3.79	44.00 55.00	%	64.54	90.00	%	54.08%	90.00%
Months		April	May	June	April	May	June	April	May	June	Score	Response	April	May	June	April	May	June
Trust	%	4.30%	3.69%	5.08%	0.91	1.12	0.62	97.38%	99.90%	99.90%			64.9	65.68	64.54	47.80%	49.65%	54.08%
Care Group	C&F	5.04%	3.59%	5.53%	0.54	0.54	0.14	100.00%	100.00%	100.00%	3.68	47.00	73.28	71.55	68.46	50.41%	49.38%	52.65%
	D&P	3.02%	3.92%	3.18%	0.55	1.11	0.90	100.00%	100.00%	99.70%	3.59	40.00	65.77	66.37	77.45	47.61%	50.30%	53.56%
	Em	3.68%	3.11%	6.21%	0.85	1.22	0.87	99.77%	99.76%	99.75%	3.79	42.00	58.90	57.14	55.43	45.04%	44.59%	50.72%
	M&F	3.44%	3.53%	4.09%	1.45	1.04	0.73	85.38%	100.00%	100.00%	3.84	50.00	73.61	78.28	80.79	63.64%	66.92%	70.78%
	Sp	5.26%	3.34%	5.24%	0.45	0.44	0.74	100.00%	100.00%	100.00%	3.95	49.00	62.84	63.69	65.40	51.99%	53.29%	58.18%
	Su	4.83%	3.14%	4.31%	1.00	1.60	0.59	99.74%	99.73%	100.00%	3.79	41.00	62.84	60.16	59.06	48.74%	51.14%	55.12%
Corp Dir	CEO	9.19%	4.86%	6.61%	0.00	0.00	0.00	100.00%	100.00%	99.86%	4.24	77.00	55.00	35.00	25.00	32.93%	34.02%	50.62%
	E&F	5.98%	6.12%	9.02%	0.92	0.46	0.58				3.65	24.00	68.30	67.49	63.80	17.01%	20.03%	28.73%
	Fi	3.61%	3.03%	2.12%	2.42	1.46	1.98	100.00%	100.00%	100.00%	3.66	67.00	76.73	72.50	61.86	73.98%	79.58%	84.79%
	MD	0.93%	0.00%	0.00%	0.00	0.00	0.00	100.00%	100.00%	100.00%			37.50	37.50	37.50	25.81%	25.71%	27.71%
	NS	2.06%	5.33%	5.99%	0.00	0.00	1.63	100.00%	100.00%	100.00%	3.99	75.00	45.00	37.70	34.43	57.02%	54.07%	56.33%
	P&OD	2.24%	1.15%	0.59%	1.86	10.67	0.00	100.00%	100.00%	100.00%	3.95	92.00	64.71	80.61	82.80	70.72%	73.81%	86.18%
	Pe	5.55%	6.13%	6.84%	0.45	0.00	0.34	100.00%	100.00%	100.00%	3.68	55.00	45.59	44.78	37.95	42.51%	50.64%	30.62%
	Strat & Im	0.00%	0.00%	0.00%	0.00	0.00	0.00	100.00%	100.00%	100.00%			100.00	100.00	30.77	37.50%	34.62%	53.41%

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Junior doctors safe working quarterly report**		
Report to:	**Board of Directors**	Date:	**January 2017**
Author:	**Dr Jayant Dugar, Guardian for Safe Working**		
For:	**Assurance**		

Purpose of Paper: Executive Summary containing key messages and issues

This report sets outs the background and context around the introduction of the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust. Along with the report attached as an appendix is a presentation developed by NHS Employers to brief Board members on the role of the Guardian for Safe Working.

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctor contract agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours.

The 2016 contract has been implemented for 27 junior doctors employed by this Trust in December 2016.This contract changes how safe working is delivered compared to previous contract. This relies on exception reporting by junior doctors and proactive changes by the Trust to avoid unsafe working. This is done through an electronic system called DRS4 provided by Skills for Health. The previous contract relied on a monitoring process.

The Guardian is required to provide the Board of Directors with quarterly reports. The data on this first report needs to be taken as indicative due to data collections teething problems. No gross safety issues have been raised with the Guardian by any trainee. There have been 10 exceptions raised by junior doctors within Emergency Care which have been resolved without any fines being levied.

Recommendation

Board members are asked to note this first report from the Guardian of Safe Working.

Delivering the Values – We Care

We always put the patient first

- *The 2016 contract is designed to ensure that doctors are working safely and receiving the appropriate training*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity

-

Committed to quality and continuously improving patient experience

- *By having appropriately trained doctors patients will receive a good experience whilst receiving care*

Always caring and compassionate

- *By having appropriately trained doctors patients will receive a good experience whilst receiving care*

Responsible and accountable for our actions – taking pride in our work

-

Encouraging and valuing our diverse staff and rewarding ability and innovation

-

Related Strategic Objectives

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

Analysis of risks

The Guardian for Safe Working and the new contract is designed to ensure that doctors in training are able to access the training within their educational contract by not working excessive service hours. This will ensure they have the appropriate skills to deliver service requirements in the future.

Board Assurance Framework

13	Inability to recruit right staff and ensure staff have the right skills to meet operational needs	4x3=12

QUARTERLY REPORT ON SAFE WORKING HOURS OCT 2016 – DEC 2016: DOCTORS AND DENTISTS IN TRAINING

Introduction

This report sets outs the background and context around the introduction of the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctor contract agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary
- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received as a result of fines for safety breaches.
- Give assurance to the board that doctors are rostered and working safe hours.
- Identify to the board any areas where there are current difficulties maintaining safe working hours.
- Outline to the board any plans already in place to address these
- Highlight to the board any areas of persistent concern which may require a wider, system solution.

The Board will receive a quarterly report from the Guardian, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on rota gaps / staff vacancies/locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern

Other new features of the 2016 contract include:

Work scheduling –junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the

hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement.

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

Requirement for junior doctor forums to be set up - principally these forums will advise the Guardian of safe working who will oversee the processes in the new contract designed to protect junior doctors from being overworked. The Guardian and Director of Medical Education in each Trust and relevant organisation shall jointly enable a nomination/election process to establish a Junior Doctors Forum (or fora) to advise them and make appropriate arrangements to enable the elected representatives time off for their activities & duties in connection with their role. Election onto the forum will be for the period of rotation and replacements must be sought for any vacancies.

Guardian Report

Guardian appointment has been well received by the junior doctors who believe this gives the required independence. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish the role in the Trust and build relationships.

In December 27 junior doctors in the Trust transferred onto the contract. By the end of 2017 all junior doctors will be on the new contract. The table below shows the number of trainee posts available

High level data	
Total number of Junior doctors in DBH	239
Number of posts contracted by DBH	111
Number of posts contracted by DBH filled by trainee doctors	91
Number of posts contracted by DBH vacant or filled by trust doctors	20
Number of posts contracted by other Organisations	128
Number of doctors / dentists in training on 2016 TCS directly employed by DBH:	27
Amount of time available in job plan for guardian to do the role:	2 PAs /per week
Admin support provided to the guardian (if any):	support from P&OD
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

The picture will change over the coming year when all the junior doctors have transitioned onto the new contract. There will be a small number of junior doctors who hold longer contracts will continue on 2002 contract.

a) Exception reports (with regard to working hours)

For this quarter, exception reports have only been submitted by individuals in the Emergency Care Group, it is worth noting that all the individuals who did report exceptions are all scheduled to work on the same rota.This is being looked at by the rota organiser to adjust it to allow headroom for time adjustments

With regards to doctors still on the 2002 contracts there is no hours monitoring information available at present . This does pose a risk to the Trust going forward given any changes to rotas going forward if result in a re-banding of grade and could leave the Trust open to requests of back pay.

The 2002 terms and conditions of service stipulate monitoring must be done twice a year (or once by agreement) so this should be taken in to account. *This is a risk as information on actual working hours for doctors on 2002 contracts is not available. This also poses further risk when these jobs move to new contract in terms of on call pattern and allowed hours.*

Exception reports by Care Group					
Care Group	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	No. exceptions actioned after the 7 day time limit
Emergency Medicine	0	10	10	0	7
Total	0	10	10	0	7

b) Work schedule reviews

There are no formal work schedule reviews required for this quarter.

c) Locum and bank usage

	October	**November**	**December**	**Quarter**
Agency - Medical	**627,673**	**586,742**	**234,642**	**1,449,056**
Accident and Emergency Department	**245,606**	**244,510**	**145,863**	**635,980**
Senior House Officer	50,580	38,855	38,587	128,021
Specialist Registrars	-12,411	32,649	-4,279	15,959
Staff Grade	207,437	173,006	111,556	492,000
Anaesthetics, Critical Care & Pain Management	**11,308**	**15,978**	**18,940**	**46,225**
Senior House Officer	1,548	2,053	636	4,237
Specialist Registrars	879	6,241	8,447	15,567
Staff Grade	8,881	7,683	9,857	26,421
Breast			**10,017**	**10,017**

Senior House Officer			10,017	10,017
Cardiology	**15,296**	**23,773**	**10,519**	**49,588**
Senior House Officer	2,025	8,411	-7,456	2,980
Specialist Registrars	13,271	15,362	17,975	46,608
Care of the Elderly/Rehabilitation	**598**	**-598**		**0**
Senior House Officer	598	-598		0
Childrens	**56,949**	**24,192**	**11,738**	**92,880**
Associate Specialist			0	0
Senior House Officer	27,058	30,820	2,504	60,382
Specialist Registrars	6,215	-5,036	2,753	3,932
Staff Grade	23,676	-1,592	6,481	28,566
Diabetes & Endocrinology	**12,197**	**11,274**	**-19,200**	**4,271**
Specialist Registrars	12,197	11,274	-19,200	4,271
Emergency Medicine	**46,281**	**19,823**	**13,199**	**79,303**
Senior House Officer	36,920	3,475	14,531	54,926
Specialist Registrars	9,361	16,349	-1,332	24,377
ENT	**-2,611**	**27,123**	**66,937**	**91,449**
Senior House Officer	-11,778	27,123	66,937	82,282
Specialist Registrars	3,690		0	3,690
Staff Grade	5,477	0		5,477
Gastro Intestinal Surgery	**-88**	**41,240**	**21,802**	**62,954**
Associate Specialist	2,766	19,430	13,806	36,002
House Officer		0		0
Senior House Officer	-2,853	14,017	-7,856	3,308
Staff Grade		7,793	15,851	23,644
Ophthalmology		**5,404**	**1,076**	**6,480**
Staff Grade		5,404	1,076	6,480
Pathology			**0**	**0**
Staff Grade			0	0
Trauma & Orthopaedics	**112,848**	**105,158**	**-36,486**	**181,520**
Senior House Officer	112,848	105,158	-36,486	181,520
Specialist Registrars		0		0
Urology	**0**	**0**	**12,689**	**12,689**
Specialist Registrars			8,489	8,489
Staff Grade	0	0	4,200	4,200
Womens & Maternity	**129,288**	**68,864**	**-22,452**	**175,700**
Senior House Officer	42,986	7,340	19,910	70,237
Specialist Registrars	3,023	3,530	5,750	12,303
Staff Grade	83,278	57,994	-48,112	93,160
Medical Bank Staff	**53,182**	**38,685**	**53,813**	**145,680**
Accident and Emergency Department	**16,441**	**11,878**	**22,899**	**51,218**
Senior House Officer	8,452	8,061	7,625	24,138
Specialist Registrars	7,989	565		8,554
Staff Grade		3,252	15,274	18,526
Breast	**8,875**			**8,875**
Specialist Registrars	8,875			8,875

Childrens	**3,058**	**3,693**	**1,769**	**8,521**
Senior House Officer		3,693	1,769	5,462
Specialist Registrars	3,058			3,058
Emergency Medicine	**6,705**	**13,127**	**12,058**	**31,891**
Senior House Officer			1,998	1,998
Specialist Registrars	6,705	13,127	10,060	29,893
Gastro Intestinal Surgery		**7,877**	**4,247**	**12,124**
Associate Specialist		7,877	4,247	12,124
Ophthalmology	**11,335**	**2,110**	**2,850**	**16,295**
Specialist Registrars	11,335			11,335
Staff Grade		2,110	2,850	4,960
Trauma & Orthopaedics	**6,767**		**3,075**	**9,842**
Senior House Officer	6,767		3,075	9,842
Womens & Maternity			**6,915**	**6,915**
Staff Grade			6,915	6,915
Grand Total	**680,855**	**625,427**	**288,455**	**1,594,736**

The figures on this table should be taken as indicative only as management accounts are unable to provide figures for actual usage due to billing being done in different months and coding errors. Detailed drill down on reasons for bookings is not available ,but efforts are being made to collect this information.

d) Locum work carried out by trainees

This data is not available as the trust does not collect this. I understand efforts are being made to collect this information.

e) Vacancies

Some data on vacancies by department is provided. Unfortunately the Trust currently has no establishment control systems in place, therefore at present we cannot confirm if vacancies are filled with Trust Grade staff or confirm funding of trainee posts.

Total Vacancies for posts contracted by DBH		
Department	Grade	Vacancy
Emergency Medicine	GP Trainee	8
Emergency Medicine	F2	1
General Surgery	GP Trainee	3
Head and Neck	GP Trainee	2
Trauma and Orthopaedics	GP Trainee	2
Children's	GP Trainee	1
Women's and Maternity	GP Trainee	2
Surgery (Breast)	GP Trainee	1
Total		20

f) **Fines**

No fines have been levied in this quarter. The table below will detail any fines collected and disbursed in future reports.

Fines by department		
Department	Number of fines levied	Value of fines levied
	0	£
	0	£
Total	0	£0

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0.00	£0.00	£0.00

Qualitative information

It is reassuring that no instance of unsafe working has been brought to my notice by junior doctors on 2002 or the 2016 contract.2 instances of missing training opportunities due to service commitments have been highlighted and progressed to educational supervisors to remedy.

I have been assured by medical staffing department that all doctors are rostered on a rota which is compliant with 2002 and 2016 contracts as applicable.

Engagement

Engagement with the junior doctor workforce has been difficult due to the fact that the majority of them associate the guardian role with the new contract, to which many are still opposed. Since November there have been a number of engagement events for junior doctors, including:

Attendance at junior doctors' induction day and attendance at junior doctors training session. 2 junior doctors have agreed to join the forthcoming LNC meeting which will establish the junior doctors' forum.

Engagement with the Educational Supervisors (ES) has also been challenging as the national team were unable to provide any training or standard information for ES until late December. Guardian held training session for ES which is recorded and available through trust intranet.

Software System

The Trust uses a nationally procured system for medical staff rotas called the Doctors Rostering System 4, which is the system now used for exception reporting. There have been significant problems and delays in getting the system live and we were unable to test this out until the day before the first doctors transferred onto the new contract. Each junior doctor on the new contract has been given log in details and been registered on the system in order to submit an exception report as necessary. The Educational Supervisors have also

been registered and set up on the system. This process has to happen with each rotation. All exception reports, once seen and signed off by the supervisor go to a central inbox monitored by the Guardian, the Director of Medical Education (DME) and the Administrator.

The DRS4 does not 'speak' to payroll and as a result all requests for additional payment for hours worked have to be administered manually.

Workload

Due to the complexity of this implementation and the amount of administration associated with introducing and administering the new contract, some help has been provided through Director of POD.

The new contract does have workload implications for both educational and clinical supervisors when a trainee submits an exception report. The amount of time will depend on the number of exception reports submitted and it is too early to make a judgement about this currently.

Issues arising & Actions

1. The IT system to report and approve exception reports are provided by 2 suppliers. We are currently using DRS4 .This was free but there is going to be a charge going forwards. Trust will need to evaluate the benefits of moving to Allocate which supplies rest of the trust's erostering or to keep with DRS4 .One of the features of new contract is to limit maximum hours worked, unless the junior doctors are on erostering which is linked to exception reporting ,it's difficult to extract this data. Currently junior doctor rostering is manual and checked for compliance on an electronic system.This is being looked at actively by Director of POD
2. It will be a good idea to monitor to make sure the rota works as expected, especially if it has been changed to meet the 2016 rota rules. Monitoring the rota might help to show junior doctors that the rota is working safely and that DBH take their safe working seriously.
3. Adequate administrative support will be required going forwards. I am assured by Director of POD that this is being taken forward.
4. The data required to draw assurance about safe working of all junior doctors is currently lacking. As this was a new requirement, better information and analysis should allow this to happen in future reports.

Recommendation

1. The Board are asked to read and note this first report from the Guardian of Safe Working

2. The Board are asked to encourage clinical managers, directorate managers and educational and clinical supervisors to be aware of their responsibilities within the new contract, in particular that payment or time in lieu, for additional hours worked should be the exception rather than the rule.

3. Board should expect the trust to monitor the hours for junior doctors on 2002 contract as its contractually binding. Monitoring the rota might help to show junior doctors that the rota is working safely and that DBH take their safe working seriously.

Dr Jayant Dugar
Guardian for Safe Working
Appendix:
Board Slide Pack


Board_briefing_slides
_on_the_role_of_the

Junior doctors
The new 2016 contract

NHS Employers

2016 Terms and conditions of service: Guardians of safe working hours

Jayant Dugar
Guardian for safe working for junior doctors
Doncaster and Bassetlaw Teaching Hospitals NHS Trust

NHS Employers

Safe working hours

- Current twice-yearly monitoring mechanism under the old contract was not a good measure of rota safety.
- Penalty bandings meant that health and safety issues were unhelpfully conflated with pay, creating pay disputes and preventing issues from being resolved.
- The BMA, Department and Health and NHS Employers all agreed a new system was needed – and a system of work scheduling and exception reporting was agreed in 2013/14 negotiations.

NHS Employers

Safe working hours

- The new contract ended the hours monitoring system and replaced it with work schedules and exception reports.
- Work schedules set out the work that doctors in training are expected to do, and the training they can expect to receive.
- When a doctor's work exceeds that set out in the work schedule, they can raise an exception report highlighting the risk to safe working hours.
- The employer then responds to that report by adjusting the doctor's hours to ensure that they remain safe.

NHS Employers

Why do we need a guardian?

- Junior doctors concerned that employers would not act on exception reports and that managers would not be interested in what they showed.

- It was agreed that there should be an independent person responsible for championing safe working hours.

NHS Employers

The role of the guardian

- The role of the guardian of safe working hours is to reassure junior doctors and employers that rotas and working hours are safe for doctors and patients.

- The guardian is the champion of safe working hours and a backstop if normal processes haven’t resolved an issue.

- The guardian is copied in to all exception reports so they can fulfil their oversight role and escalate things as necessary, but is not expected to be involved in every issue.

NHS Employers

The role of the guardian

- The guardian oversees the work schedule review process and seeks to address concerns relating to hours worked and access to training opportunities.

- The guardian supports safe care for patients through protection and prevention measures to stop doctors working excessive hours.

- The guardian has the power to levy financial penalties against departments where safe working hours are breached.

NHS Employers

The role of the guardian

- The guardian will provide regular and timely reports to the board on the safety of doctors' working hours.
- The guardian will report annually on improvement plans to resolve rota gaps.
- This information will be incorporated into the trust’s quality accounts and made available to the regulators.

NHS Employers

The guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary.

NHS Employers

The guardian will:

- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received as a result of fines for safety breaches.
- Provide assurance on safe working and compliance with TCS.

NHS Employers

Distinction between roles

- The guardian is not responsible for education and training, this remains the role of the DME.
- The guardian role does not replace the role of educational supervisors.
- The guardian of safe working hours should not be confused with other guardian roles such as the Caldicott guardian or Freedom to Speak up guardian.

NHS Employers

Quarterly reporting

The Board will receive a quarterly report from the guardian, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on rota gaps / staff vacancies.
- Data on locum usage.
- Other data deemed to be relevant by the guardian.
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

NHS Employers

Quarterly reporting

The guardian will use the quarterly report to:

- Give assurance to the board that doctors are rostered and working safe hours.
- Identify to the board any areas where there are current difficulties maintaining safe working hours.
- Outline to the board any plans already in place to address these
- Highlight to the board any areas of persistent concern which may required a wider, system solution.

NHS Employers

Other reporting processes

- The guardian may identify issues which cannot be resolved at a local level, and should inform the Board of such issues as they arise.

- The guardian will produce a consolidated annual report on rota gaps and the plan for improvement, and is responsible for providing this to external national bodies.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Complaints, Concerns, Comments and Compliments Quarterly Report – Q3 2016/17**		
Report to:	**Board of Directors**	Date:	**31 January 2017**
Author:	**Moira Hardy – Acting Director of Nursing, Midwifery and Quality** **Rick Dickinson – Acting Deputy Director of Nursing, Midwifery and Quality**		
For:	**Discussion**		

Purpose of Paper: Executive Summary containing key messages and issues

This report provides the Board of Directors with information relating to Quarter 3 performance using the information available from Datix and the learning points from the organisation.

Recommendation

The Board of Directors is asked to NOTE and SUPPORT the developments of the implementation of the revised policies and procedures.

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

We always put the patient first

- *By listening and responding to their concerns and feedback*

Everyone counts – we treat each other with courtesy, honesty, respect and dignity

- *By providing proportionate investigation and response to complaints raised to us*

Committed to quality and continuously improving patient experience

- *By improving our methods of identifying the aspects of learning from each contact made.*

Always caring and compassionate

- *By supporting people to feedback their concerns without fear of repercussions.*

Responsible and accountable for our actions – taking pride in our work

- *By ensuring that actions and improvements are evidenced.*

Encouraging and valuing our diverse staff and rewarding ability and innovation

- *By supporting teams to make improvements to the quality of care.*

Related Strategic Objectives

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

Analysis of risks

Risks to Trust reputation from patients, the public and potential loss of confidence in their local health services.

Board Assurance Framework

9	Failure to achieve compliance with performance and delivery aspects of Monitor Risk Assessment Framework, CQC and other regulatory standards, triggering regulatory action	4 x 4 =16

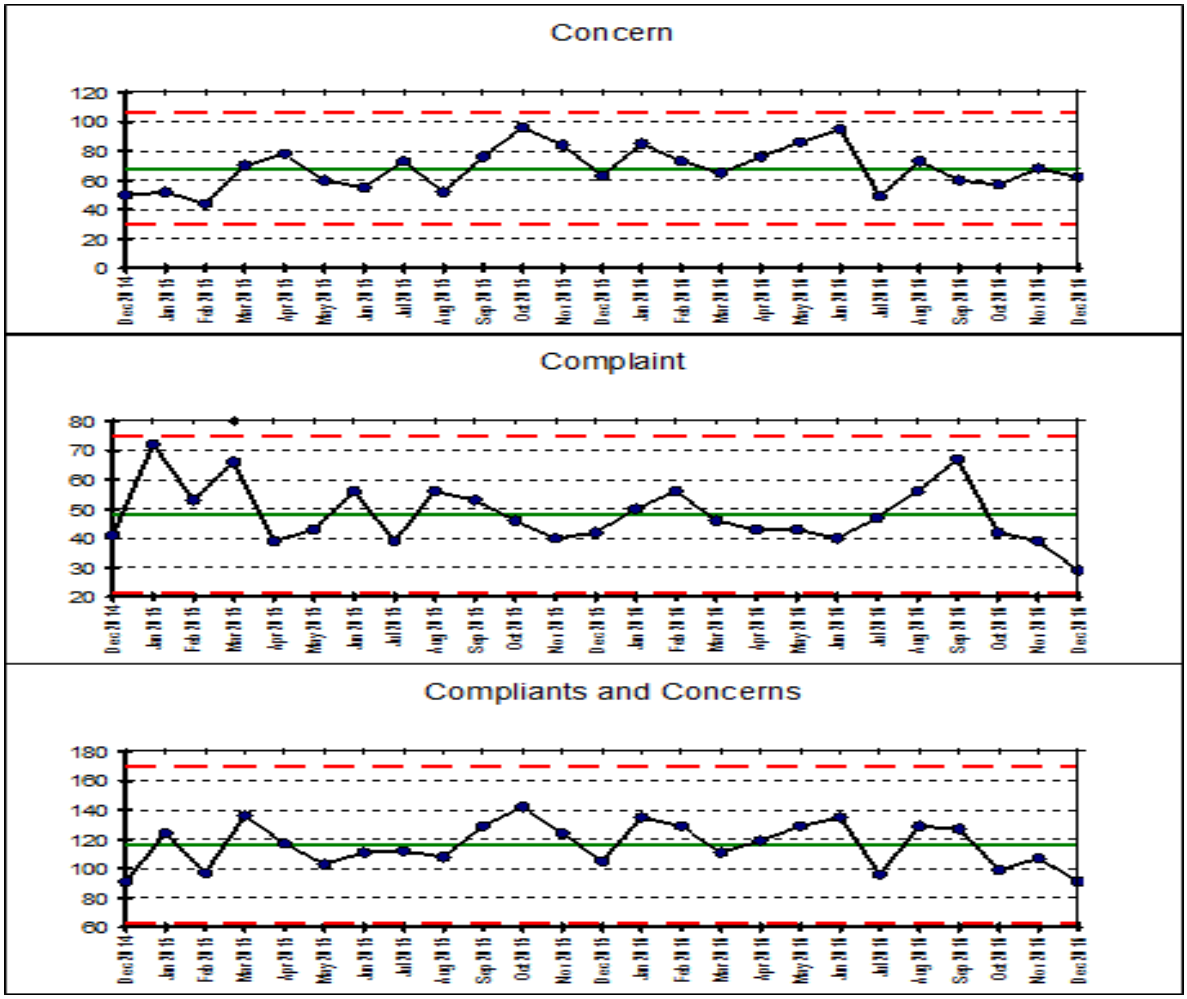
COMPLAINTS, CONCERNS, COMMENTS AND COMPLIMENTS – Q3 2016-17 REPORT

1. INTRODUCTION

This paper provides the Board of Directors with information relating to the Trusts performance against the standards identified in the Trusts policy; *complaints, concerns, comments and compliments; resolution and learning*.

2. COMPLAINTS AND CONCERNS RECEIVED

The statistical process control (SPC) charts below show the trend in complaints and concerns in total, and separately, from December 2014 to December 2016. These charts illustrate normal variation and fluctuations within expected limits. More recent data may be indicating a movement towards the active management of concerns with a reciprocal reduction in formal complaints; however more data points are needed to confirm this trend.

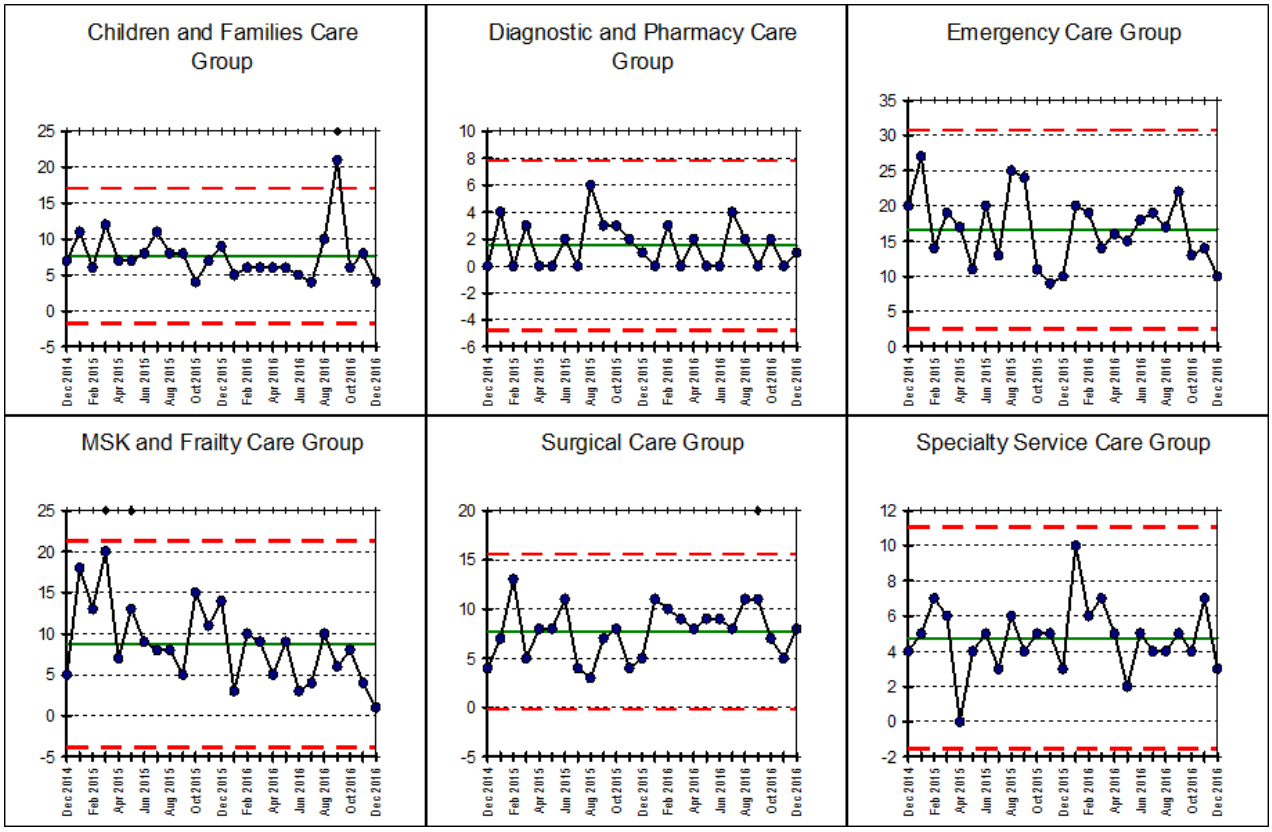


2.1. COMPLAINTS & CONCERNS BY MANAGEMENT TEAM

The table below shows the Care Group rate of complaints and concerns for the last quarter.

Q3 care group and corporate directorate summary	Concern	Complaint	Total
Emergency Care Group	31	37	68
Surgical Care Group	37	20	57
Chief Operating Officer	35	1	36
Children and Families Care Group	17	18	35
Specialty Service Care Group	21	14	35
MSK and Frailty Care Group	12	13	25
Directorate of Finance and Infrastructure (incl Estates)	18	2	20
Diagnostic and Pharmacy Care Group	14	3	17
Directorate of Nursing and Quality	2	2	4
Total	187	110	297

The charts below illustrate the trend for complaints within Care Groups and it is evident that there is normal variation over the Q3 2016/17. The Children and Families Care Group and Surgical Care Group had higher rates of complaint in September, and have since returned to normal variation. Investigation of the cause for the rise associated with surgery is partially correlating with the timing of Bassetlaw site service changes. Otherwise, no specific cause or pattern could be identified.



3. TOP 10 REASONS CITED IN A COMPLAINT

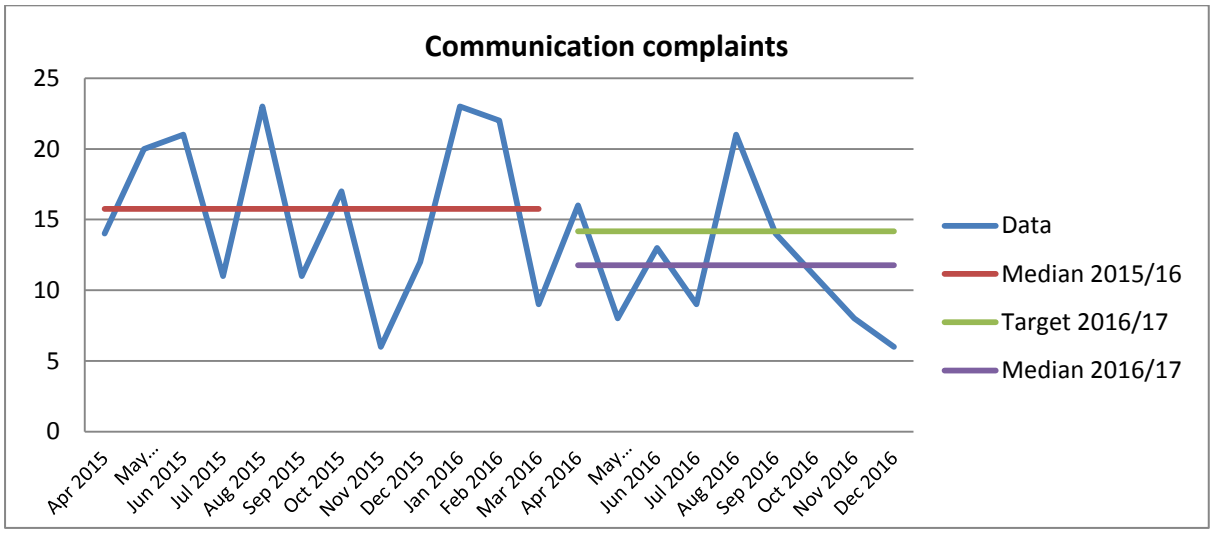
The following table lists the top 10 themes identified from complaints and concerns for the period from October – December 2016. More than one issue can be identified for each complaint and this data is based on the number of issues, rather than the number of complaints. The arrows indicate change from the last quarter period.

	Chief Operating Officer	Families Care Group	Pharmacy Care Group	Finance and Infrastructure (incl Estates)	Nursing and Quality	Emergency Care Group	MSK and Frailty Care Group	Specialty Service Care Group	Surgical Care Group	GRAND TOTAL
Communication ↑	8	6	5	3		21	5	13	18	79
Admissions / transfers / discharge procedure / Sleeper out ↓	15	5	2	1		7	10	8	15	63
Staff Attitude and Behaviour →		9	6	1		15	6	8	11	56
Diagnosis ↑		4	3			17	2	3	7	36
Treatment ↓		5		1		7	3	3	4	23
Medical records ↑	9	4	2			1			2	18
Other ↑		2	1	6	1	1		1	4	16
Diagnostic Tests ↑		2	2			9		3		16

Competence ➔	3	1				4		2	3	13
Hospital environment ➘			2	8		1			1	12

3.1. COMMUNICATION COMPLAINTS

The Trust set an objective of reducing the number of complaints about communication by 10% for the quality account for 2016/17. The chart below illustrates that this is being achieved at the end of Quarter 3.



3.2. STAFF ATTITUDE AND BEHAVIOUR

The Trust set an objective of reducing the number of complaints about staff attitude and behaviour by 10% for the quality account for 2016/17. The chart below illustrates that this is being achieved at the end of Quarter 3.

3.3. RISK CATEGORISATION OF COMPLAINTS

The table below illustrates the distribution of risk on complaints over each quarter. The timescale for investigation for Low risk cases is typically 20 days, Moderate risk is 40 days and High risk is 90 days. Performance against these standards is reported monthly in the BIR.

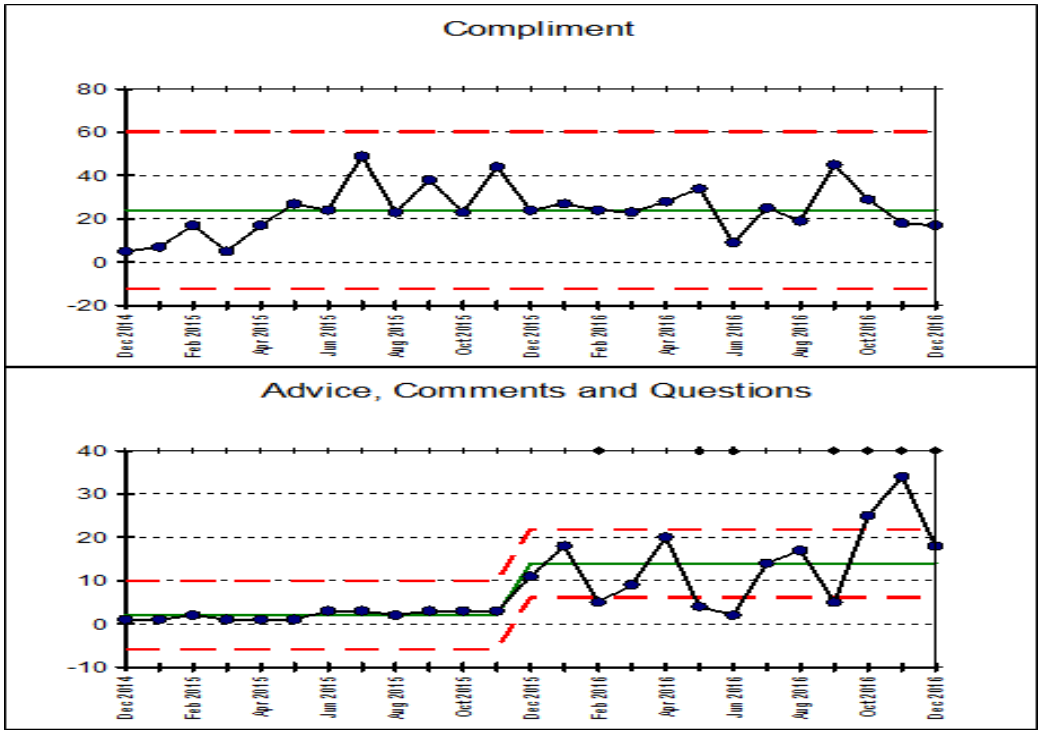
	Low risk	Medium risk	High risk	Total
Apr 2016	21	21	1	43
May 2016	24	18	1	43
Jun 2016	25	13	2	40
Jul 2016	35	12	0	47
Aug 2016	42	12	2	56
Sep 2016	44	20	3	67
Oct 2016	26	16	0	42
Nov 2016	20	17	2	39
Dec 2016	21	7	1	29
Total	258	136	12	406

4. COMPLAINT REPLY PERFORMANCE

Clearing historical cases at a greater rate than the rate of new complaints is a key aim of improving the handling and management of complaints. Supportive interventions from the Patient Experience Team, to help improve processes are being taken forward with each Care Group Head of Nursing/Midwifery/Therapies and the Clinical Governance Lead in Diagnostic and Pharmacy Care Group. This method has increased the productivity of Care Groups and there is a gradual reduction of overdue complaints seen in the weekly reports complaint tracking reports. The performance against the reply performance is reported monthly in the BIR.

5. COMPLIMENTS/ ADVICE, COMMENTS & QUESTIONS

This data relates to the number of other contacts & compliments sent to the Patient Experience Team, or passed on from wards and departments in quarter. This shows normal variation in compliments being made. The rate of advice, comments and questions has increased with changes made in the Patient Experience Team capturing more of their contacts, which are resolved by the team. The recent rise in the last quarter is due to some system changes with processes and staff duties enabling more accurate capture of data.



6. PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

The PHSO has reported on Q1 and Q2 2016/17 in November 2016. This data is shown below with 2015/16 data. The rate of upheld complaints is lower than the national average.

	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Total
Complaints we received	9	6	11	11	9	7	53
Complaints we accepted for investigation	4	2	2	4	3	1	16
Investigations we fully or partly upheld	1	0	2	2	0	1	6
Investigations we didn't uphold	0	1	1	0	3	3	8
Investigations discontinued or resolved without a finding	0	0	1	0	0	0	1
Upheld rate (National rate for this data is 42.22%)							37.50%

There are currently 6 active investigations with the PHSO. For the period of Quarter 3:

- 4 complaints were accepted for investigation by the PHSO
- Outcomes of investigations:
  - 0 complaint was partly or fully upheld
  - 2 complaints were not upheld

N.B. Trust data may not show the number of enquiries received by the PHSO, as the PHSO does not always involve the Trust.

7. LEARNING FROM COMPLAINTS AND IMPROVING PATIENT EXPERIENCE

Surgical Care Group

In General Surgery a Named Consultant system for patients with recurrent Volvulus who may be admitted multiple times under differing Consultants has been introduced. The Consultant is informed of each patient attendance via Surgical Assessment Ward (SAW) and also provides a consistent management plan to be put in place, providing continuity and Outpatient follow up with the same Consultant.

Shared learning in terms of involving community Learning Disability (LD) liaison nurses at BDGH and DRI in the outpatient clinic appointments for patients with a Learning Disability who may have a recurring Gastro-intestinal or Colorectal condition related to their Learning Disability or Autism. When earlier engagement takes place, then proactive plans in terms of the patient's conservative management can be agreed with the patient, carers, GP and community LD staff, thereby reducing recurrent admissions and recurrent GP attendances. This has also built up good working relationships between LD liaison nurses and the General Surgeons, providing them with improved access to clinicians in a timely manner to either avoid a hospital admission or expedite a timely OPD / Surgical Assessment Unit (SAU) review.

Specialty Services Care Group

The Care Group focusses on the handling of complaints/concerns with maximum efficiency and aims for a satisfactory outcome by applying a robust process that involves working closely with the Patient Experience Team (PET), making personal contact with complainants and signposting complaints correctly to ensure they are addressed as soon as possible. The Care Group undertakes regular review of patient experience at clinical governance meetings identifying recurring themes/patterns and utilises the Friends and Family Test results addressing any areas of concern as soon as possible.

Areas of learning where the Care Group have implemented change in practice:

1. Following an incident where the wrong patient's notes were accessed resulting in an incorrect diagnosis being given, the Care Group have aimed to improve communication by using a process of positive identification (name, address and date of birth) prior to any consultation when identifying patients and also checking patient understanding.

2. Flowtron Boots on Ward 16 Stroke Specialty – Following a complaint/serious concern we have reviewed the assessment and application of anticoagulation and the application of flowtron boots for Stroke patients in all settings - DRI and Montagu Hospital.

3. Following a complaint related to IV antibiotics not being completely infused, as the volume of fluid delivery was not recalculated following the addition of the antibiotic to the bag of IV fluid, this has been raised Trust wide as it has many implications.

4. Following a patient fall we added an extra column to records to include a tick box reminder to complete and review risk assessments on transfer of all new patients. Physiotherapy now attend the board rounds and all new patients are highlighted to them. Physiotherapy notes have been added to the white episode of care folders.

5. After a complaint we changed practice in cardiology at Bassetlaw to ensure all new patients have a 12 lead ECG on admission and if symptomatic, this is recorded on coloured paper, dated and signed and must be seen by the nurse in charge.

Families and Children Care Group

Maternity have changed how women are admitted for induction of labour. Women fed back that they were expected to telephone the unit at 07.00 and were frequently told that it was too early to ring as the unit didn't have a full picture of activity. Women are now prioritised according to complexity and they call at approximately 10.00 to be given an admission time.

Paediatrics - Care group learning was achieved by a case at medical audit on both sites, with a presentation by the doctor involved in an assessment error. Consultant led training on new-born baby checks on medical induction uses a patients experience example of a complaint, so that the doctors are not to be falsely reassured by the presence of meconium indicating the child has a patent anus.

Emergency Care Group

The Care Group are utilising every opportunity, face to face, Care Group and team meetings to highlight the importance of good communication across the Care Group and within FDASS. This builds on the work they have already undertaken via a newsletter to all staff in the Care Group, which continues to be published and disseminated monthly highlighting learning from experience.

The hearing aid loop has been reintroduced in FDASS as this was not replaced in the refurbishment of the department.

MSK and Frailty Care Group

The Care Group held a competition for the best patient experience board displayed at the entrance to the ward. The aim was to use a corporate template for 'You Said, We Did' using FFT feedback or complaints, concerns and compliments and the winning ward was Mallard.

A Care Group newsletter has also been introduced to share the top 10 themes, of which 'Thank You' is consistently the number one patient experience code used for MSK&F. Staff really appreciate the balance of what they are doing well and where they need to learn.

The Senior Sisters meeting has a standard agenda item for each sister to present their FFT data and comments and QM for the month to share learning within the Care Group.

Diagnostics and Pharmacy Care Group

Diagnostics and pharmacy outpatient clinics

Bassetlaw main OPD, MMH OPD and Medical OPD DRI undertake the OPD patient experience survey on a monthly basis, which is used to inform learning and the annual report and presentation for the care group. Other patient feedback for OPD areas is in the form of FFT, which is reported to the relevant care groups.

Diagnostics and pharmacy outpatient clinics have very few complaints and these are usually resolved at first line within the department.

Pharmacy

Similarly pharmacy receives very few complaints and these are generally resolved first line within the department.

Pathology

CCTV has been installed in the mortuary area following complaints about the "loss" of a piece of jewellery which was not logged as being on the body and another event where an unidentified woman viewed a deceased. Pathology staff do not control access to the area outside their normal working hours and, if necessary, the CCTV will provide evidence to help establish who visited an individual and who was present at any events occurring in the mortuary area.

Medical imaging

Medical Imaging has introduced the patient experience survey in Interventional Radiology and this is being rolled out across all sites and modalities. The Radiology Discrepancy / QA meeting is intended as an educational tool to review misses and interpretational errors and facilitate learning from mistakes. As this process becomes more resilient and embedded across the service, there has been increased engagement from Consultant Radiologists when handling complaints that require a review of imaging, resulting in increased attendance at face to face complaint resolution meetings, in order to demonstrate image findings when concerns have been raised.

Diagnostic and Pharmacy Care group-General

As a result of general concerns regarding staff attitude across the care group, a patient experience focused training session has been developed targeting all disciplines and grades of staff. This training also includes tier 1 dementia training.

8. PATIENT EXPERIENCE AND ENGAGEMENT COMMITTEE

The terms of reference have been revised and approved by the Clinical Governance and Quality Committee. The December 2016 meeting was cancelled due to quoracy, with January 2017 meeting scheduled for 27/01/2017.

9. RECOMMENDATION

The Board of Directors is asked to NOTE the Quarter 3 Complaints, Concerns and Compliments Report.

DONCASTER & BASSETLAW HOSPITALS NHS FOUNDATION TRUST

Minutes of the Financial Oversight Committee Meeting
held at 9am on Monday 19 December 2016
in Boardroom, DRI

PRESENT	:	John Parker, Non-executive Director (Chair) David Crowe, Non-executive Director Philippe Serna, Non-executive Director
IN ATTENDANCE	:	Jonathan Sargeant, Director of Finance Andrew Thomas, Finance Programme Director Marie Purdue, Deputy Director Strategy & Improvement Matthew Kane, Trust Board Secretary Angela O'Mara, Exec Team PA
GOVERNOR OBSERVER:		Bev Marshall, Public Governor
WORKSTREAMS	:	Sewa Singh, SRO Medical Productivity Workstream Kirsty Edmondson-Jones, SRO Infrastructure Workstream

Action

Apologies for Absence

16/12/1 Apologies were received from Dawn Jarvis.

Welcome and Introductions

16/12/2 Introductions were made around the table.

Minutes of the previous meeting

16/12/3 The minutes of the meeting held on 7 November were APPROVED as a true record of the meeting subject to the following amendment:

16/12/4 16/11/27 – Philip Serna to read Philippe Serna.

Matters arising

16/12/5 John Parker advised the Committee of his intention to remain as Chair until 31 March 2017 and as a result it was suggested the review of the Committee effectiveness be delayed. The Trust Board Secretary advised that a review of all terms of reference was planned for February/March.

16/12/6 16/11/21 - It was agreed any potential impact of the CIPs on quality would be reviewed after the financial year end. The action notes were reviewed and updated. **DP**

Medical Productivity Workstream Update

16/12/7 The Committee were briefed by the workstream SRO, Sewa Singh, on the current position. In view of the delays experienced with job planning, the end of year target had been revised and now stood at 257k. The year to date saving as at November 2016 was reported at 167k, 16k behind the original plan but 41k ahead of the revised target.

16/12/8 A small number of points were still to be agreed on job planning guidance, however, a position had been reached where draft guidance had been jointly circulated to all consultants from the Medical Director and the LNC. The Trust and LNC would each present their view on the points where agreement had not been reached.

16/12/9 In response to questions from the Committee, Sewa Singh confirmed that the major programme of activities were agreed, outstanding items included allocated time for clinical admin, remuneration for out of Trust work and LNC activities.

16/12/10 In response to a question from David Crowe an update was provided on job planning progress by speciality. The three delayed areas of Obstetrics & Gynae, Trauma & Orthopaedics and Paediatrics related to revisions to current service models which needed to be defined before agreement could be reached.

16/12/11 In response to a question from Philippe Serna it was confirmed that the original savings estimate was based on a percentage of total spend on medical consultants which had subsequently been developed as the demand and capacity work progressed. Delays experienced had been factored into the year-end target and significant savings on a full year effect were still expected.

16/12/12 Demand and capacity assessments had now been completed in 10 specialties, the MRM software package procured by the Trust and General and Business Managers were trained to support this practice moving forwards. This would allow the support previously offered by Kingsgate to be replicated as an in house, business as usual, function.

16/12/13 In answer to a query from David Crowe with regards to the level of support provided via Kingsgate it was confirmed that the Trust analyst and HR support was progressing and there was no requirement to continue with the external HR guidance offered by Dearden. Additional internal support was also in place following the appointment of Mr Pillay as Deputy Medical Director who would take on the role of Clinical Lead for the workstream in January 2017.

16/12/14 The Medical Productivity workstream updated was NOTED.

Infrastructure Workstream Update

16/12/15 Kirsty Edmondson-Jones, workstream SRO and Director of Estates and Facilities provided an update of the progress to date. The Committee were advised the transport strand had been removed from this year's programme and would now be scheduled for 17/18.

16/12/16 Service Assistants Review – following completion of the 1:1 discussions with colleagues the majority of staff had agreed revised working arrangements. The

remaining eleven staff members had been issued with termination and re-engagement letters. In response to a question from David Crowe it was confirmed all reasonable efforts had been taken to reach an agreement and an option to continue discussions remained available.

16/12/17 HSDU Tender – the Committee were advised that a recent assessment of activity using private sector costs identified an increased cost as compared to current practice. As a result a need to ensure a true level of fast track activity, along with work to rationalise trays and procure additional instruments was noted. The Committee were advised that a further business case would be required to progress this activity as the initial submission was an outline case only with no public sector comparison. A wider discussion took place around the process followed to date and the necessary controls and governance required to ensure appropriate assurance was offered.

16/12/18 Catering – in response to the update provided the Committee questioned the impact of patient only catering bids when both staff and patient catering were currently provided from the same kitchen. A discussion took place around potential issues, options and transitional arrangements required. A meeting with the preferred bidder was scheduled for later in the week when these matters would be explored. The Director of Finance requested his involvement in the process moving forwards, alongside his colleagues in Procurement.

16/12/19 In addition to the potential savings the Chair also emphasised the need to ensure the quality of produce supplied. Kirsty Edmondson Jones confirmed plans to assess this would include taste tests for a cross section of staff and patients. From a pricing perspective the Chair shared his view of potential repercussions should significant cost increases for staff be introduced.

16/12/20 The need to ensure suitability across all sites and service areas was also noted by Bev Marshall. Kirsty Edmondson-Jones recognised the need for a flexible approach in areas such as paediatrics and frailty and the potential to maintain a traditional cook method in these areas would be explored.

16/12/21 Car parking - a decision regarding concessional charges and eligibility had now been agreed with 40% reduction offered to those colleagues who work at or below 0.6WTE or whose salary sits below the mid-point of band 3 (up to pay point 9). A resultant increase in availability of public parking and associated income at DRI was seen as a positive following the introduction of permits and enforcement.

16/12/22 In view of the dynamic nature of this workstream it was agreed that Kirsty Edmondson – Jones would return to provide an update after the financial year end. **KEJ**

The Infrastructure workstream update was NOTED.

Turnaround and Cost Improvement Report

16/12/23 Marie Purdue, Deputy Director of Strategy & Improvement, provided an update to the Committee. CIP delivery in M8 was reported at 177k behind plan and

305k behind stretch, with a year to date position of 628k ahead of plan but below stretch. An improved position in M9 was anticipated, although a step change had been expected as a result of the savings that had already been achieved to date.

16/12/24 Work to identify 17/18 CIPs was already underway, a target of 12m had been agreed with a focus on transformational schemes. The 6m savings for new activities were identified as opportunities only at this stage with further scoping work required. The team continue to work closely with finance with final sign off being secured by all relevant parties as part of the Quality Impact Assessment process.

16/12/25 In terms of the impact on quality, Philippe Serna reinforced the view that there should be no negative quality impact as part of the CIPs and whilst there had been no evidence to confirm this in the quality measures presented at Board a means to review this was required. Marie Purdue confirmed that this was considered on an ongoing basis but also reviewed as part of an annual check. Should the Non-Executive Director require confirmation of this an offer to review the necessary documentation was made.

16/12/26 Moving forward a review of the workstreams would take place to ensure appropriate descriptors, structure and a relevant level of oversight was in place.

16/12/27 A difference in the 17/18 Infrastructure CIP between the Strategy and Improvement update and the workstream presentation was highlighted by Philippe Serna. Marie Purdue gave an undertaking to review this in order that the Committee could be updated at the next meeting. **MPu**

The Turnaround and Cost Improvement update was NOTED.

Escalation items from workstreams

16/12/28 None were noted; those of concern had attended today to provide updates.

Minutes of the Turnaround Programme Board Meeting

The minutes of the Turnaround Programme Board meeting held on 8 November 2016 were NOTED.

Finance and Cash Report (Month 8)

16/12/29 Jon Sargeant briefed the Committee on month 8 finance position which saw a favourable variance against plan of 4.6m. The reported financial position noted a 11.5m deficit. Recent correspondence from NHSI notifying of their intention to match fund pound for pound where Trusts had met their control totals would positively impact on the Trust and a year-end deficit of just below 10m was anticipated. It was agreed that a copy of the letter would be circulated to the Committee for their information. In addition to this a further distribution of funds may be seen at the end of the year for those Trusts who expected to meet their control totals and did not. These funds cannot be spent but would reduce cash borrowing. **JS**

16/12/30 Control totals for 17/18 and 18/19 had been agreed at 16.1m and 11.4m respectively.

16/12/31 The Director of Finance reported the meeting with a neighbouring provider had now taken place. A detailed discussion around supplies/activity had taken place but evidence had been difficult to validate. Moving forward a revised approach to supply and stock control would be introduced, this would allow a more accurate indication of costs vs contract payment to be gauged. Going forward the provider had indicated an intention to consider future expansion plans.

16/12/32 In respect of the previously supplied list of debtors it was confirmed that work was ongoing to progress these.

16/12/33 In response to a question from the Chair with regards to the performance of HOLT it was felt too early to comment. An enhanced fill rate had been seen, reduced management fees noted and in the main provision was at a reasonable price with any anomalies being reviewed by the Chief Operating Officer. Unless further pressure was seen from the agency cap it was suggested this should be reviewed in a couple of months.

16/12/34 The Committee were advised that the Corporate Investment Group process was now in place for review of capital business cases.

The finance report was NOTED.

New Finance Ledger

16/12/35 The Committee were presented with a paper summarising the implementation of a new finance and procurement system with an anticipated go-live date of 3 April 2017. The project was being led by Project Manager, Anjam Fiaz. The system would introduce a strong Procure to Pay system, improved MI reporting, including board reports, balance sheet reporting and an improved speed for month end processes.

16/12/36 A discussion took place around the most appropriate committee to receive the papers, which from a process perspective was felt to be ANCR, however, as the terms of reference would impact directly on finance colleagues and resultant outputs it was acknowledged this was relevant to this Committee too and in the interim an element of crossover was likely to be seen.

The New Finance Ledger Report was NOTED.

Purchase to Pay (P2P) Process Issues

16/12/37 Following the update at the last Committee meeting the paper was provided to summarise the background, identified issues and next steps required. A system fix had been implemented ahead of the move to SBS and work was ongoing to establish a full picture of accruals for outstanding invoices. In answer to a question the view was that the Trust was over accruing although evidence to justify this was limited. In terms of the timescale for resolution a position would

be known by the end of January 2017 in terms of those invoices that are due to be paid and those that should be in dispute.

16/12/38 In view of these difficulties Bev Marshall sought assurance that no similar backlog existed in terms of income that the Trust was owed. The Director of Finance advised the bulk of the Trust's income came from CCG payments which were posted on a national system, regular meetings took place to debate these in an open and honest way and there was no cause for concern in this respect. Where the Trust was trading with other parties a programme of work was underway to establish a complete list of customers which included a review of service level agreements, pricing structures and details of inter-trade activity. As this piece of work had only just commenced a timeframe had not yet been agreed.

16/12/39 In response to a question from David Crowe, the Director of Finance confirmed communication had taken place with suppliers regarding the requirement for a purchase order ahead of the known transition process. Many of the Trust's suppliers would already be familiar with SBS practices as a number of trusts were already utilising their services.

The Purchase to Pay (P2P) Process Issues update was NOTED.

Annual Leave Accrual

16/12/40 Jon Sargeant confirmed he had now met with Ernst & Young, who in principle were happy with the Trust's proposal; an element of verification should be expected as part of the agreement. Next steps would include a communication to all staff reminding them of the Trust's policy and a paper to Management Board to restate and reinforce the policy. A baseline assessment to establish the level of outstanding leave would be completed in January to provide an opportunity for action to ensure carry forward leave was minimised by the end of March 2017.

The Annual Leave Accrual report was NOTED.

Financial Plan

16/12/41 John Sargeant presented to the Committee the Financial Plan 17/18 and 18/19. Apologies were offered for the short notice due to ongoing final negotiations. The control totals, CIP and agency cap were as detailed in the report with further detail to add around the CCG contract meetings. The Trust was now almost ready to sign the Doncaster contract, and an update on Bassetlaw was given. Initial discussions had taken place with NHSI and a challenge around the level of contingency had subsequently been received with an adjustment made to leave a real contingency of 1.5m.

16/12/42 In response to feedback from NHSI's technical team a request for removal of any capital that was linked to Sustainability and Transformation Plans, unless signed off by NHSE and NHSI, had been made. Also the national CQUIN relating to an assumption that the STP delivered its control totals should also be removed. An update would be provided at Board and changes subsequently made to the capital element of the report to reflect the above.

Items for escalation to Board of Directors

None noted.

Any other business

None

Time and date of next meeting:

Date: 17 January 2017
Time: 9am
Venue: Learning Room 1, Education Centre, DRI

Signed:…….. **…….**
John Parker **Date**

UNAPPROVED **Minutes of the Meeting of the Management Board**
of
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
on
Monday 5 December 2016 at 1pm
in the Boardroom, DRI

Present:

Richard Parker	Director of Nursing, Midwifery and Quality (in the Chair)
Andrew Barker	Care Group Director - Diagnostics & Pharmacy
Jeremy Cook	Interim Director of Finance
Karen Barnard	Director of People & Organisational Development
Kirsty Edmondson-Jones	Director of Estates & Facilities
Dawn Jarvis	Director of Strategy & Improvement
Thrinath Kumar	Care Group Director - MSK & Frailty
Fiona Littlewood	General Manager - Children and Families
Tim Noble	Care Group Director - Emergency
Gillian Payne	Care Group Director - Speciality Services
Woolagasen Pillay	Care Group Director - Surgical
David Purdue	Chief Operating Officer

In attendance:

Leanne Shaw	Executive PA
Matthew Kane	Trust Board Secretary
Mandy Espey	General Manager - MSK & Frailty [MB/16/12/17 - MB/16/12/20]
Suzanne Bolam	Head of Clinical Therapies [MB/16/12/21 - MB/16/12/25]
Sarah Bayliss	General Manager - Speciality Services [MB/16/12/38 - MB/16/12/41]
Richard James	Deputy General Manager - Diagnostics & Pharmacy [MB/16/12/29 - MB/16/12/34]
Jas Sawhney	Assistant Care Group Director - Diagnostics & Pharmacy
Rebecca Wright	Business Manager - Speciality Services [MB/16/12/35 - MB/16/12/37]
Louise Deakin	Business Manager - Speciality Services [MB/16/12/26 - MB/16/12/28]

Apologies:

Eki Emovon	Care Group Director - Children and Families
Simon Marsh	Chief Information Officer
Mike Pinkerton	Chief Executive
Jon Sargeant	Director of Finance
Sewa Singh	Medical Director

Action

Minutes of the previous meeting

MB/16/12/1 The minutes of Management Board on 31 October 2016 were approved as an accurate record of the meeting, subject to the following amendments:

MB/16/12/2 MB/16/10/27 - Paragraph to read "Willy Pillay suggested establishing how many bladder scanners were currently in the Trust".

Fiona Littlewood agreed to contact Andrew Leverton to action as part of the ultrasound review across the Trust. **FL**

Matters arising and action notes

MB/16/12/3 The action notes were reviewed and updated.

MB/16/12/4 MB/16/05/25 - David Purdue reported that the new Children's Outpatient Department at Bassetlaw Hospital had opened its doors to patients on Monday 5 December 2016. The Board agreed that a retrospective business case would not be required to be submitted.

MB/16/12/5 MB/16/06/28 - The Nurse Endoscopist post that had previously been supported by Management Board, subject to clarification of the banding in the job description and a review of the costings, had been unsuccessful in the recruitment process and was being re-advertised. A review would take place once the post had been filled.

MB/16/12/6 Tim Noble raised concerns in relation to approving business cases and felt that the case for the Nurse Endoscopist post had not followed the correct process.

MB/16/12/7 **Post meeting note:** Richard Parker agreed to ensure that the elements of the case which had been identified in the previous discussion were checked and would report back at the next meeting. **RP**

MB/16/12/8 MB/16/07/19 - Willy Pillay reported that there was some difficulty in reconciling the source of funding for the recruitment of Advanced Clinical Practitioners and First Assistant. Dawn Jarvis agreed to pick up as part of the turnaround project. **DJ**

MB/16/12/9 MB/16/09/19 - Willy Pillay informed the Board that the actions had been completed for the case to purchase three non-mydriatic fundus cameras. The case would be closed on the Business Planning Register. **LS**

MB/16/12/10 MB/16/10/11 - Karen Barnard undertook to obtain an update from Alasdair Strachan in relation to VTS trainees and the future workforce plan. **KB**

MB/16/12/11 MB/16/10/25 - Management Board noted the update in relation to the Outpatients Self Check-in Kiosks and e-Outcomes. A further update would be provided once a review of the reception desks had been concluded.

MB/16/12/12 MB/16/10/40 - Richard Parker reported that agreement had been given by the Director of Finance to carry out a further test around option 3 and extend the Enhanced Care Team at Bassetlaw Hospital, providing no additional funding would be sought. A full business case would be submitted to Management Board once the test had been completed and would provide evidence of the effectiveness of the team.

MB/16/12/13 MB/16/10/54 - Tim Noble reported that he had sent a log of SBS non-payment issues to Anthony Jones for review. Karen Barnard commented that forms had not been received in time to be processed, however would raise any further issues at the project board meeting on Tuesday 6 December 2016, and would report back at the next Management Board. **KB**

MB/16/12/14 MB/16/10/72 - Matthew Kane confirmed that inherent ratings on the board assurance framework summary related to the risk rating before mitigation. A full review of the risk register would be taking place shortly.

Decision Tracker

MB/16/12/15 The decision tracker was reviewed and updated.

MB/16/12/16 The case to relocate the Education Centre at Bassetlaw Hospital was approved at Executive Team and would therefore be closed on the Business Planning Register. **LS**

PART 1 - PROPOSALS / BUSINESS CASES

0631/MSK&F - Implementing a Single on-call Rota

MB/16/12/17 Thrinath Kumar delivered a presentation proposing the implementation of a single consultant on-call rota in Trauma and Orthopaedics. The benefits would include;

- Improved waiting times for all patients awaiting IP trauma surgery
- Improved outcomes
- Daily Consultant-led ward rounds
- Maximised utilisation of theatres
- Reduced agency costs

MB/16/12/18 Mandy Espey commented that staff engagement had taken place and broad support had been given. Work linked to the theatres workstream would continue.

MB/16/12/19 Thrinath Kumar informed the Board that the new service model would require four additional theatre lists at DRI per week, however Willy Pillay raised concerns with current workloads and reported that the Surgical Care Group had been experiencing difficulties in recruiting to vacant Consultant Anaesthetist posts.

MB/16/12/20 Management Board was asked to agree the new rota and recognised the need for a different service model, however requested that further discussions took place outside of the meeting with David Purdue and Richard Parker. A reworked paper would return to Management Board in due course in order for a decision to be made on progressing the case. **TK**

0632/MSK&F - Retraction of Orthotics Manufacturing Unit

MB/16/12/21 Suzanne Bolam presented the paper and highlighted the options to close the orthotics manufacturing unit due to the inability to recruit and retain trained technicians, and the failure to realise the benefits originally expected. It was confirmed that there would be no impact on patients.

MB/16/12/22 All options contained a financial risk, but the preferred option would be to discontinue the manufacturing of orthotics and utilise the building for storage or office space.

MB/16/12/23 The original lease was for 15 years, 12 of which still remained, and discussions with the landlord in relation to early termination had been unsuccessful.

MB/16/12/24 A discussion took place and it was agreed to build the post implementation review of future cases into the new Corporate Investment Group (CIG) process.

MB/16/12/25 Management Board NOTED the paper and supported further work on the preferred option.

0627/SS - Extra Length Resectoscope for TURT Procedures - update

MB/16/12/26 Louise Deakin presented the paper and provided the additional information requested at the last meeting for the case to purchase two extra length resectoscopes.

MB/16/12/27 In response to a query from Andrew Thomas, Louise Deakin confirmed that there would not be any ongoing costs associated with the equipment.

MB/16/12/28 Management Board APPROVED the case, subject to confirmation that the required items could not be prepared and packed as a supplementary instrument.

Post meeting assurance was provided and the purchase had been approved.

0632/D&P - Film Array

MB/16/12/29 Richard James presented the paper to seek approval to approach the Fred and Ann Green Committee for the investment in a new piece of diagnostic equipment to be used within Pathology to detect viral and bacterial causes of meningitis.

MB/16/12/30 The benefits would include;

- Rapid diagnosis
- Reduction in bed stays
- Reduction in the need for external testing
- Reduction in the use of broad-spectrum antivirals
- Reduction in unnecessary and potentially painful treatments

MB/16/12/31 The cost of a one-year proof of concept would be £58,515, and if successful, a further business case would be submitted to the local commissioners for ongoing funding.

MB/16/12/32 Management Board SUPPORTED the case to be recommended to the Fred & Ann Green Committee, subject to the following detail being provided; **RJ**

- That it is not currently core NHS business?
- Would the STH virologists be supportive of the machines accuracy?
- Do we believe it will be successful?
- How likely are we to keep the machine after 1 year?
- Prove the savings are greater than the ongoing costs of the cartridges / cost of current service
- Provide feedback from other trusts who had trialled the equipment

0634/D&P - Second CT Scanner

MB/16/12/33 Richard James sought approval to develop a full business case for one or more of the options presented in the paper for a second CT scanner at DRI, and highlighted the financial analysis, anticipated benefits and risks associated with the following options;

1. Do nothing
2. Procure a second CT scanner installed within the current Medical Imaging Department
3. Hire from a third party provider
4. Procure a second CT scanner installed outside the current Medical Imaging Department, adjacent to ED

MB/16/12/34 Management Board SUPPORTED the development of a business case to be submitted, to include full details for options two and four. Richard James was asked to liaise with Estates in relation to the location of the CT scanner outlined in option four. **RJ**

0636/SS - Dermatology Consultant

MB/16/12/35 Rebecca Wright presented the case to seek approval to recruit 1.0wte Dermatology Consultant, funded by a forthcoming retirement (0.5wte) and long-standing vacancies within the department (1.5wte).

MB/16/12/36 The benefits would provide an increased clinic capacity, procedural and 2-week wait capacity, improved RTT position and minimised impact on patients and the Trust.

MB/16/12/37 Management Board APPROVED the case. **RW**

0637/SS - Breast Workforce Model: First Assistant and ANP

MB/16/12/38 Sarah Bayliss presented the paper to seek approval to covert the funding from

the current vacant staff grade post to a First Assistant (band 6) for theatre, and to fund the uplift of two existing band 6 Breast Care Nurse Practitioners to band 7 once they have completed the ANP training.

MB/16/12/39 In response to a query from Karen Barnard in relation to the training of the nurses, Sarah Bayliss confirmed that there would not be any additional cost implications.

MB/16/12/40 A discussion took place in relation to the financial element of the case and Sarah Bayliss explained the funding that would be available and the potential saving in agency costs.

MB/16/12/41 Management Board APPROVED the case, subject to confirmation that the financial element was correct and that the savings were as described.

Tender update

MB/16/12/42 The Tender update was provided for information and NOTED.

PART 2

Finance Report as at 31 October 2016

MB/16/12/43 Andrew Thomas presented the finance report that set out the Trust's financial position at month 7 2016/17. Management Board was advised that the deficit at month 6 was £10.1m, £4.5m favourable against the planned deficit.

MB/16/12/44 Key points from the report included;

- The Trust was underperforming by £1.5m against the income plan
- Pay was below plan by £643k in the month and £2.4m below year-to-date plan. A cost pressure of £500k relating to additional agency staffing for winter was included in the £16m year-end target
- Non-pay was £72k better than plan and £530k better than year-to-date plan
- Capital expenditure was on target, £5.3m year-to-date against a plan of £5.7m. Cash position was £2.3m against a plan of £1.9m
- CIP performance was £5.5m, £29k behind plan. The overall forecast CIP saving was expected to be £11.7m
- Care Group controlled totals were required to be signed off by February 2017.

MB/16/12/45 Fiona Littlewood raised concerns about Holt costs, and this was echoed by Tim Noble. Dawn Jarvis and David Purdue commented that continuing issues with agency spend rates had been identified at other meetings and would need to be addressed.

MB/16/12/46 Andrew Thomas commented that there were still a number of invoices that had been logged in the system but not passed back to Finance department for

processing. Andrew also reported that a system change in relation to how invoices were receipted would be implemented and would involve reminders being sent to Procurement.

MB/16/12/47 Andrew Thomas reported that the capital programme was slightly ahead of plan. The introduction of the Capital Monitoring Group would improve the current process of monitoring and controlling the progress of the capital programme. A rolling forecast of spend would be produced.

The Finance Report was NOTED.

Feedback from Accountability Meetings

MB/16/12/48 Children & Family Services - Fiona Littlewood reported that the recent invited Royal College Obs & Gynae review had highlighted some issues. The final report was due at the end of December and it was expected to include some specific recommendations around staff rotation.

MB/16/12/49 Emergency - Tim Noble provided the following update;

- CIPs on track
- Ongoing work with Kingsgate in relation to respiratory and gastro job planning
- Ongoing coding issues
- SET training rates increasing
- Winter plan approved
- Recruitment issues
  - 28% of Band 6 posts were vacant on the respiratory ward (this was in part due to the re-banding of current Band 5 posts)
  - Gastro and Respiratory Consultant vacancies
- RTT struggling
- 'Red and green days' well adopted
- Ongoing issues with Estates

MB/16/12/50 MSK & Frailty - Thrinath Kumar provided the following update:

- Impact of Norovirus on Care of the Elderly wards
- Clinical Governance parameters improving
- 18 week pathway performance slightly lower
- Possible re-opening of Ward 6
- Finances behind (due to consultant sickness)
- Lost activity due to ward closures
- Sickness rates slightly improved

MB/16/12/51 Diagnostics & Pharmacy - Andrew Barker provided the following update;

- CT (business case on the agenda)

- Long term dispute with Radiographers coming to a satisfactory conclusion and new rotas to commence in January 2017
- Overseas visitors - need to ensure the Trust is recovering income
- Expenditure on budget, surplus with pathology income

MB/16/12/52 Speciality Services - Gill Payne provided the following update;

- Ongoing issues with Dermatology and Urology
- Ongoing issue with Ward 17 staffing establishment

MB/16/12/53 Surgical - Willy Pillay provided the following update;

- Finances - £630k over budget
- Consultant vacancies in Ophthalmology
- Issue with White Rose SLA (audiology contract)
- Non-payment of additional sessions
- Kingsgate work had identified additional PAs may be required in general surgery
- Bowel scope achieving above plan
- Building works commence on Bassetlaw Endoscopy in December
- Best practice tariff for tonsils improving
- Ongoing medical staffing / sickness issues
- Appraisal rate slightly improving
- Region wide problem with recruiting Intensivists
- Care Group Director interviews on 19 December 2016
- Internal / local Children's Board with neighbouring trusts to discuss options for Hubs

MB/16/12/54 David Purdue raised the potential for improved collaboration and performance associated to management change for some key areas and asked for proposals to be sent to him for discussion at the Strategic Executive Team. Any outcomes would be reported at the next meeting. Richard Parker clarified that there would not be a Care Group restructure. **ALL**

The verbal update was NOTED.

Strategy & Improvement Report

MB/16/12/55 Dawn Jarvis presented the report and provided updates on the following;

- CIP programme 16/17 progress
- 2 year operational plan and CIPs
- Strategic planning process led by the Directorate of Strategy and Improvement

MB/16/12/56 Dawn Jarvis explained that the CIP programme at month 7 was slightly behind the stretch target at £29K, although delivery ahead of the original plan was still forecasted.

MB/16/12/57 Dawn Jarvis reported that a draft two year operational plan was required to be submitted by 23 December 2016, and agreed to circulate it to members of the Management Board marked 'Commercial in Confidence'. **DJ**

The Strategy & Improvement report was NOTED.

Update on Financial Oversight Committee activity

MB/16/12/58 Andrew Thomas gave a verbal update from the previous Financial Oversight Committee and reported that the committee was pleased with progress and therefore agreed that reports that were submitted on a monthly basis would now be presented to the Audit and Non Clinical Risk Committee on a quarterly basis. This would ensure that the Financial Oversight Committee would concentrate more on finance based issues.

MB/16/12/59 In relation to the issue raised earlier in the meeting about the number of invoices that had been logged in the system but not passed back to Finance department for processing, Andrew Thomas was tasked with producing a list for the next Financial Oversight Committee meeting. **AT**

The verbal update was NOTED.

Business Case Policy

MB/16/12/60 Following a discussion at the last Management Board meeting in relation to the changes to governance arrangements for revenue and capital, Andrew Thomas presented the business case policy which set out further guidance, the process, terms of reference and new templates.

MB/16/12/61 Matthew Kane had recommended some minor changes to wording in the policy.

MB/16/12/62 Richard Parker commented that as part of the business planning process, Care Groups would need to identify schemes they thought would require capital investment so that these could be considered as the capital plan was formalised, it was also noted that IT implications should be considered.

MB/16/12/63 The dates for the Corporate Investment Group meetings for 2017 would be circulated. **LS**

The Business Case Policy was NOTED.

Corporate Risk Register

MB/16/12/64 Matthew Kane presented the report which set out the current board assurance framework and risk register, and reported that an executive review would be taking place and risks would be updated accordingly. Recommendations made by the governance review carried out by Deloitte would also need to be taken into account.

The Corporate Risk Register was NOTED.

Hazardous Materials and Chemical, Biological, Radiation, Nuclear and Explosives Plan

MB/16/12/65 David Purdue presented the Hazardous Materials and Chemical, Biological, Radiation, Nuclear and Explosives Plan that formed part of the Trust's emergency preparedness arrangements. Key changes to the plan were outlined as follows;

- Amendments to mass decontamination process
- Amendments to escalation flow chart
- Addition of appendix 3 - Mass Decontamination protocol
- Addition of action cards for activating and managing the mass decontamination protocol

The HazMat and CBRNE plan was NOTED.

Chief Executive's Report

MB/16/12/66 The Chief Executive's Report was provided for information and NOTED.

Training Plan

MB/16/12/67 Karen Barnard presented the training plan and reported that basic awareness training would be included as part of the corporate induction programme. Discussions had taken place with education leads to ensure two and three yearly updates would be staggered appropriately.

The Training Plan was NOTED.

Business Intelligence Report as at 31 October 2016

MB/16/12/68 The Business Intelligence Report as at 31 October 2016 was provided for information and NOTED.

Any Other Business

MB/16/12/69 Thrinath Kumar raised concerns in relation to inappropriate and unnecessary attendances in A & E and asked if there was some way to screen patients. A discussion took place and Thrinath agreed to send some examples to David Purdue to review with the CCG. **TK/DP**

MB/16/12/70 Thrinath Kumar asked about 'acting down' rates for agency staff over the Christmas period and David Purdue confirmed that Holt would be made aware of the process and expectations.

Items for escalation to the Board of Directors

MB/16/12/71 None.

Items for escalation from Sub-Committees

MB/16/12/72 None.

Date and Time of Next Meeting:

MB/16/12/73 Date: 30 January 2017
Time: 1pm
Venue: Learning Room 1, Education Centre, DRI

HEALTH AND WELLBEING BOARD (HWB) – 12 January 2017

DECISION SUMMARY

In advance of the production of the minutes, the following is a summary of the decisions/actions arising from the Health and Wellbeing Board meeting held on Thursday 12 January 2017.

Agenda Item No. and Subject Matter		Decision	Action
1.	Welcome, introductions and apologies	The Chair welcomed Paul Tanney to his first meeting of the Board following his appointment as the new Chief Executive of St Leger Homes of Doncaster. The Chair also welcomed Chief Superintendent Tim Innes, District Commander for Doncaster, to his first meeting as a Board Member. Apologies were received from Councillor Nuala Fennelly, Kathryn Singh, Steve Helps, Paul Moffat (Jacqueline Wilson deputised), Peter Dale, Kim Curry (Jon Tomlinson deputised) and Karen Curran.	
2.	Appointment of Vice-Chair	It was proposed by Councillor Glyn Jones and seconded by Councillor Cynthia Ransome that Dr David Crichton be appointed as Vice-Chair of the Board for the remainder of the 2016/17 Municipal Year. Upon being put to a vote, it was unanimously agreed that Dr David Crichton be appointed as Vice-Chair of the Board for the remainder of the 2016/17 Municipal Year.	All to note.
3.	Chair's Announcements	The Chair advised the Board that Mike Pinkerton was stepping down from his role as Chief Executive of Doncaster and Bassetlaw Hospitals NHS Foundation Trust later this month, so sadly this would be his last meeting as a member of the Health and Wellbeing Board. On behalf of the Board, the Chair expressed her sincere thanks to Mike for the significant contribution he had made to the work of the Board and wished him all the very best for the future. She added that Richard Parker, who was in attendance at today's meeting, would be the Interim Chief Executive following Mike's departure, so the Board would look forward to welcoming Richard as a formal Board Member at its next meeting in March. The Chair also confirmed that, since the last meeting, Norma Wardman had tendered her resignation from the Board, due to the impending closure of Doncaster CVS. She therefore wished	

Agenda Item No. and Subject Matter		Decision	Action
		to place on record the Board's thanks both to the CVS for its work in the past and to Norma for the contribution she had made as a member of the Board. On behalf of the Board, the Chair congratulated RDaSH on receiving an overall rating of 'good' following a re-inspection by the Care Quality Commission.	
4.	Exclusion of Press and Public	There were no items of business where the press and public were to be excluded.	
5.	Public Questions	Mr Doug Wright referred to the contents of the Sustainability and Transformation Plan (STP) at agenda item 8 and stated that he was concerned over the lack of detail provided as to where the savings would come from to make up the financial shortfall of £571m that had been identified. He also stressed the importance of carrying out public consultation on the proposals. He asked whether the implementation of the STP could be temporarily halted to enable a listening exercise to be carried out between the clinicians and the public. ~~~~~~~~~~~~~~~~~~~ Parish Councillor Stephen Platt expressed concerns over how the shortfall of £571m quoted in the STP would be met, particularly in light of the current reported problems in the NHS, such as a lack of resources, bed shortages and long waiting times for patients in hospitals and at a time when it was clear that the NHS needed more funding. On a different subject, Parish Councillor Platt explained that Angela Curtis, who had asked a question about air pollution at the Board's last meeting, was unable to attend today's meeting. He confirmed that Mrs Curtis had received a letter from Dr Rupert Suckling following the Board's meeting outlining some of the measures being taken in the Borough to tackle the problem of air pollution. Parish Cllr Platt expressed the view that these measures alone would not reduce pollution to an adequate extent and he stressed that what was needed was a change in everyone's habits and behaviours. He also suggested that air pollution should be a standing item on every HWB agenda in order that the Board could monitor progress in this area.	

Agenda Item No. and Subject Matter		Decision	Action
		Parish Cllr Platt concluded by highlighting the valuable contribution that community libraries and parish councils could make in helping to publicise health awareness campaigns such as those which encouraged people to live healthier lifestyles. ~~~~~~~~~~~~~~~~~~~ Parish Councillor Lynette Chipp asked Dr Rupert Suckling whether any progress had been made with regard to establishing an air pollution steering group, as referred to in the minutes of the Board's last meeting. In response, Dr Suckling confirmed that a meeting had been arranged with the Council's Chief Executive and Pollution Control Officers to discuss this issue with a view to moving things forward. ~~~~~~~~~~~~~~~~~~~ Mrs Anne Gilbert referred to the STP and stated that she shared the concerns of the previous speakers regarding the financial position. She was particularly interested in how the STP would link GPs with Social Care and hoped that the presentation later in this meeting would address these points. In thanking the members of public for their questions, the Chair explained that all of the points raised regarding the STP would be addressed under agenda item 8.	All to note.
6.	Declarations of Interest, if any	No declarations of interest were made.	
7.	Minutes of HWB meeting held on 3 November 2016	The minutes of the HWB meeting held on 3 November 2016 were approved as a correct record and signed by the Chair.	All to note.
8.	Health and Social Care Transformation Update – Sustainability and Transformation Plan/Better Care Fund.	The Board received and noted presentations by Jackie Pederson and Jon Tomlinson which provided updates on progress with the implementation of the STP and the Better Care Fund (BCF).  Presentation South Yorkshire and Bassetl  BCF Planning Guidance Support We	

Agenda Item No. and Subject Matter		Decision	Action
		Councillor Glyn Jones referred to a recent article which had quoted the view expressed by the Chair of the BMA that STPs, proffered as the solution to the NHS deficit, had "revealed a health service that is in fact unsustainable without urgent further investment, and with little capacity to 'transform' in any meaningful way other than by closing services on a drastic scale". Councillor Jones suggested that it would be helpful if a Due Regard Statement was produced to measure the impacts of the STP proposals. He also expressed the view that the STP was high level in terms of its content and there was little detail in the Plan to allow people to come to an informed decision about the proposals and he looked forward to seeing the results of the consultation exercise. In response, Jackie Pederson agreed to take back to colleagues the suggestion in relation to producing a Due Regard Statement. Jackie also confirmed that Healthwatch Doncaster, along with other voluntary sector organisations, would be heavily involved in the public consultation exercise on the STP and therefore suggested asking Steve Shore to report back to a future meeting of this Board on the outcome of the consultation.	Jackie Pederson Steve Shore
9.	Quarter 2 2016/17 Performance Report and Focus on Mental Health Transformation and Learning Disabilities.	In response to a query with regard to the implementation of the Domestic Abuse Strategy 2016-20, Jacqueline Wilson stated that there were issues around governance to address and that the Strategy would be brought to the Board's next meeting. The Board:- 1. Noted the performance against the key outcomes; and 2. Received and noted a presentation on the Mental Health Transformation and Learning Disabilities area of focus. Transformation Programme Work for	All to note

Agenda Item No. and Subject Matter		Decision	Action
10.	Whole Service Review – Physical Activity and Sport.	The Board received a presentation and paper by Andrew Maddox outlining the work being carried out in relation to a whole service review of the delivery and provision of physical activity and sport.  health and wellbeing boardWhole service r The Board endorsed the report and review and agreed that the Doncaster Active Partnership be formally tasked with taking forward the delivery of the review and be held accountable for its delivery.	All to note Andrew Maddox
11.	Report from HWB Steering Group and Forward Plan.	In presenting the report, Dr Rupert Suckling drew particular attention to the date of the Board's Time-out and Development Session on 9 February 2017 and asked Members to note this date in their diaries. Dr Suckling also informed Members that the first walk of the 'Get Doncaster Walking' 2017 program would be taking place at Lakeside, Doncaster on 21 January 2017 and would be led by Paratrooper, L/Cpl Ben Parkinson MBE and everyone was welcome to come along. The Board:- (a) received the update from the HWB Steering Group; and (b) agreed the proposed forward plan at Appendix A to the report.	All to note All to note
12.	Briefing on the use of Licensing powers to secure health improvement (For Information only)	The Board received and noted a briefing paper on the use of licensing powers to secure health improvement, as requested at the last meeting.	All to note

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

11 November 2016, Birch/Elm Room, Oak House, Rotherham

Decision Summary

Reference	Item	Lead
1	**South Yorkshire and Bassetlaw Plan**	
05/16	(a) that the South Yorkshire and Bassetlaw Sustainability and Transformation Plan Collaborative Partnership Board (STP CPB) published the plan, supporting the principles, ambition, vision and priorities and to work with the STP partners, noting this would also be discussed by each organisation for a considered response.	**ALL**
2	**Communications approach and publishing the plan**	
06/16	(a) that The STP CPB approved the communications and engagement approach to publishing the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.	**ALL**
3	**Independent review of hospital services**	
07/16	(a) that Doncaster and Bassetlaw NHS Foundation Trust would share learning and information with WCG from work done to date on sustainability of services (b) GF agreed to lead on PH intelligence regarding the independent review of hospital services with support. Further detail to be discussed with WCG (c) that the Yorkshire Ambulance Service would be included within the terms of reference and further comments be received by the STP CPB by 25 November on the terms of reference (d) that the STP CPB supported the next steps, including the proposal for a summary scope to be developed to be used to invite proposals from external consultant. An update on progress to be delivered at the next meeting.	**DAWN JARVIS** **GREG FELL** **WILL CLEAY-GRAY, ALL** **ALL**
4	**Terms of reference**	
08/16	(a) that JS would provide comments on scope of the sustainability funding key responsibilities bullet point. (b) that the terms of reference be brought back to the next meeting as a holding position of governance and that these be kept live to be amended as required.	**JOHN SOMERS** **WILL CLEARY-GRAY**

5	**Summary Version of the STP**	
09/16	(a) that all comments on the summary STP document be received by 15th November to be published on that date to accompany the main plan.	**ALL**
6	**Strategic Commissioning Intentions**	
12/16	(a) that the STP CPB approved the STP Strategic Commissioning Intentions to the shared with the SYB System.	**RACHEL GILLOTT**
7	**Implementation plan and resourcing the approach proposals**	
13/16	(a) that the STP CPB noted the immediate resource requirements and capacity gaps and agreed the principle of a fair share approach across SYB providers, commissioners and local authorities to resourcing the STP. (b) that the STP CPB supported delegating the working up of proposals to the Finance Oversight Committee. (c) that the potential risk to delivery as a result of the resource gap was noted. (d) that a fair shares approach to resourcing be brought back to the next meeting	**ALL** **STP PMO** **ALL** **STP PMO**
8	**Governance review**	
14/16	(a) that the STP CPB noted the interim governance proposals and supported the approach to establish a Governance Review Group, Chaired by the STP Lead and supported by Jayne Brown, Chair of SHSC.	**ALL, STP PMO**

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

Minutes of the meeting of 11 November 2016, Birch/Elm Room, Oak House, Rotherham

Present:

Andrew Cash, South Yorkshire and Bassetlaw STP Lead/Chief Executive, Sheffield Teaching Hospital NHS Foundation Trust (CHAIR)
Louise Barnett, Chief Executive, The Rotherham NHS Foundation Trust
Adrian Berry, Medical Director, South West Yorkshire Partnership NHS Foundation Trust
Patrick Birch, Director of Improvement, Doncaster Council
Des Breen, Medical Director, Sheffield Teaching Hospital NHS Foundation Trust
Sandra Crawford, Associate Director of Transformation, Nottinghamshire Healthcare
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw STP
Chris Edwards, Accountable Officer, Rotherham Clinical Commissioning Group
Adrian England, Chair, Healthwatch Barnsley
Greg Fell, Director of Public Health, Sheffield City Council
Idris Griffiths, Interim Accountable Officer, Bassetlaw Clinical Commissioning Group
Steve Hackett, Director of Finance, Chesterfield Royal Hospital
Dawn Jarvis, Director of Strategy and Improvement, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Alison Knowles, Locality Director North of England, NHS England
Wendy Lowder, Acting Executive Director of Communities, Barnsley Council
Ainsley Macdonnell, Service Director – North Nottinghamshire & Direct Services, Adult Social Care, Health and Public Protection, Nottinghamshire County Council
John Mothersole, Chief Executive, Sheffield Council
Jackie Pederson, Accountable Officer, Doncaster Clinical Commissioning Group
Matthew Powls, Interim Director of Commissioning, Sheffield Clinical Commissioning Group
Mathew Sandord, Associate Director of Planning and Development, Yorkshire Ambulance Service
Kathryn Singh, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Steve Shore, Chair, Healthwatch Doncaster
John Somers, Chief Executive, Sheffield Children's Hospital NHS Foundation Trust
Helen Stevens, Associate Director of Communications and Engagment, Commissioners Working Together
Lesley Smith, Accountable Officer, Barnsley CCG
Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Neil Taylor, Chief Executive, Bassetlaw Council
Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust
Janette Watkins, Programme Director, Provider Working Together Programme
Janet Wheatley, Chief Executive, Voluntary Action Rotherham
Kate Woods, Programme Office Manager, South Yorkshire and Bassetlaw STP

Apologies:
Julia Newton, Chief Finance Officer, Sheffield Clinical Commissioning Group
Jo Miller, Chief Executive, Doncaster Council
Diana Terris, Chief Executive, Barnsley Council
Simon Morritt, Chief Executive, Chesterfield Royal Hospital
Anthony May, Chief Executive, Nottinghamshire Council
Frances Cunning, Deputy Director of Health and Wellbeing, Public Health England
Mike Pinkerton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
Richard Stubbs, Acting Chief Executive, The Yorkshire and Humber Academic Health and Science Network
Maddy Ruff, Accountable Officer, Sheffield Clinical Commissioning Group

Tim Moorhead, Clinical Chair, Sheffield Clinical Commissioning Group
Mike Curtis, Chief Executive, Health Education England
Leaf Mobbs, Director of Planning and Development, Yorkshire Ambulance Service
Richard Henderson, Chief Executive, East Midlands Ambulance Service
Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Andy Hilton, GP, Sheffield Clinical Commissioning Group
Neil Priestley, Director of Finance, Sheffield Teaching Hospital NHS Foundation Trust

Minute reference	Item	ACTION
01/16	**Welcome and introductions** AC welcomed all to the inaugural meeting of the Sustainability and Transformation Plan Collaborative Partnership Board meeting (STP CPB)	
02/16	**Apologies for absence** Apologies were noted and recorded as above.	
03/16	**Reflections on past 9 months STP development** AC outlined the intentions of the first STP CPB; to support the vision, ambition and priorities of the SYB STP. It was advised that following the meeting, the SYB STP would be published in public. All interim governance arrangements would be discussed at the meeting. Reflections were noted by AC as follows: An SYB plan had been compiled in a very short space of time with clear ambition, vision and priories which was an achievement. The plan was high level and would be followed up with detailed work. Place plans, serving neighborhoods and keeping people close to home with care were fundamental to the SYB STP, connecting centres of health and social care, sectors of choice, opportunity, employment and education with a wider public sector reform programme. The high level ambitions developed to date would lead on to delivery. Some challenges were noted around moving from the current situation to realise the development of the strategic agenda. To achieve this, all leaders must hold their organisations to the plan to serve local neighbourhoods. Reflections were welcomed from the STP CPB. A comment was made around the political sensitives of the STP process to date, noting that all must be mindful of openness and transparency while engaging stakeholders as the STP developed. The publication of the STP should be viewed as a starting point for politicians. It was felt that it should also be emphasised that the detail of any changes that	

	followed the STP CPB meeting would go through all usual processes for engagement, service change and decision making. It was requested that local councils and politicians be given the time and space required to react to the document. A comment was made that the language being used to date had been helpful that the role of the leaders was clear in supporting the ambitions, visions and priorities of the STP. A comments was made that the STP being centered around place based design would be key moving forward. Chief executives would lead this through individual organisations. AC would also be meeting with key stakeholders after publication.	
04/16	**National update from the STP lead** The STP CPB noted that all 44 STPs were submitted on 21 October 2016. The SYB STP had been advised that work could commence. Nationally there were 4 cohorts that an STP could be placed within. The SYB STP was in cohort 1 alongside other well established collaborations such as Manchester. All STPs were now beginning to publish. AC reported on a meeting with the Arms Length Bodies (ALB), stating that work would take place with SYB STP on finances, the transformation themes relating to demand and flow, and the interface with social care. Discussions had also taken place nationally around reconfigurations and assistance would be given by the ALBs on this in due course if this was needed. Discussions had also taken place around capital and the need to be realistic on priorities. The STP would align with the contracting and planning round.	
05/16	**SYB Plan** The STP CPB received the plan that was submitted on 21 October 2016 noting that it had been well received. This would allow the SYB STP to have transparent conversations with wider stakeholders and the approach for this would be outlined further on the STP CPB agenda. The Board noted that initial testing of the plan had taken place with Health and Wellbeing Board Chairs and the feedback had been positive. Work would also take place with associate partnerships outside the SYB STP, noting that the vision, ambition and priorities linked well with other areas, especially supporting people to stay well within communities which was consistent in all the STPs. All noted the need to consider how to use the plan and subsequent supporting documentation around communications and engagement and incorporating existing collaborative work undertaken to date.	

Place feedback was requested from the group.

Barnsley

It was reported that the STP was built upon place based plans that had been developed with colleagues across the system and were in the process of being signed off. The principles of co design and coproduction would result in the right solutions for local people. The group was asked to consider the involvement of the police force in the STP particularly in relation to Mental Health.

Bassetlaw

The group noted that an accountable care partnership was in place and therefore place based plans fitted well with the STP. All local systems were sighted on the ambition and priories and supportive of it. Some local issues were noted around how to engage the public on this. A good correlation between the SYB STP and the Nottinghamshire STP was noted. IG would be presenting the place based plan to Nottinghamshire Health and Well Being Board in December. It was noted that meetings with the MPs would be a key component of the consultation process. Language being used in the STP was also important as part of the communication with the public.

Doncaster

Integrated commissioning with an accountable care partnership approach had been agreed in Doncaster. This had been codesigned across the system and had been a positive experience. Place plans had been discussed across the system, and the STP would be taken to Doncaster GB.

Rotherham

A joint plan, designed by the whole system was well established. A briefing session had taken place for councilors, MPs and stakeholders. Next steps would be to move to an accountable care system and work was taking place with Capsticks to design this.

Sheffield

A joint plan had been produced with a collaborative approach across the system. Two large stakeholder events had taken place in Sheffield. The local system was signed up to the plan. Governance arrangements were being worked through. Useful and robust sessions had taken place with scrutiny committee. Detailed work on clinical systems would be the next step.

LS highlighted to all that there may be some local interest in Barnsley when the STP was taken public with some potential opposition to the changes which would need careful management.

The SYB CPB agreed to publish the plan, supporting the principles, ambition, vision and priorities and to work with STP partners, noting this would also be discussed by each organisation for a considered response.

06/16	**Communications approach and publishing the plan** All noted that a supporting pack had been circulated for all to use locally, including a Board level paper to amend as required. This was to ensure a planned and consistent approach to publishing the SYB STP across the footprint. An email had been circulated to all MPs in SYB alerting them to the fact that the STP was being published. Joint OSC Chairs and local Healthwatch and Health and Wellbeing Board Chairs had also been contacted. The STP would be published on 11 November 2016 at 3pm. This would be placed on the website alongside videos from stakeholder events. Each organisation would be handling the management of the information on a local level. All communications leads from Local Authorities, Providers and Commissioners would input into the communication and engagment of the STP and all were asked to note a resource implication for individual organisations on this. Wider engagement with staff and public would take place December to March 2017. The dates for publication of other STPs was outlined to the group as well as the timeline for publication across the SYB STP. Any inaccuracies in the dates circulated should be highlighted to HS or KW. A reactive approach to handling the media until the plan had been discussed at boards would be adopted. A media protocol was in place and all enquiries should be directed to the STP PMO. A comment was raised around the decision to take a reactive approach to media enquiries, rather than proactive. It was highlighted that discussions should take place across all originations initially and then a proactive approach would take place with key partners. A query was raised around circulating the plan to regional unions and it was agreed that this would be a positive step, and the plan would be circulated when live with accompanying correspondance from AC. In response to a query around publication of place plans, it was noted that the STP been developed using local place plans and were therefore integrated. The communications and engagement around the STP would articulate this. The STP CPB approved the communications and engagement approach to publishing the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.	**ALL**
07/16	**Independent review of hospital services** The STP CPB noted the work to date, that trusts had collectively identified undertaking a review of hospital services to be able to plan and mitigate and identify sustainable models of provision, supported by commissioners. It was proposed that the SYB STP with wider partners	

	undertake a review of hospital services: - To define and agree a set of criteria for what constituted "sustainable hospital services" for each place and for SYB, ND and MY in the contract of the SYB STP - To identify any services that are unsustainable, short, medium and long-term including tertiary services - To put forward future services delivered within and beyond the STP - To consider the role of the District General Hospital in the context of the aspirations outlined in the SYB STP and emergent models of sustainable service provision. Draft terms of reference (ToR) were circulated to the STP CPB to enable providers to have a discussion around what a review might look like and to engage discussions around next steps. The ToR would remain draft until objectives had been developed. The timeframe identified for this work was ambitious, noted as December 2016 to September 2017, however this work would enable and develop a better understanding and new thinking about acute services for a number of key areas of the STP. The resource implications were highlighted as well as the benefits of this review in terms of developing an understanding and improving equity and access and quality for all. The STP CPB was invited to comment. AC highlighted that this had been discussed at a meeting of the CEOs and chairs of provider organisations and was supportive. A comment was made around the current drivers for providing hospital services. With a tier 1, 2, 3 service approach, the tiers would need to be agreed and to then agree how to deliver in a safe and sustainable way to a local population. This work would address the whole range of services. A comment was made that supporting services in the context of a wider plan will be beneficial. Services provided outside of hospitals must be considered as part of this work. It was suggested that calls for additional resources were not sustainable for CCGs and therefore must look ways of working together to support the STP in terms of resourcing. It was noted that Doncaster and Bassetlaw Hospital NHS Foundation Trust had undertaken work around sustainability of services and findings of the work done to date would be shared with WCG. Some concerns were noted around the timescales for this work and that scrutiny must be involved. GF agreed to lead on PH intelligence regarding the independent review of hospital services with support. Further detail to be discussed with WCG A request was made for YAS to be included within the ToR and this was agreed.	**DAWN JARVIS** **GREG FELL** **WILL CLEARY-GRAY**

	All were asked to note that this was a large and important piece of work that would have implications on key work streams within the STP. The date of September 2017 would be important to shape commissioning for 17/18. It was requested that community services, currently outside of scope, be given careful consideration. These fed into place based discussions around developments of intermediate care and this should be cross referenced with this work. All further comments on the draft terms of reference were requested by 25 November to WCG. The STP CPB supported the next steps including the proposal for a summary scope to be developed to be used to invite proposals. An update on progress would be delivered at the next meeting.	**ALL TO NOTE**
08/16	**Terms of reference** The STP CPB received draft terms of reference noting the proposal that these would remain live. All were reminded that the partnership board had committed to looking at governance and that the current set up was interim. Governance would be reviewed around how to work collaboratively at a SYB level and the terms of reference should be viewed in this context. The following feedback was noted: - The scope of the sustainability funding under key responsibilities of the CPB was unclear. JS agreed to help redraft this bullet point. - That further consideration be given to inclusion of chairs for CCGs only under membership - That as the CPB was a collection of individuals on behalf of sovereign organisations, and would not be making decisions but to develop and recommend, a point on quoracy was not required for the ToR. - That comms briefings would need to clearly stipulate that the CPB was a guiding coalition and that responsibilities would remain within statutory organisations. - That Healthwatch be added to the membership list - That the STP finance lead be added to the membership list - CFO to be added to the list All further comments were welcomed to WCG. The ToR would be brought back to the next meeting as holding position of governance. The Terms of Reference would be kept live to be amended as required.	**JOHN SOMERS** **ALL**
09/16	**Summary Version of the STP** The STP summary plan was circulated. The document had been developed taking comments from all communications links across the footprint. It was anticipated that the summary version of STP would be used to support stakeholder discussions and would be placed on the website alongside the main version. LS highlighted some comments and agreed to pick up with HS outside	**LESLEY**

	the meeting. All were asked to comment on the document and this would be published Tuesday 15th November.	**SMITH** **ALL**
10/16	**NHS E arm's length bodies feedback on SYB plan** It was reported that each ALB in Yorkshire and the Humber had been asked to assess the plans independently and agree the assessment collectively. There had been consensus around how well the plan was presented with a clear level of ambition and clear strategic priorities. The overall rating was that the SYB STP was ready to progress. Medium confidence was noted in delivery of the plan. This was due to the work still to be undertaken to develop business cases and strategic priorities. The STP CPB noted the formal feedback from NHS England and the ALBS and the feedback on the plan which had been shared with the centre.	
11/16	**NHS planning round** An update was delivered on the operational planning round which would be the first step in moving from the plan to implementation. Key messages and must be dones were outlined to the group; milestones and metrics, finance including control totals, demand management, financial balance and other efficiencies including Right Care and carter, primary care with a GP Forward View emphasis, urgent and emergency care, referral to treatment times and elective care, cancer with a 62 day standard, mental health with a mental health forward view emphasis, people with learning disabilities and improving quality in organisations STPs would provide the basis for operational plans with a 2 year timeline for activity, workforce, finance and performance assumptions. The timetable had been brought forward so that all plans and contracts would be completed by 23 December 2016. The plans offered the opportunity for financial control totals for each STP. Local principles were being developed for how operational plans would be tested: - Each CCG and provider need to plan for level of growth articulated in the STPs - Operational plans must reflect milestones for the next two years - The figures from the STP must follow through into contracts Activity growth was outlined for the STP with big ambitions in terms of activity reductions. Local systems must work together to deliver. The timetable was outlined to all. The STP CPB noted the contents of the NHS England presentation.	

12/16	**Strategic Commissioning Intentions** The purpose of the Commissioning Intentions was to provide a commissioning dimension of the STP ambition, to signal strategic intent to providers and stakeholders and to inform 17 – 19 contract discussions (in-year change). The CPB noted that there was a gap between scale of ambition and current business as usual, that this work was at a transitionary stage of planning timeline and was evolutionary and that change would be implemented within the contract period. Alignment of CCG operational plans to the STP and inclusions in contract agreements would be required. In response to a query, it was confirmed that with an SYB control total, each organisation would still retain its own control total. The CPB noted the recommendation of the Finance Oversight Committee in response to NHS England that flexibility on control totals would not be required at this point in time, however the SYB STP would wish to reserve the right to revisit this at a later date. The STP CPB approved the STP Strategic Commissioning Intentions to be shared with the SYB system.	
13/16	**Implementation plan and resourcing the approach proposals** A draft implementation plan had been circulated, addressing moving into implementation of the STP, highlighting that to date, work had been undertaking by the WTP teams as additional work and a robust mechanism to undertake the STP would be required. An immediate resource issue around senior finance capacity into the STP was noted and the roll forward of additional support to ensure the work continued to progress. A query was raised around involvement in the Finance Oversight Committee and it was noted that there was representation from each group at those meetings as per the terms of reference. The STP CPB noted the immediate resource requirements and capacity gaps and agreed the principle of a fair share approach across SYB providers, commissioners and local authorities to resourcing the STP. The STP CPB supported delegating the working up of proposals to the Finance Oversight Committee. The potential risk to delivery as a result of the resource gap was noted. The fair shares approach to resourcing would be brought back to the next meeting.	
14/16	**Governance review** The STP CPB noted a summary of the agreed interim governance for SYB STP, confirming the STP's commitment to undertake a review of governance between the point of reporting and the end of March 2017. It was noted that reshaped governance arrangements would run in parallel with partner's organisational statutory governance to help make decisions to deliver the STP ambitions at SYB level. LS advised that an aspect of the interim governance would be an	

	Oversight Group of members and chairs that would sit above the STP CPB and be in place by January 2017. The establishment of a governance review group would also take place, involving Jayne Brown, Chair of Sheffield Health and Social Care who had offered to assist with work around longer term governance. The STP CPB noted the interim governance proposals and supported the approach to establish a Governance Review Group, Chaired by the STP Lead and supported by Jayne Brown, Chair of SHSC.	
15/16	**STP work in progress** Item for noting	
16/16	**Unadopted minutes of the STP finance oversight committee meeting 31 October** Item for noting.	

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

16 December 2016, The Boardroom, 722 Prince of Wales Road

Decision Summary

Ref	Item	Lead
1	**Minutes of the previous meeting held 11 November 2016**	
19/16	(a) that we take a consistent approach of all partners taking Sustainability and Transformation Plan Collaborative Partnership Board (STP CPB) ratified minutes through their organisations Boards and Governing Bodies was agreed	**ALL**
	(b) that all would review the 11 November 2016 minutes and provide comments to WCG by 22 December with a view to ratifying at the 13 January 2017 STP CPB and publishing thereafter	**ALL**
	(c) that all future minutes would be routinely ratified at each meeting and published	**ALL**
2	**Summary update to the Collaborative Partnership Board**	
22/16	(a) that work stream leads and membership would be shared with the STP CPB	**STP PMO**
	(b) that the summary update was agreed and to be used to inform local discussions and form part of a consistent approach of partners taking through their organisations	**ALL**
3	**Terms of reference**	
23/16	(a) that amendments from the meeting be made to the Terms of Reference (TOR) and any further comments to be received from all by 24 December 2016	**WILL CLEARY-GRAY, ALL**
4	**Sustainable Hospital Services Review**	
24/16	(a) that the STP CPB approved the TOR and specification for the review, subject to amendments and discussion at the meeting	**JAMES SCOTT**
5	**SYB STP resources**	
26/16	(a) that all participating organisations were included in the resource plans	**JEREMY COOK**
	(b) that local authorities would take away and consider a proposal in due course which would be based on focusing support in each local place and therefore be removed from the SYB fair shares approach	**JEREMY COOK, LOCAL AUTHORITY LEADS**
	(c) that the STP CPB noted the fair shares approach and supported the proposal and the STP budget, subject to confirmation of actual	**ALL JERMEY COOK**

	costs and the reworking of the fair shares approach, following the decision above	
6	**Social Kinetic 3d Proposal for Leadership Analysis**	
29/16	(a) that the STP CPB would take the project forward in principle with a smaller leadership group to consider the detail. A meeting would be arranged for January 2016 for this	**STP PMO**
	(b) that Social Kinetic would discuss via WCG in further detail with a view to starting in February 2017	**SOCIAL KINETIC/WILL CLEARY-GRAY**

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

Minutes of the meeting of 16 December 2016, The Boardroom, 722 Prince of Wales Road, Sheffield

Present:

Andrew Cash, South Yorkshire and Bassetlaw STP Lead/Chief Executive, Sheffield Teaching Hospital NHS Foundation Trust (CHAIR)
Louise Barnett, Chief Executive, The Rotherham NHS Foundation Trust
Des Breen, Medical Director, Provider Working Together Programme
Catherine Burn, Director, Voluntary Action Barnsley
Julia Burrows, Director of Public Health, Barnsley Council
Tracey Clarke, Associate Director of Strategy and Commercial Development, Rotherham, Doncaster and South Humber NHS Foundation Trust
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw STP
Frances Cunning, Deputy Director of Health and Wellbeing, Public Health England
Jeremy Cook, Interim Director of Finance, South Yorkshire and Bassetlaw STP
Mike Curtis, Local Director, Health Education England
Chris Edwards, Accountable Officer, Rotherham Clinical Commissioning Group
Greg Fell, Director of Public Health, Sheffield City Council
Idris Griffiths, Interim Accountable Officer, Bassetlaw Clinical Commissioning Group
Sharon Kemp, Chief Executive, Rotherham Council
Alison Knowles, Locality Director North of England, NHS England
Ainsley Macdonnell, Service Director – North Nottinghamshire & Direct Services, Adult Social Care, Health and Public Protection, Nottinghamshire County Council
Simon Morritt, Chief Executive, Chesterfield Royal Hospital
John Mothersole, Chief Executive, Sheffield Council
Jackie Pederson, Accountable Officer, Doncaster Clinical Commissioning Group
Mike Pinkerton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Matthew Powls, Interim Director of Commissioning, Sheffield Clinical Commissioning Group
Sean Raynor, District Director, South West Yorkshire Partnership NHS Foundation Trust
Jade Rose, Head of Strategy, Barnsley Clinical Commissioning Group
Mathew Sandord, Associate Director of Planning and Development, Yorkshire Ambulance Service
Steve Shore, Chair, Healthwatch Doncaster
John Somers, Chief Executive, Sheffield Children's Hospital NHS Foundation Trust
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together
Richard Stubbs, Acting Chief Executive, The Yorkshire and Humber Academic Health and Science Network
Lesley Smith, Accountable Officer, Barnsley Clinical Commissioning Group
Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Neil Taylor, Chief Executive, Bassetlaw Council
Jon Tomlinson, Assistant Director of Commissioning, Doncaster Council
Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust
Janette Watkins, Programme Director, Provider Working Together Programme
Kate Woods, Programme Office Manager, South Yorkshire and Bassetlaw STP

Apologies:
Adrian Berry, Medical Director, South West Yorkshire Partnership NHS Foundation Trust
Moira Dumma, Director of Commissioning Operations, NHS England
Adrian England, Chair, Healthwatch Barnsley
Matthew Groom, Assistant Director of Specialised Commissioning, NHS England
Specalised Commissioning Services
Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust

Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Jo Miller, Chief Executive, Doncaster Council
Tim Moorhead, Clinical Chair, Sheffield Clinical Commissioning Group
Leaf Mobbs, Director of Planning and Development, Yorkshire Ambulance Service
David Pearson, Corporate Director Adult Social Care, Health and Public Protection, Nottinghamshire County Council
Maddy Ruff, Accountable Officer, Sheffield Clinical Commissioning Group
Kathryn Singh, Chief Executive, Rotherham Doncaster and South Humber NHS Foundation Trust
Rob Webster, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust

Minute reference	Item	ACTION
17/16	**Welcome and introductions** The Chair welcomed all members of the STP CPB. The aim of the session was noted; - to update all on the national position and place - to collectively debate resourcing for the STP - to welcome Social Kinetic 3de to receive information around the development of the STP - to receive information on core business.	
18/16	**Apologies for absence** Apologies were recorded as above.	
19/16	**Minutes of the meeting held 11 November 2016** The minutes of the meeting were accepted as a true and accurate record subject to the following: - Item 05/16 refers: South Yorkshire and Bassetlaw Plan, amend **supported** the plan to **published** the plan - Item 07/16 refers: Independent review of hospital services, amend to state that GF would lead on PH intelligence, with support, further detail to be discussed with WCG The STP CPB noted the intention to publish ratified minutes to be available to the public and all partners. A discussion took place around this. It was felt that that the minutes should be publically available. To enable all partners to have discussions with their organisations, the minutes would be published after the next STP CPB meeting on 13 January 2017. It was agreed that we take a consistent approach of all partners taking STP CPB minutes through their organisations Boards and Governing Bodies was agreed. In response to this a query was raised around briefings for boards and WCG confirmed that at the time of reporting, the STP was still being taken through key meetings. A further update and briefing would follow when this had been through all meetings across the patch. The STP CPB agreed to review the 11 November 2016 minutes and provide comments to WCG by 22 December. The November meeting minutes would be ratified at the 13th January 2017 STP CPB and	**ALL** **ALL**

	published thereafter. All future minutes would be routinely ratified at each meeting. It was confirmed that minutes only would be made public at this stage.	
20/16	**National STP Update** AJC delivered an update, noting that the South Yorkshire and Bassetlaw STP (SYB STP) had been well received nationally. There would be no further progression on STPs nationally until the new year. It was noted that discussions had taken place with the national team around funding for the plan and capital. This was being favorably received and feedback would be given in due course. Contracts and delivery were being confirmed locally by 23 December 2016. Some issues were reported around operational delivery plans at place level not matching the STP. These were being worked through. The STP would assist in doing things differently and moving all into different ways of working and would be a health and care plan for all. A discussion followed around some concerns that had been raised; these were around governance, local decision making and local accountability. It was noted that the governance of the STP was a key area to develop and would be considered carefully. A crucial piece of work would be on communications and engagement and how messages were put across must be considered by all. Due process must be in place to engage and a scrutiny process was required. All leaders were asked to support the process around how place plans connected to the STP and facilitate local conversations. The importance of the STP collaboration for system resilience and sustainability of services was noted by all.	
21/16	**Update from local place plans** The STP CPB were updated on local place plans, noting visions and principles of system collaboration, priority work areas, engagement, and next steps across the footprint. The presentations would be shared with all.	
22/16	**Update from the Collaborative** **Commissioners Working Together** The STP CPB were briefed on commissioning collaborative working, noting the key business of the Joint Committee of CCGs (JCCC) around the Hyper Acute Stroke Unit and Children's Surgery and Anaethesia consultation and the Acutely Ill Child case for change. This group was evolving and anticipated that this would become the forum for collective commissioning decisions with delegated authority around STP transformation.	

	Providers Working Together The STP CPB were updated on progress of the three hub model – with further work being undertaken around localised theatre procedures. Radiology workforce challenges were being focused on, developing education and recruitment programmes. Engagement across the trusts was taking place. Responses to the consultation to ensure this fitted together with children's provision were being compiled. Work was taking place around a pilot across Rotherham and Sheffield regarding integration of the community through to relationship with children's. This was being undertaken, interfacing with other elements of the AIC work as well as elective work. Work to drive out further savings regarding procurement was taking place. Some savings had been made to date. Cancer pathway reviews were taking place. Links were being made with the STP digital work stream to ensure road map activity came together. Work was also taking place around corporate services the principles of working together, noting some difficulties around the practicalities of implementation. A governance proposal around estates would be brought to the next meeting. **Combined Authorities** The STP CPB noted that the Combined Authority was focusing on the economy. CE would be a member of this Board bringing together all partners system wide from January 2017. **Mental Health Alliance** The mental health work stream would be up implemented from January 2017, supporting vulnerable services and addressing workforce issues and back office opportunities. The alliance would develop from this. An initial meeting between the two executive teams of Sheffield Health and Social Care and Rotherham, Doncaster and South Humber Foundation Trusts would take place in January 2017.	
22/16	**Summary Update to the Collaborative Board** A summary document had been compiled by work stream leads. The STP CPB agreed that the format was useful and be adopted for updates to individual organisations. It was anticipated that programme leads would produce these updates for timely sign off by SROs. The STP CPB noted an offer from the Leadership Academy regarding funding for leadership development. The STP had been asked to outline the proposals to utilise this funding and this was being developed by WCG and LB. The STP CPB were asked to join this small working group if of interest. It was reported that funding had been made available from NHS England to support the primary care work stream to work with local place on primary care to support the implementation of the GP Five Year Forward View (GPFV) and a recruitment process was completed on this. It was agreed that work stream leads and membership would be shared with the STP CPB. A workshop was planned for January to review working together, with a piece of work taking place to look at how the collaboratives were working. All areas of commonality would be addressed as part of this.	**STP PMO**

	The intention was for private boards to use these as part of communications out to organisations. It was noted that a session around governance to include the Local Authority Chief Executives would be useful and would be considered. The STP CPB noted the summary update and agreed this would be used to inform local discussions and form part of a consistent approach of partners taking through their organisations.	**ALL**
23/16	**Terms of reference** The STP CPB noted the revisions to the interim ToR since the previous meeting. WCG highlighted discussions that had taken placed around primary care representation at the meetings and this may impact on governance and the ToR when resolved. The ToR would be brought back to the next meeting as final. Further comments were received by the STP CPB as follows: - that Doncaster Children's Trust be added to the TOR. - that the key responsibly of the STP CPB was to engage with patients and the public in the work of the STP and this be added. - that engaging trade unions be considered further - that "consider" replace "adopt" under paragraph 2. Any further comments were requested by 24 December 2016.	**ALL**
24/16	**Independent review of hospital services** A summary of the comments received since the 11 November STP CPB was delivered and the group was invited to comment further. It was requested that resilience be added to theme and scope as many rotas, currently sustainable, were close to being unsustainable and this needed addressing. It was noted that themes should focus on outcomes as well as effectiveness. It was requested that governance links be made across with this work and membership across the groups (this work, the JCCC, the STP CPB) should be consistent. It was noted that a clinical chair on the steering group was positive however this should also have a commissioning officer as support and a link through to the commissioning review. A comment was made that the review should be cognisant of other reviews taking place across the region and the knock-on impact across trusts and factor in impact of other reconfigurations. A discussion took place around research as a key driver within the sustainable hospital review terms of reference and how this might unduly impact on the scope of the review. A comment was made that research	

	helped to attract and maintain workforce and therefore whilst research was not the main criterion for assessing sustainability it was non the less an important criterion to consider. The STP CPB approved the TOR and specification, subject to amendments and discussion at the meeting.	
25/16	**Communications and engagement approach to public consultation** This item would be deferred until the next meeting.	
26/16	**SYB STP resources** The STP CPB noted the action from the previous meeting for the STP Finance Oversight Committee (FOC) to consider a fair shares proposal and provide clarity around the impact of this. A possible additional funding requested from NHS E/I was noted that could reduce the contribution requirements from partners. An indicative budget for 17/18 was put forward noting final budgets to be brought back to the STP CPB in March around 17/18. This paper had been shared widely with finance colleagues. The STP CPB noted principles and activity taking place that may impact on 17/18: - National transformation funding - Review of how work together - Review of NHS E around resource, ALB support the STPs - Review of commissioning The STP CPB were invited to comment. It was noted that Nottinghamshire County Council be added into the proposals. A query was also raised around some omitted providers, to be addressed. The proposal was made to the group that local authorities would take away and consider a proposal in due course which would be based on focusing support in each local place and therefore be removed from the SYB fair shares approach. This was agreed. In response to a query raised, it was confirmed that money for 16/17 would come out of cost pressures immediately and further work was required for future years. The timeline for further development of the 17/18 indicative plan would be brought back to March 2017 board. The STP CPB were asked to note that system commissioning must be regarded as core business moving forward and to consider existing resources differently. In response to a query it was confirmed that the repurposing of some existing resource was taking place to support communal aims of the STP. The STP CPB noted the fair shares approach and supported the proposal and the STP budget, subject to confirmation of actual costs and	**JEREMY COOK, LA CEOS**

	the reworking of the fair shares approach, following the decision above.	
27/16	**Healthy Lives** This item would be deferred until the next meeting.	
28/16	**Health disability and employment** This item would be deferred until the next meeting.	
29/16	**Social Kinetic 3De proposal for leadership analysis** A presentation was delivered to the STP CPB, noting that a change readiness tool was being developed with NHS E and had been piloted successfully. The Social Kinetic were looking to test this pilot in its second phase with the SYB STP. The background to the 3d framework and tool was outlined to the STP CPB, including opportunities for the SYB STP. As part of this work, a facilitated workshop would take place to map the ecosystem, the data would be analysed and a further workshop to dissect the data would follow. The action plan was collaboratively created. Post event support was also given. The SYB STP leadership team would work together on the vision for the ecosystem blueprint for change to develop a blue print of the ecosystem and how it fitted together. The STP CPB were invited to comment. It was noted that this was an effective organisational development tool and applying to a whole ecosystem would be interesting. Some concerns were noted around the commitment of senior leader's time. It was confirmed that the Y&H Academic Health and Science Network were paying for the academic evaluation by York Health Economic Consortium that will support the activity. In response to a query, it was confirmed that the programme had been designed around working within the NHS and the workshops were interactive to enable a clear and collaborative understanding of the issues. Extra time was also built into the schedule to refine and work with all to ensure the best possible outputs, outcomes and return of investment. A discussion took place around the future potential of rolling this out to the wider workforce however this would have to be a separate activity. The STP CPB discussed the possibility of creating an OD work stream and this linked to early discussions around leadership development that were taking place. The STP CPB would take this forward in principle with a smaller leadership group to consider the detail. A meeting would be arranged for January 2016 for this. Social Kinetic would discuss via WCG in further detail with a view to starting in February 2017.	**STP PMO**

30/16	**Review of Commissioning** This paper was formally noted by the STP CPB.	
31/16	**Specialised Commissioning Transformation Programmes in Yorkshire and the Humber** This paper was formally noted by the STP CPB.	
32/16	**Next steps on STPs and the 17-19 planning round** This paper was formally noted by the STP CPB.	
33/16	**Unadopted minutes of the STP Finance Oversight Committee meeting on 13 December 2016** This paper was formally noted by the STP CPB.	

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
FEBRUARY 2017			
CE Report	CGOC Minutes	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Monitor Quarterly Declaration Q3		
Nursing Workforce	Board Assurance Framework & corporate risk register Q3		
MB Minutes	ANCR Minutes		
HWB Decision Summary			
Financial Oversight Minutes			
MARCH 2017			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Budget Setting / Business Planning / Draft Annual Plan	Committees in Common
Business Intelligence Report	Monitor Q3 Results Notification	Staff Survey	
Nursing Workforce		Fred & Ann Green Legacy minutes	
MB Minutes			
HWB Decision Summary			
Financial Oversight Minutes			
APRIL 2017			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Business Intelligence Report	Chief Executive's Objectives	Draft Quality Account	RFID (part 2)
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report	Budget Setting / Business Planning / Final Annual Plan	
MB Minutes	R&D Strategy metrics (in BIR)		
HWB Decision Summary	Safeguarding & maternity metrics (in BIR)		
Financial Oversight Minutes	P&OD Quarterly report		
MAY 2017			
CE Report	Monitor Quarterly Declaration Q4	Annual Report	
Business Intelligence Report	CGOC Minutes	Quality Account	
Nursing Workforce	Report from the Chair of the ANCR committee (Verbal)	Annual accounts	
MB Minutes	Board Assurance Framework & corporate	ISA260 and quality account assurance	

As at 20 July 2016

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
	risk register Q4 (inc. annual assurance summary)		
HWB Decision Summary		Charitable Funds minutes	
Financial Oversight Minutes		Statement of Compliance – Elimination of Mixed-Sex Accommodation	
JUNE 2017			
CE Report	Board Assurance Framework	MB Annual Report	
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Monitor Q4 Results Notification	ANCR Annual Report	
Bed Plan			
MB Minutes			
Financial Oversight Minutes			
JULY 2017			
CE Report	Chief Executive's Objectives	CGOC Annual Report	Reference Costs
Business Intelligence Report	Complaints, Compliments, Concerns and Comments Report		
Nursing Workforce	R&D Strategy metrics (in BIR, to include R&D annual summary)		
MB Minutes	Safeguarding & maternity metrics (in BIR)		
Financial Oversight Minutes	P&OD Quarterly report		
NHSI Undertakings tracker	ANCR Minutes		
AUGUST 2017			
CE Report	Monitor Quarterly Declaration Q1	Proposed AMM arrangements	Annual Revalidation update(medical)
Business Intelligence Report	CGOC minutes	Annual Security Report	
Nursing Workforce	Board Assurance Framework & corporate risk register Q1	Infection Control Annual Report	
MB Minutes	ANCR Minutes		
Financial Oversight Minutes			
NHSI Undertakings tracker			

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
SEPTEMBER 2017			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Risk Policy	
Business Intelligence Report	Monitor Q1 Results Notification	Fred & Ann Green Legacy minutes	
Nursing Workforce		Annual Security Report	
MB Minutes			
Financial Oversight Minutes			
NHSI Undertakings tracker			
OCTOBER 2017			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives		
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Financial Oversight Minutes	Safeguarding & maternity metrics (in BIR)		
NHSI Undertakings tracker	P&OD Quarterly report		
NOVEMBER 2017			
CE Report	CGOC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Business Intelligence Report	Monitor Quarterly Declaration Q2		
Nursing Workforce	Board Assurance Framework & corporate risk register Q2		
MB Minutes			
Financial Oversight Minutes			
NHSI Undertakings tracker			
DECEMBER 2017			
CE Report	Monitor Q2 results notification		Team Doncaster Update
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)		
Nursing Workforce			
Grip & Control Plan			
MB Minutes			

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
Financial Oversight Minutes			
NHSI Undertakings tracker			
JANUARY 2018			
CE Report	ANCR minutes	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Financial Oversight Minutes	Safeguarding & maternity metrics (in BIR)		
	P&OD Quarterly report		

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)